STATE PLAN MATERIAL  FOR: HEALTH CARE FINANCING ADMINISTRATION  TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION  DEPARTMENT OF HEALTH AND HUMAN SERVICES  S. TYPE OF PLAN MATERIAL (Check One):  ONEW STATE PLAN  ARENDMENT TO BE CONSIDERED AS NEW PLAN  COMPLETE BLOCKS 5 THRU 10 IP THIS IS AN AMENDMENT (Separate Transmitted for each amendment)  FOR PART HEALTH AND SECTION OR ATTACHMENT:  ACT FOR PART 447 Subpart C  B. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-D, Page 18  10. SUBJECT OF AMENDMENT: The purpose of this amendment is to increase the per diem rate for non-string intermediate care facilities for persons with developmental disabilities.  11. GOVERNOR'S REVIEW (Check One):  GOVERNOR'S REVIEW (Check One):  GOVERNOR'S REVIEW (Check One):  NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE C  13. TYPED NAME:  Alan Levine  14. TITLE:  September 8, 2009  FOR REGIONAL OPPICE USE ONLY  15. DATE SUBMITTED:  September 8, 2009  FOR REGIONAL OPPICE USE ONLY  16. RETURN TO:  State of Louisiana  Department of Health and Hospitals  628 N. 4° Street  PLAN APPROVED - ONE COPY ATTACHED  OFFICIAL:  SEPTECTIVE DATE of APPROVED ATTERIAL  OFFICIAL:	TRANSMITTAL AND NOTICE OF APPROVAL OF		OMB NO. 0938-019	
FOR: HEALTH CARE FINANCING ADMINISTRATION  1. PROGRAM IDENTIFICATION: TITLE XIX OF THE SCHALL SECURITY ACT (MEDICAID)  1. PROGRAM IDENTIFICATION: TITLE XIX OF THE SCHALL SECURITY ACT (MEDICAID)  1. PROPOSED EFFECTIVE DATE  1. PROPOSED EFFECTIVE DATE  1. PROPOSED EFFECTIVE DATE  1. PROPOSED EFFECTIVE DATE  1. September 1, 2009  2. September 1, 2009  3. September 1, 2009  4. PROPOSED EFFECTIVE DATE  3. September 1, 2009  4. PROPOSED EFFECTIVE DATE  4. PROPOSED EFFECTIVE DATE  5. September 1, 2009  5. September 1, 2009  5. September 1, 2009  6. FEDERAL BUDGET IMPACT:  4. FEDERAL BUDGET IMPACT:  4. FEDERAL BUDGET IMPACT:  4. FEDERAL BUDGET IMPACT:  4. FEY 2002  5. FFY 2002  5. FFY 2002  5. FFY 2010  5.		1. TRANSMITTAL NUMBER:		
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### STATE OF LOUISIANA

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.

## 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 DHH 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 DHH 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 25<sup>th</sup> 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.

TN# 09-43 A	pproval Date	OCT 29	2002 ffective Date	9-1-09
Supersedes				
TN# 09-11				