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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: LA 23-0006

This file contains the following documents in the order listed:

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

Financial Management Group

July 14, 2023

Tara A. LeBlanc, Medicaid Executive Director
Louisiana Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

RE: Louisiana State Plan Amendment (SPA) 23-0006

Dear Director LeBlanc:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 23-0006. Effective for services on or after May 1, 2023, 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.

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. We hereby inform you that Medicaid State plan amendment 23-0006 is approved effective May 1, 2023. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,

[redacted]

Rory Howe
Director

Enclosure

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: **23-0006**

2. STATE: **LA**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 1, 2023

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY **2023** **$2,327,007**
b. FFY **2024** **$4,872,820**

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Page 15a
Attachment 4.19-D, Pages 16-16a
Attachment 4.19-D, Pages 17 and 19
Attachment 4.19-D, Page 23

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same (TN 22-0011)
Same (TN 07-05)
Same (TN 05-33)
Same (TN 21-0001)

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)*
☐ 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.

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Pam Diez, designee for Stephen R. Russo, JD

13. TITLE
Secretary

14. DATE SUBMITTED
April 14, 2023

15. RETURN TO
Tara A. LeBlanc, Medicaid Executive Director
Louisiana Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR CMS USE ONLY

16. DATE RECEIVED
April 19, 2023

17. DATE APPROVED
July 14, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
May 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

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;
e. provider fee; and
f. dental pass-through/add-on per diem rate

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^{th} 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.

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^{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/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^{th} 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^{th} 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.

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.

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.

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;
    6. the provider fee; and
    7. dental pass-through/add-on per diem rate