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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: 18-0011 NIRT

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Mrs. Jen Steele, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 18-0011

October 23, 2018

Dear Mrs. Steele:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-0011. This amendment proposes to revise the methodology for intermediate care facilities for individuals with intellectual disabilities (ICF/IID) in order to: 1) clarify the provisions governing cost reports to align the direct care floor requirements for pervasive plus supplemental payments and complex care add-on payments with current practices; 2) require the annual renewal of the complex care add-on rate and submission of the associated documentation; and 3) eliminate the qualifying loss review requirement.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

We are pleased to inform you that Medicaid State plan amendment 18-0011 is approved effective August 20, 2018. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **18 - 0011**
2. STATE: **Louisiana**
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **August 20, 2018**

5. TYPE OF PLAN MATERIAL (Check One)
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447, Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY **2019** $ **0.00**
b. FFY **2020** $ **0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
***continued in box 23**
Attachment 4.19-D, Pages 14
Attachment 4.19-D, Page 15
Attachment 4.19-D, Page 15a
Attachment 4.19-D, Pages 21-22
Attachment 4.19-D, Page 23 (reserve page)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)
Same (TN 05-33)
Same (TN 14-10)
None – New Page
Same (TN 97-18)
Same (TN 97-18)

10. SUBJECT OF AMENDMENT **The SPA proposes to revise the provisions governing the reimbursement methodology for intermediate care facilities for individuals with intellectual disabilities in order to: 1) clarify the provisions governing cost reports to align the direct care floor requirements for pervasive plus supplemental payments and complex care add-on payments with current practices; 2) require the annual renewal of the complex care add-on rate and submission of the associated documentation; and 3) eliminate the qualifying loss review requirement.**

11. GOVERNOR'S REVIEW (Check One)
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor does not review State Plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Rebekah E. Gee MD, MPH

14. TITLE
Secretary

15. DATE SUBMITTED
September 12, 2018

16. RETURN TO
Jen Steele, Medicaid Director
State of Louisiana
Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
September 12, 2018

18. DATE APPROVED OCT 23 2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
August 20, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME Kristin Fan

22. TITLE Director, FMG

23. REMARKS ***continued from boxes 8 and 9**
Attachment 4.19-D, Page 24 (reserve page) **Same (TN 14-0038)**
Attachment 4.19-D, Page 24a (remove page) **Same (TN 14-0038)**

FORM CMS-179 (07/92)

Instructions on Back

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.

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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 104 percent of the total facility cost as a result of imposition of the direct care floor.

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 104 percent of the total facility cost as a result of imposition of the direct care floor.

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 Department upon submission of the cost report.

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.

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To adjust to 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.

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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:

12. Complex Care Reimbursements

A. Effective for dates of service on or after October 1, 2014, 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 recipients who require such services. The add-on rate adjustment shall be a flat fee amount and may consist of payment for any one of the following components:

1. equipment only;
2. direct service worker (DSW);
3. nursing only;
4. equipment and DSW;
5. DSW and nursing;
6. Nursing and equipment; or
7. DSW, nursing, and equipment.

B. Private (non-state) owned ICFs-IID may qualify for an add-on rate for recipients meeting major medical or behavioral complex care criteria, as documented on the complex support need screening tool provided by the Department. All medical documentation indicated by the screening tool form and any additional documentation requested by the Department must be provided to qualify for the add-on payment.

C. In order to meet the complex care criteria, the presence of a significant medical or behavioral health need must exist and be documented, to include the following:

1. endorsement of at least one qualifying condition with supporting documentation; and
2. endorsement of symptom severity in the appropriate category based on qualifying condition(s) with supporting documentation.
   a. Qualifying conditions for complex care must include at least one of the following as document on the complex support need screening tool:
      i. significant physical and nutritional needs requiring full assistance with nutrition, mobility, and activities of daily living;
      ii. complex medical needs/medically fragile; or
      iii. complex behavioral/mental health needs.

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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:

D. Enhanced supports must be provided and verified with supporting documentation to qualify for the add-on payment. This includes:

1. endorsement and supporting documentation indicating the need for additional direct service worker resources;
2. endorsement and supporting documentation indicating the need for additional nursing resources; or
3. endorsement and supporting documentation indicating the need for enhanced equipment resources (beyond basic equipment such as wheelchairs and grab bars).

E. One of the following admission requirements must be met in order to qualify for the add-on payment:

1. The recipient has been admitted to the facility for more than 30 days with supporting documentation of necessity and provision of enhanced supports; or
2. The recipient is transitioning from another similar agency with supporting documentation of necessity and provision of enhanced supports.

F. Qualification for a complex care add-on payment may be reviewed and re-determined by the Department, annually, from the date of initial approval of each add-on payment.

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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:

RESERVED

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

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:

RESERVED

State: Louisiana
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