



State of Louisiana
Louisiana Department of Health
Office of the Secretary

VIA ELECTRONIC MAIL ONLY

September 29, 2020

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

RE: Louisiana Title XIX State Plan
Transmittal No. 20-0014

Dear Mr. Brooks:

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan.
Should you have any questions or concerns regarding this matter, please contact Karen Barnes at (225) 342-3881 or via email at Karen.Barnes@la.gov.


Warmly,

A handwritten signature in blue ink, appearing to read "Courtney N. Phillips".

_____, for
Dr. Courtney N. Phillips
Secretary

Attachments (3)

CNP:RJ:KS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER 20-0014	2. STATE Louisiana
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE August 26, 2020	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION 42 CFR 447 Subpart C		7. FEDERAL BUDGET IMPACT a. FFY 2021 \$ 930,180 b. FFY 2022 \$ 801,588	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-D, Page 18 Attachment 4.19-D, Page 18a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Same (TN 12-45) Same (TN 06-26)	
10. SUBJECT OF AMENDMENT The purpose of this SPA is to amend the provisions governing reimbursement for non-state intermediate care facilities for persons with intellectual disabilities (ICFs/IID) to increase the reimbursement rates to facilities that downsized from over 100 beds to less than 35 beds prior to December 31, 2010, without the benefit of a cooperative endeavor agreement.			
11. GOVERNOR'S REVIEW (Check One) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED The Governor does not review State Plan material. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL 		16. RETURN TO Ruth Johnson, Medicaid Director State of Louisiana Department of Health 628 North 4th Street P.O. Box 91030 Baton Rouge, LA 70821-9030	
13. TYPED NAME Ruth Johnson, designee for Dr. Courtney N. Phillips			
14. TITLE Secretary			
15. DATE SUBMITTED September 29, 2020			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED		18. DATE APPROVED	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL		20. SIGNATURE OF REGIONAL OFFICIAL	
21. TYPED NAME		22. TITLE	
23. REMARKS			

LA TITLE XIX SPA
TRANSMITTAL #: 20-0014
TITLE: ICF-IID Reimbursement Methodology
EFFECTIVE DATE: August 26, 2020

FISCAL IMPACT:
Increase

	year	% inc.	fed. match		*# mos	range of mos.	dollars
1st SFY	2021			0.00%	10.19	August 26, 2020 - June 2021	\$1,083,628
2nd SFY	2022			0.00%	12	July 2021 - June 2022	\$1,184,204
3rd SFY	2023			0.00%	12	July 2022 - June 2023	\$1,184,204

*#mos-Months remaining in fiscal year

Total Increase Cost FFY 2021							
SFY	2021	\$1,083,628	for	10.19	months	August 26, 2020 - June 2021	\$1,083,628
SFY	2022	\$1,184,204	for	12	months	July 2021 - June 2022	
		\$1,184,204 /		12 X 3		July 2021 - September 2021	= \$296,051
							<u>\$1,379,679</u>
FFP (FFY		2021) =		\$1,379,679	X	67.42%	= <u>\$930,180</u>
Total Increase Cost FFY 2022							
SFY	2022	\$1,184,204	for	12	months	July 2021 - June 2022	
		\$1,184,204 /		12 X 9		October 2021 - June 2022	= \$888,153
SFY	2023	\$1,184,204	for	12	months	July 2022 - June 2023	
		\$1,184,204 /		12 X 3		July 2022 - September 2022	= \$296,051
							<u>\$1,184,204</u>
FFP (FFY		2022)=		\$1,184,204	X	67.69%	= <u>\$801,588</u>

STATE OF LOUISIANAPAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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.

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.

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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).