III. METHOD FOR REIMBURSEMENT TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

A. INTRODUCTION

Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are defined as intermediate care facilities whose primary purpose is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions and which meet the standards in Subpart D or Part 483 of the Code of Federal Regulations.

B. PROVIDER GROUPING

Providers are divided into two major groups, Public and Private.

1. Public ICF/MR Facilities

   a. State-owned or operated facilities.
   b. A quasi-public facility is an ICF/MR facility that:
      i. is an organization that is a component unit of a governmental reporting entity, and
      ii. receives funding in excess of $25,000 directly from the owner governing body for operation of the facility.

SUPERSEDES TN 89-45

2. Private ICF/MR Facilities

Included under this classification are private proprietary and nonprofit facilities who are grouped based upon peer group.

Peer group classifications are as follows:

a. 1-8 beds;
b. 9-15 beds;
c. 16-32 beds;
d. 33 or more beds.

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C. REIMBURSEMENT TO PUBLIC ICF/MR PROVIDERS

1. Effective February 9, 2003, Medicaid payments to state-owned and operated ICFs/MR shall be based on the basic Medicare formula for determining the routine service cost limits, as follows:

   a. Calculate each state owned and operated ICF/MR's per diem routine costs in a base year;
   b. Inflate each facility's routine cost per diem to the rate year using the skilled nursing facility (SNF) market basket index of inflation;
   c. Inflate each facility's routine cost per diem determined in b. by 12%;

d. Each state-owned and operated facility's capital and ancillary costs will be paid on a "pass-through" basis.

The sum of the calculations for routine service costs and the capital and ancillary costs "pass-through" shall be the per diem rate for each state-owned and operated ICF/IID. The base year cost reports to be used for the initial calculations shall be the cost reports for the fiscal year ended June 30, 2002.

Effective for the dates on or after October 1, 2012, a transitional Medicaid reimbursement rate of $302.08 per day per individual shall be established for a public ICF/IID facility over 50 beds that is transitioning to a private provider, as long as the provider meets the following criteria:

a. shall have a fully executed agreement with the Office for Citizens with Developmental Disabilities (OCDD) for the private operation of the facility;
b. shall have a high concentration of medically fragile individuals being served, as determined by LDH. For the purposes of these provisions, a medically fragile individual shall refer to an individual who has a medically complex condition characterized by multiple, significant medical problems that require extended care;
c. incurs or will incur higher existing costs not currently captured in the private ICF/IID rate methodology; and
d. shall agree to downsizing and implement a pre-approved OCDD plan.

Effective for the dates on or after October 1, 2013, the transitional Medicaid reimbursement rate shall only be for the period of transition, which is defined as the term of the agreement or a period of four years, whichever is shorter. The transitional Medicaid reimbursement rate is all inclusive and incorporates the following cost components:

a. direct care staffing;
b. medical/nursing staff, up to 23 hours per day;
c. medical supplies;
d. transportation costs;
e. administrative and operating costs; and
f. the provider fee.

If the community home meets the above criteria and the individuals served require that the community home has a licensed nurse at the facility 24 hours per day, seven days per week, the community home may apply for a supplement to the transitional rate. The supplement to the rate shall not exceed $25.33 per day per individual. The total transitional Medicaid reimbursement rate, including the supplement, shall not exceed $327.41 per day per individual.

Effective for dates of service on or after October 1, 2014, the transitional Medicaid reimbursement rate shall be increased by $1.85 of the rate in effect on September 30, 2014.

State: Louisiana
Date Received: October 23, 2017
Date Approved: DEC 13 2017
Date Effective: October 1, 2017
Transmittal Number: 17-0027

Effective October 1, 2017, the Department may extend the period of transition for ARC of Acadiana (Bossier) for an additional year, if deemed necessary.

Effective October 11, 2018, the Department may extend the period of transition for ARC of Acadiana (Bossier) for two additional years, if deemed necessary.

The transitional rate and supplement shall not be subject to the following:
a. inflationary factors or adjustments;
b. rebasing;
c. budgetary reductions; or
d. other rate adjustments.

Any ICF/IID home to which individuals transition to satisfy downsizing requirements, shall not exceed 6-8 beds.

No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

2. Quasi-public facilities are reimbursed a facility specific prospective rate based on budgeted costs. Providers submit a projected budget for the state fiscal year (SFY) beginning July 1. Rates are determined as follows:

   a. Determine each ICF/IID's per diem for the base year beginning July 1.
   b. Calculate the inflation factor using an average CPI index applied to each facility's per diem for the base year to determine the inflated per diem.
   c. Calculate the median per diem for the facilities' base year.
   d. Calculate the facility's routine cost per diem for the SFY beginning July 1, by using the lowest of the budgeted, inflated, or median per diem rates plus any additional allowances.
   e. Calculate the final approved per diem rate for each facility by adding routine costs plus any "pass through" amounts for ancillary services, provider fees, and grant expenses.
   f. Providers may request a final rate adjustment subject to submission of supportive documentation and approval by the LDH rate committee.

D. REIMBURSEMENT TO PRIVATE ICF/IID PROVIDERS

Private providers are reimbursed a per diem rate for each resident. Rates are calculated based on information reported on the cost report.

1. **Definitions**

   a. *Acuity Factor*—an adjustment factor which will modify the direct care portion of the Inventory for Client and Agency Planning (ICAP) rate based on the ICAP level for each resident.

State: Louisiana
Date Received: October 18, 2018
Date Approved: NOV 0 1 2018
Date Effective: October 11, 2018
Transmittal Number: 18-0018

b. *Administrative and Operating Costs*—include: in-house and contractual salaries; benefits; taxes for administration and plant operation maintenance staff; utilities; accounting; insurances; maintenance staff; maintenance supplies; laundry and linen; housekeeping; and other administrative type expenditures.

c. *Capital Costs*—include: depreciation; interest expense on capital assets; leasing expenses; property taxes; and other expenses related to capital assets.

d. *Care Related Costs*—include in-house and contractual salaries, benefits, taxes, and supplies that help support direct care but do not directly involve caring for the patient and ensuring their well being (e.g., dietary and educational). Care related costs would also include personal items, such as clothing, personal hygiene items (soap, toothpaste, etc), hair grooming, etc.

e. *Direct Care Costs*—consist of all costs related to the direct care interaction with the patient. *Direct care costs* include:

- in-house and contractual salaries;
- benefits; and
- taxes for all positions directly related to patient care, including: medical; nursing; therapeutic and training; ancillary in-house services; and recreational.

f. *ICAP—Inventory for Client and Agency Planning.* A standardized instrument for assessing adaptive and maladaptive behavior and includes an overall service score. This ICAP service score combines adaptive and maladaptive behavior scores to indicate the overall level of care, supervision or training required.

g. *ICAP Service Level—r*anges from 1 to 9 and indicates the service need intensity. The lower the score the greater is the client need.

h. *ICAP Service Score*—indicates the level of service intensity required by an individual, considering both adaptive and maladaptive behavior.

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Note: The relationship between the service level and service score for ICAP support levels is as follows:

ICAP Relationship Graph

ICAP Service Level	ICAP Service Score	ICAP Support Levels
		Pervasive +
1	1-19	Pervasive
2	20-29	Extensive
3	30-39	
4	40-49	Limited
5	50-59	
6	60-69	
7	70-79	Intermittent
8	80-89	
9	90+	

i. *Index Factor*—this factor will be based on the *Skilled Nursing Home without Capital Market Basket Index* published by Data Resources Incorporated or a comparable index if this index ceases to be published.

j. *Level of Care(LOC)* – service needs of the client based upon his/her comprehensive functional status.

k. *Pass through Cost Component*—includes the provider fee.

l. *Peer Group*—the administrative and operating per diem rate and the capital per diem rate are tiered based on peer group size. Peer groups are as follows:

i. 1 - 8 beds;

ii. 9 - 15 beds;

iii. 16 - 32 beds;

iv. 33 or more beds.

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m. *Rate Year*—a one-year period corresponding to the state fiscal year from July 1 through June 30.

n. *Rebasing*—recalculation of the per diem rate components using the latest available audited or desk reviewed cost reports.

o. *Support Levels*—describe the levels of support needed by individuals with mental retardation and other developmental disabilities. The five descriptive levels of service intensity using the ICAP assessment are summarized below.

i. Intermittent - supports on an as needed basis. Characterized as episodic in nature, the person does not always need the support(s), or short-term supports needed during life-span transition (e.g., job loss or an acute medical crisis). Intermittent supports may be high or low intensity when provided.

ii. Limited - supports characterized by consistency over time, time-limited but not of an intermittent nature, may require fewer staff members and less costs than more intense levels of support (e.g., time-limited employment training or transitional supports during the school to adult provided period).

iii. Extensive - supports characterized by regular involvement (e.g., daily) in at least some environment (such as work or home) and not time-limited (e.g., long term support and long-term home living support).

iv. Pervasive - supports characterized by their constancy, high intensity; provided across environments; potential life-sustaining nature. Pervasive supports typically involve more staff members and intrusiveness than do extensive or time-limited supports.

v. Pervasive Plus - a time-limited specific assignment to supplement required Level of Need services or staff to provide life sustaining complex medical care or to supplement required direct care staff due to dangerous life threatening behavior so serious that it could cause serious physical injury to self or others and requires additional trained support staff to be at "arm's length" during waking hours.

2. Cost Reports

Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) are required to report all reasonable and allowable costs using the state-specific cost report, including any supplemental schedules designated by the Department. Each provider shall submit an annual cost report for the fiscal year ending June 30, within ninety (90) days after the State's fiscal year ends.

Limited exceptions for extensions to the cost report filing requirements will be considered on an individual facility basis, upon written request by the provider to the Medicaid director or designee. Providers must attach a statement fully describing the nature of the exception request. The extension must be requested by the normal due date of the cost report.

State: Louisiana
Date Received: September 12, 2018
Date Approved: OCT 23 2018
Date Effective: August 20, 2018
Transmittal Number: 18-0011

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:

Direct Care Floor

A facility wide direct care floor may be enforced upon deficiencies related to direct care staffing requirements noted during the Health Standards Section (HSS) annual review or during a complaint investigation.

For providers receiving pervasive plus supplements, the facility wide direct care floor is established at 94 percent of the per diem direct care payment and at 100 percent of any rate supplements or add-on payments received by the provider, including the pervasive plus supplement, the complex care add-on payment and other client-specific adjustments to the rate. The direct care floor will be applied to the cost-reporting year in which the facility receives a pervasive plus supplement and/or a client-specific rate adjustment. In no case, however, shall a facility receiving a pervasive plus supplement and/or client-specific rate adjustment, have total facility payments reduced to less than a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except in connection with an administrative penalty as noted below for repeat non-compliance with direct care floor requirements.

For providers receiving complex care add-on payment, but not receiving pervasive plus supplements or other client-specific adjustments to the rate, the facility wide direct care floor is established at 85 percent of the per diem direct care payment and at 100 percent of the complex care add-on payment. The direct care floor will be applied to the cost-reporting year in which the facility receives a complex care add-on payment. In no case shall a facility receiving a complex care add-on payment, have total facility payments reduced to less than a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except in connection with an administrative penalty as noted below for repeat non-compliance with direct care floor requirements.

For facilities to which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to the Department, the difference between these two amounts, times the number of facility Medicaid days paid during the cost-reporting period. This remittance shall be payable to the Bureau upon submission of the cost report.

Effective for dates of service on or after July 1, 2022, if a provider receiving complex care or pervasive plus add-on payments has facility payments reduced as a result of imposition of the direct care floor, the Department may, at its discretion, levy a non-refundable administrative penalty separate from any other reduction in facility payments. The administrative penalty is not subject to any facility specific safe harbor percentage and is calculated solely on the final reduced payment amount for the cost report period in question.

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:

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:

Consecutive Cost Report Period with Reduced Payments	Administrative Penalty Levied on Reduced Payments	Safe Harbor Percentages
1st Year	0%	104%
2nd Year	0%	102%
3rd Year	5%	100%
4th 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; and
   e. provider fee.

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/MR 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 (50th 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-MR 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 $14.93; and

iii. Per diem rates for recipients residing in 16+ bed facilities will be increased by $8.00.

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/MR 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^{th} 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/MR 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 (50th 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/MR 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 (50th 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.

Peer Groups 00-44

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 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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Reimbursement rates for the 33 or more beds peer group will be limited to 95 percent of the 16-32 bed peer group reimbursement rates.

Per Diem Rate Adjustments

Effective for dates of service on or after February 20, 2009, the reimbursement rate shall be reduced by 3.5 percent of the per diem rate on file as of February 19, 2009.

Effective for dates of service on or after September 1, 2009, the reimbursement rate shall be increased by 1.59 percent of the per diem rate on file as of August 31, 2009.

Effective for the dates of service on or after August 1, 2010, the reimbursement rate shall be reduced by 2 percent of the per diem rates on file as of July 31, 2010.

Effective for the dates of service on or after August 1, 2010, per diem rates for ICFs/IID which have downsized from over 100 beds to less than 35 beds prior to December 31, 2010 shall be restored to the rates in effect on January 1, 2009.

Effective for dates of service on or after July 1, 2012, the per diem rates for non-state intermediate care facilities for persons with developmental disabilities (ICFs/IID) shall be reduced by 1.5 percent of the per diem rates on file as of June 30, 2012.

Effective for dates of service on or after July 1, 2020, private ICFs/IID that downsized from over 100 beds to less than 35 beds prior to December 31, 2010 without the benefit of a cooperative endeavor agreement (CEA) with LDH or transitional rate and who incurred excessive capital costs, shall have their per diem rates (excluding provider fees) increased by a percent equal to the percent difference of per diem rates (excluding provider fees) they were paid as of June 30, 2019, as follows:

Peer Groups	Intermittent	Limited	Extensive	Pervasive
1-8 beds	6.2 percent	6.2 percent	6.2 percent	6.1 percent
9-15 beds	3.2 percent	6.2 percent	6.2 percent	6.1 percent
16-32 beds	N/A	N/A	N/A	N/A
33+ beds	N/A	N/A	N/A	N/A

The applicable differential shall be applied anytime there is a change to the per diem rates (for example, during rebase, rate reductions, inflationary changes, or special legislative appropriations). This differential shall not extend beyond December 31, 2024.

Adjustments to the Medicaid daily rate will be made when changes occur that are recognized in updated cost report data; these changes include but are not limited to a change in minimum wage, Federal Insurance Contribution Act changes, or a utility rate change. These rates will be effective until such time that the database used to calculate rates, fully reflects the change.

4. Rebasing

Rebasing of rates will occur at least every three years utilizing the most recent audited and/or desk reviewed cost reports.

5. Requests for Supplemental Services

a. Requests for pervasive plus rate supplement must be reviewed and approved by the LDH ICAP Review Committee. A facility requesting a pervasive plus rate supplement shall bear the burden of proof in establishing the facts and circumstances necessary to support the supplement in a format and with supporting documentation specified by the LDH ICAP Review Committee.

The ICAP Review Committee shall make a determination of the most appropriate staff required to provide requested supplemental services.

The amount of the pervasive plus supplement shall be calculated using the Louisiana Civil Service pay grid for the appropriate position as determined by the ICAP Review Committee and shall be the 25th percentile salary level plus 20 percent for related benefits times the number of hours approved.

b. Other Client Specific Adjustments to the Rate

A facility may request a client specific rate supplement for reimbursement of the costs for enteral nutrition, ostomy, tracheotomy medical supplies or a vagus nerve stimulator. The provider must submit sufficient medical supportive documentation to the ICAP Review Committee to establish medical need for enteral nutrition, ostomy or tracheotomy medical supplies.

The amount of reimbursement determined by the ICAP Review Committee shall be based on the average daily cost for the provision of the medical supplies. The provider must submit annual documentation to support the need for the adjustment to the rate.

Sufficient medical supportive documentation must be submitted to the Prior Authorization Unit to establish medical necessity. The amount of reimbursement shall be the established fee on the Medicaid Fee Schedule for medical equipment and supplies.

6. ICAP Requirements

An ICAP must be completed for each recipient of ICF/IID services upon admission and while residing in an ICF/IID in accordance with departmental regulations.

Providers must keep a copy of the recipient's current ICAP protocol and computer scored summary sheets in the recipient's file. If a recipient has changed ICAP service level, providers must also keep a copy of the recipient's ICAP protocol and computer scored summary sheets supporting the prior level

ICAPs must reflect the resident's current level of care.

Providers must submit a new ICAP to Regional Health Standards office when the resident's condition reflects a change in the ICAP level that indicates a change in reimbursement.

7. ICAP Monitoring

ICAP scores and assessments will be subject to review by LDH and its contracted agents. The reviews of ICAP submissions include, but are not limited to reviews when statistically significant changes occur with ICAP submission(s).

desk reviews of a sample of ICAP submissions; and

on-site field review of ICAPs.

ICAP Review Committee

The ICAP Review Committee shall represent DHH 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 DHH.

In addition to the exclusions and adjustments made during desk reviews and on-site audits, DHH 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 DHH 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.

93-08

STATE Louisiana
DATE RECD 11-28-05
DATE APPVD 3-15-06
DATE EFF 10-1-05
HCFA 179 05-33
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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

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:

12. Complex Care Reimbursements

A. Private (non-state) owned intermediate care facilities for individuals with intellectual disabilities (ICFs-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.

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.

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:

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.

STATE OF LOUISIANA

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; and
    6. the provider fee.

STATE OF LOUISIANA

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 (continued)

D. The temporary rate and supplement shall not be subject to the following:

1. inflationary factors or adjustments;
2. rebasing;
3. budgetary reductions; or
4. other rate adjustments.

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS FOR PAYMENT FOR RESERVING BEDS DURING A RECIPIENT'S ABSENCE FROM AN INPATIENT FACILITY

Intermediate Care Facilities for Individuals with Intellectual Disabilities
Evacuation and Temporary Sheltering Costs

Payment of Eligible Expenses for Medicare and/or Medicaid Licensed Facilities

A. For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses.
   1. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

B. Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the Department by the end of each calendar quarter.

C. All eligible expenses documented and allowed will be removed from allowable expenses when the ICF/IID's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set ICF/IID reimbursement rates in future years.
   1. Equipment purchases that are reimbursed on a rental rate may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the ICF/IID and being used. If the remaining basis requires capitalization then deprecation will be recognized.

D. Payments shall remain under the upper payment limit cap for ICFs/IID.

E. ICFs/IID may also be entitled to reimbursement in accordance with the Medicaid leave day provisions contained in Attachment 4.19-C, Page 1, Paragraph I.A & B.

State: Louisiana
Date Received: June 30, 2017
Date Approved: SEP 15 2017
Date Effective: April 1, 2017
Transmittal Number: 17-0001