

STATE OF LOUISIANA

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:

10. Private Facilities Dedicated Program Funding Pool Payments

Effective for providers licensed and operating Medicaid certified as of September 1, 2019; a one-time lump sum payment will be made to intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

Methodology

- A. Payment will be based on each provider's specific pro-rated share of an additional dedicated program funding pool not to exceed \$4,665,635.
- B. The pro-rated share for each provider will be determined utilizing the provider's percentage of total annualized program Medicaid days. -Annualized program Medicaid days will be calculated utilizing the most recently desk reviewed or audited cost reports as of July 1, 2019.
- C. The additional dedicated program funding pool lump sum payments shall not exceed the Medicare upper payment limit in the aggregate for the provider class.
- D. The one-time payment will be made for the fiscal year ending June 30, 2020.

A one-time lump sum payment will be made to ICF/IID providers licensed and operating as of August 3, 2022.

Methodology

- A. Payment will be based on each provider's specific pro-rated share of an additional dedicated program funding pool totaling \$27,974,178.
- B. The pro-rated share for each provider will be determined utilizing the provider's percentage of program Medicaid days for dates of service in a three consecutive month period selected by the Department occurring between January 1, 2022 and December 31, 2022.
- C. If the additional dedicated program funding pool lump sum payments exceed the Medicare upper payment limit in the aggregate for the provider class, the Department shall recoup the overage using the same means of distribution stated above.
- D. The one-time payment will be made on or before June 30, 2023.
- E. All facilities receiving payment shall be open and operating as an ICF/IID at the time the payment is made.

~~11. —RESERVED~~

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Effective for providers, active and Medicaid certified as of July 1, 2024, a one-time lump sum payment will be made to non-state, non-public ICF/IID.

Methodology

- A. Payment will be based on each provider's specific prorated share of an additional dedicated program funding pool. This payment shall not exceed \$31,000,000.
- B. The prorated share for each provider will be determined utilizing the provider's percentage of program Medicaid days for dates of service within a period of three consecutive months selected by the Department, occurring between January 1, 2024, and December 31, 2024.
- C. If the additional dedicated program funding pool lump sum payment exceeds the Medicare upper payment limit in the aggregate for the provider class, the Department shall recoup the overage using the same means of distribution stated above.
- D. The one-time payment will be made on or before June 30, 2025.
- E. All facilities receiving payment shall be open and operating as an ICF/IID at the time the payment is made.

~~42.11.~~ 11. Complex Care Reimbursements

- A. Private (non-state) owned ~~intermediate care facilities for individuals with intellectual disabilities (ICFs IID)~~ ICF/IID may receive an add-on payment to the per diem rate for providing complex care to Medicaid beneficiaries when medically necessary. The add-on payment shall be a flat fee daily amount and consists of payment for one of the following components alone or in combination:

- 1. equipment add-on;
- 2. direct service worker (DSW) add-on; and
- 3. skilled nursing add-on.

- B. To qualify, beneficiaries must meet medical necessity criteria established by the Medicaid program. Supporting medical documentation must also be submitted as specified by the Medicaid program. The duration of approval of the add-on payment(s) is at the sole discretion of the Medicaid program and shall not exceed one year.

Medical necessity of the add-on payment(s) shall be reviewed and re-determined by the Medicaid program no less than annually from the date of initial approval of each add-on payment. This review shall be performed in the same manner and using the same medical necessity criteria as the initial review.

- C. Each add-on payment requires documentation that the enhanced supports are already being provided to the beneficiary, as specified by the Medicaid program.

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- D. One of the following admission requirements must be met in order to qualify for the add-on payment:
1. The beneficiary has been admitted to the facility for more than 30 days with supporting documentation of medical necessity; or
  2. The beneficiary is transitioning from another similar agency with supporting documentation of medical necessity.
- E. The following additional requirements apply:
1. Beneficiaries receiving enhanced rates must be included in annual surveys to ensure continuation of supports and review of individual outcomes.
  2. Fiscal analysis and reporting is required annually.
- F. The Medicaid program requires compliance with all applicable laws, rules, and regulations as a condition of an ICF/IID qualifying for any complex care add-on payment(s), and may evaluate such compliance in its initial and annual qualifying reviews.