



**State of Louisiana**  
Louisiana Department of Health  
Office of the Secretary

April 19, 2023

James G. Scott, Director  
Division of Program Operations  
Medicaid & CHIP Operations Group  
601 East 12<sup>th</sup> Street, Room 0300  
Kansas City, Missouri 64106-2898


RE: Louisiana Title XIX State Plan  
Transmittal No. 23-0006

Dear Mr. Scott:

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan. Should you have any questions or concerns regarding this matter, please contact Karen Barnes at (225) 342-3881 or via email at [Karen.Barnes@la.gov](mailto:Karen.Barnes@la.gov).

Sincerely,

 \_\_\_\_\_, for  
Stephen R. Russo, JD  
Executive Counsel

Attachments (3)

CNP:TAL:UN

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER <b>23-0006</b>	2. STATE <b>LA</b>
	3. PROGRAM IDENTIFICATION: TITLE <u>XIX</u> OF THE SOCIAL SECURITY ACT	

TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <b>May 1, 2023</b>
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5. FEDERAL STATUTE/REGULATION CITATION <b>42 CFR 447, Subpart F</b>	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2023</u> <b>\$2,327,007</b> b. FFY <u>2024</u> <b>\$4,872,820</b>
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7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  <b>Attachment 4.19-D, Page 15a</b> <b>Attachment 4.19-D, Pages 16-16a</b> <b>Attachment 4.19-D, Pages 17 and 19</b> <b>Attachment 4.19-D, Page 23</b>	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <b>Same (TN 22-0011)</b> <b>Same (TN 07-05)</b> <b>Same (TN 05-33)</b> <b>Same (TN 21-0001)</b>
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9. SUBJECT OF AMENDMENT  
**The purpose of this SPA is to amend the provisions governing the reimbursement methodology for ICFs/IID in order to allow for an additional add-on rate for comprehensive dental care provided to Medicaid beneficiaries age 21 or older who reside in these facilities.**

10. GOVERNOR'S REVIEW (Check One)

<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT	<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor does not review State Plan material.
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	
<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	

11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. RETURN TO  <b>Tara A. LeBlanc, Medicaid Executive Director</b> <b>Louisiana Department of Health</b> <b>628 North 4<sup>th</sup> Street</b> <b>P.O. Box 91030</b> <b>Baton Rouge, LA 70821-9030</b>
12. TYPED NAME <b>Pam Diez, designee for Stephen R. Russo, JD</b>	
13. TITLE      Executive Counsel <del>Secretary</del> Director of Legal Audit and Regulatory Compliance	
14. DATE SUBMITTED <del>April 14, 2023</del> April 19, 2023	

**FOR CMS USE ONLY**

16. DATE RECEIVED	17. DATE APPROVED
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**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL	19. SIGNATURE OF APPROVING OFFICIAL
20. TYPED NAME OF APPROVING OFFICIAL	21. TITLE OF APPROVING OFFICIAL

22. REMARKS    **The State makes pen and ink changes to boxes 13 and 14, prior to submittal.**

LA TITLE XIX SPA

TRANSMITTAL #: 23-0006

TITLE: ICF-IID Reimbursement Methodology - Dental Services

EFFECTIVE DATE: May 1, 2023

**FISCAL IMPACT:**

Increase

	year	% inc.	fed. match		*# mos	range of mos.	dollars
1st SFY	2023			0.00%	2.33	April 20, 2023 - June 2023	\$1,658,476
2nd SFY	2024			0.00%	12	July 2023- June 2024	\$7,200,857
3rd SFY	2025			0.00%	12	July 2024 - June 2025	\$7,200,857

\*#mos-months remaining in fiscal year

**Total increase or decrease cost FFY 2023**

SFY 2023 \$1,658,476 for 2.33 months April 20, 2023 - June 2023 \$1,658,476

SFY 2024 \$7,200,857 for 12 months July 2023- June 2024  
 \$7,200,857 / 12 X 3 July 2023 - September 2023 = \$1,800,214  
\$3,458,690

**FFP (FFY 2023 ) = \$3,458,690 X 67.28% = \$2,327,007**

**Total increase or decrease cost FFY 2024**

SFY 2024 \$7,200,857 for 12 months July 2023- June 2024  
 \$7,200,857 / 12 X 9 October 2023 - June 2024 = \$5,400,643

SFY 2025 \$7,200,857 for 12 months July 2024 - June 2025  
 \$7,200,857 / 12 X 3 July 2024 - September 2024 = \$1,800,214  
\$7,200,857

**FFP (FFY 2024 )= \$7,200,857 X 67.67% = \$4,872,820**

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

The Department may impose sanctions for noncompliance with Medicaid laws, regulations, rules, and policies. Facilities that have payments reduced as a result of the imposition of the direct care floor with consecutive subsequent years of reduced payments, shall incur the following safe harbor and administrative penalties:

<b>Consecutive Cost Report Period with Reduced Payments</b>	<b>Administrative Penalty Levied on Reduced Payments</b>	<b>Safe Harbor Percentages</b>
1st Year	0%	104%
2 <sup>nd</sup> Year	0%	102%
3 <sup>rd</sup> Year	5%	100%
4 <sup>th</sup> Year and Onwards	10%	100%

At its discretion, the Department may terminate provider participation in the complex care or pervasive plus add-on payment programs, as a result of imposition of the direct care floor.

Upon completion of desk reviews or audits, facilities will be notified by the Department of any changes in amounts due based on audit or desk review adjustments.

3. Rate Determination

Resident specific per diem rates are calculated based on information reported on the cost report. The cost data used in setting base rates will be from the latest available audited or desk reviewed cost reports. The initial rates will be adjusted to maintain budget neutrality upon transition to the ICAP reimbursement methodology.

To adjust budget neutrality, at implementation, the direct care component is multiplied by 105 percent of the previously stated calculation. For rate periods between rebasing, the rates will be trended forward using the Skilled Nursing Facility without Capital Market Basket Index, published by IHS Global Insight, Inc. (IGI), formerly Data Resources Inc. (DRI), for December 2018, divided by the index for December 2017.

For dates of service on or after October 1, 2005, a resident’s per diem will be the sum of:

- a. direct care per diem rate;
- b. care related per diem rate;
- c. administrative and operating per diem rate;
- d. capital rate;
- e. provider fee; and
- f. dental pass-through/add-on per diem rate

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Determination of Rate Components

- a. The direct care per diem rate shall be a set percentage over the median adjusted for the acuity of the resident based on the ICAP, tier based on peer group. The direct care per diem rate shall be determined as follows:

Median Cost. The direct care per diem median cost for each ICF/IID is determined by dividing the facility's total direct care costs reported on the cost report by the facility's total days during the cost reporting period. Direct care costs for providers in each peer group are arrayed from low to high and the median (50<sup>th</sup> percentile) cost is determined for each group.

Median Adjustment. The direct care component shall be adjusted to 105 percent of the direct care per diem median cost in order to achieve reasonable access to care.

Inflationary Factor. These costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

Acuity Factor. Each of the ICAP levels will have a corresponding acuity factor. The median cost by peer group, after adjustments, shall be further adjusted by the acuity factor (or multiplier) as follows:

ICAP Support Level	Acuity Factor (Multiplier)
Pervasive	1.35
Extensive	1.17
Limited	1.00
Intermittent	.90

**Direct Care Worker Wage Enhancement.** For dates of service on or after February 9, 2007, the direct care reimbursement to ICF-IID providers shall include a direct care service worker wage enhancement incentive in the amount of \$2 per hour. The wage enhancement will be added on to the current ICAP rate methodology as follows:

- i. Per diem rates for recipients residing in 1 - 8 bed facilities will be increased by \$16.00;
- ii. Per diem rates for recipients residing in 9 - 16 bed facilities will be increased by \$15.00; and
- iii. Per diem rates for recipients residing in 16+ bed facilities will be increased by \$8.00.

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- b. The care related per diem rate shall be a statewide price at a set percentage over the median and shall be determined as follows:
- Median Cost. The care related per diem median cost for each ICF/IID is determined by dividing the facility's total care related costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Care related costs for all providers are arrayed from low to high and the median (50<sup>th</sup> percentile) cost is determined.
- Median Adjustment. The care related component shall be adjusted to 105 percent of the care related per diem median cost in order to achieve reasonable access to care.
- Inflationary Factor. These costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.
- c. The administrative and operating per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The administrative and operating component shall be determined as follows:
- Median Cost. The administrative and operating per diem median cost for each ICF/IID is determined by dividing the facility's total administrative and operating costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Administrative and operating costs for all providers are arrayed from low to high and the median (50<sup>th</sup> percentile) cost is determined.
- Median Adjustment. The administrative and operating component shall be adjusted to 103 percent of the administrative and operating per diem median cost in order to achieve reasonable access to care.
- Inflationary Factor. These costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.
- d. The capital per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The capital per diem rate shall be determined as follows:
- Median Cost. The capital per diem median cost for each ICF/IID is determined by dividing the facility's total capital costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Capital costs for providers of each peer group are arrayed from low to high and the median (50<sup>th</sup> percentile) cost is determined for each peer group.
- Median Adjustment. The capital cost component shall be adjusted to 103 percent of the capital per diem median cost in order to achieve reasonable access to care.
- Inflationary Factor. Capital costs shall not be trended forward.
- e. The provider fee shall be calculated by the Department in accordance with state and federal rules.

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- f. The dental add-on per diem rate shall be a statewide price, and the pass-through, once calculated, will be facility specific. This pass-through/add-on may be adjusted annually, and will not follow the rebasing and inflationary adjustment schedule. The dental pass-through/add-on per diem rate shall be determined as follows:
- i. Prior to inclusion of these costs on facility cost reports, a per diem add-on will be created based on estimates provided by the state's actuary and should reflect the costs associated with those basic dental services that are excluded from the dental per member per month (PMPM) paid to the Louisiana Medicaid dental managed care entity(ies).
  - ii. The above dental add-on per-diem, but not the pass-through rate, paid to each facility will be subject to a wholly separate and distinct floor calculation for each cost report year that the per-diem is in effect, beginning July 1, 2023. The total sum of the per-diem add-on paid to each facility will be compared to each facility's costs associated with basic dental services that are excluded from the dental PMPMs paid to the Louisiana Medicaid dental managed care entity(ies). Should 95 percent of the total per-diem add-on paid exceed the facility's noted cost, the facility shall remit, to the Bureau, the difference between these two amounts.
  - iii. Once these dental expenses have been recognized in a facility's cost report with a year ended on or after June 30, 2024 that is utilized in a rate rebase period, the add-on will no longer be paid to that facility and a facility's specific pass-through per-diem rate will be calculated as the total dental cost reported on the cost report, divided by total cost report patient days. These per-diem rates and costs will follow the same oversight procedures as noted under number 8 – Audits. The facility specific pass-through per-diem may be reviewed and adjusted annually, at the discretion of the Department.

Peer Groups

The rates for the 1-8 bed peer group shall be set on costs in accordance with provisions in D.3. above. The reimbursement rates for peer groups of larger facilities will also be set in accordance with the provisions in D.3. above; however, the rates, excluding any dental pass-through/add-on will be limited as follows:

Reimbursement rates for the 9-15 bed peer group will be limited to 95 percent of the 1-8 bed peer group reimbursement rates.

Reimbursement rates for the 16-32 bed peer group will be limited to 95 percent of the 9-15 bed peer group reimbursement rates.

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desk reviews of a sample of ICAP submissions; and on-site field review of ICAPs.

ICAP Review Committee

The ICAP Review Committee shall represent LDH should a provider request an informal reconsideration regarding the department's determination. The committee shall make final determination on any ICAP level of care changes prior to the appeals process. When an ICAP score is determined to be inaccurate, the department shall notify the provider and request documentation to support the level of care. If the additional information does not support the level of care, an ICAP rate adjustment will be made to the appropriate ICAP level effective the first day of the month following the determination.

8. Audits.

All providers who elect to participate in the Medicaid program shall be subject to financial and compliance audits by state and federal regulators or their designees. Audit selection for the Department shall be at the discretion of LDH.

In addition to the exclusions and adjustments made during desk reviews and on-site audits, LDH may exclude or adjust certain expenses in the cost report data base in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur.

The facility shall retain such records or files as required by LDH and shall have them available for inspection for five years from the date of service or until all audit exceptions are resolved, whichever period is longer.

9. Exclusions from the database.

Providers with disclaimed audits and providers with cost reports for other than a 12-month period will be excluded from the database used to calculate the rates.

Providers who do not submit ICAP scores will be paid at the intermittent level until receipt of ICAP scores.



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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

**Temporary Reimbursement for Private Facilities**

- A. Effective February 2, 2021, the Department shall establish temporary Medicaid reimbursement rates of \$352.08 per day per individual for a 15-bed private ICF/IID community home and \$327.08 for an 8-bed private ICF/IID community home that meet the following criteria. The community home:
1. shall have a fully executed cooperative endeavor agreement (CEA) with the Office for Citizens with Developmental Disabilities (OCDD) for the private operation of the facility and shall be subject to the direct care floor as outlined in the executed CEA;
  2. shall have a high concentration of people who have intellectual/developmental disabilities with significant behavioral health needs, high risk behavior, i.e. criminal-like, resulting in previous interface with the judicial system, use of restraint, and elopement. These shall be people for whom no other private ICF/IID provider is able to support as confirmed by OCDD;
  3. incurs or will incur higher existing costs not currently captured in the private ICF/IID rate methodology; and
  4. shall have no more than 15-beds in one facility and 8-beds in the second facility.
- B. The temporary Medicaid reimbursement rate shall only be for the period of four years.
- C. The temporary Medicaid reimbursement rate is all-inclusive and incorporates the following cost components:
1. direct care staffing;
  2. medical/nursing staff;
  3. medical supplies;
  4. transportation;
  5. administrative;
  6. the provider fee; and
  7. dental pass-through/add-on per diem rate