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, p~~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~~recipients~~ when medically necessary.~~who require such services.~~ The add-on payment~~rate adjustment shall be~~ is a flat fee daily amount and ~~may~~ consists of payment for ~~any~~ one or more of the following components ~~alone or in combination~~:

1. equipment add-on~~only~~;
2. direct service worker (DSW) add-on; and
3. skilled nursing add-on.~~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~~ To qualify, beneficiaries must meet medical ~~or behavioral complex care~~ necessity criteria established by the Medicaid program.~~, as documented on the complex support need screening tool provided by the Department. All~~Supporting medical documentation ~~indicated by the screening tool form and any additional documentation requested by the Department~~ must also be ~~provided to qualify for the add-on payment~~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.

~~B.~~C. ~~In order to meet~~ Each add-on payment requires documentation that the ~~complex care criteria, the presence of a significant medical or behavioral health need must exist and be documented, to include the following:~~ enhanced supports are already being provided to the beneficiary, as specified by the Medicaid program.

~~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:~~

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:

~~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.~~

~~C.~~D. ~~Enhanced supports~~One of the following admission requirements must be ~~provided and verified with supporting documentation~~met in order to qualify for the add-on payment~~. This includes~~:

1. ~~endorsement and~~T~~t~~he beneficiary has been admitted to the facility for more than 30 days with supporting documentation ~~indicating the need for additional direct service worker resources~~of medical necessity; or

2. ~~endorsement and the~~The beneficiary is transitioning from another similar agency with supporting documentation ~~indicating the need for additional nursing resources; or~~of medical necessity.

~~3. endorsement and supporting documentation indicating the need for enhanced equipment resources (beyond basic equipment such as wheelchairs and grab bars)~~

~~D.~~E. ~~One of T~~T~~t~~he following additional~~admission~~ requirements apply~~must be met in order to qualify for the add-on payment~~:

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:

~~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.~~

~~E.~~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.~~ 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.