INCOME CONSIDERATION IN DETERMINING PAYMENT

Beneficiaries Receiving Care under Title XIX

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF), Medicaid Eligibility Section determines the beneficiary's applicable income (liability) when computing the Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID's) vendor payments. Vendor payments are subject to the following conditions:

1. Vendor payments will begin with the first day the beneficiary is determined to be categorically and medically eligible or the date of admission, whichever is later;

2. Vendor payment will be made for the number of eligible days as determined by the ICF/IID per diem rate less the beneficiary's per diem applicable income; and

3. If a beneficiary transfers from one facility to another, the vendor payment to each facility will be calculated by multiplying the number of eligible days times the ICF/IID per diem rate less the beneficiary's liability.

Beneficiary Personal Care Allowance

The ICF/IID will not require that any part of a beneficiary's personal care allowance be paid as part of the ICF/IID's fee. Personal care allowance is an amount set apart from a beneficiary's available income to be used by the beneficiary for his/her personal use. The amount is determined by LDH.

Payment Policy and Limitations

Temporary Absence of the Beneficiary

A beneficiary's temporary absence from an ICF/IID will not interrupt the monthly vendor payment provided a bed is kept available for the beneficiary's return, and the absence is for one of the following reasons:

1. Hospitalization, which does not exceed seven days per hospitalization; or

2. Leave of Absence.

Hospitalization

The reimbursement for hospital leave days is 75 percent of the applicable ICF/IID per diem rate.

Leave of Absence

A leave of absence is a temporary stay outside the ICF/IID provided for in the beneficiary's IHP. A leave of absence will not exceed 45 days per fiscal year (July 1 through June 30), and will not exceed 30 consecutive days in any single occurrence.

Certain leaves of absence will be excluded from the annual 45-day limit as long as the leave does not exceed the 30 consecutive day limit and is included in the written Individualized Health Program (IHP). These exceptions are as follows:

1. Special Olympics;

2. Official state holidays;

3. Road Runners Club of America events, including but not limited to events intended to raise money to help ICF/IID beneficiaries participate in the Special Olympics;

4. Louisiana planned conferences such as, but not limited to, those sponsored by the Community Residential Services Association (CRSA) a consumer driven support system that advocates choices for persons with disabilities;

5. Trial discharge leaves-fourteen days per occurrence (must be in the plan of care); and

6. Two days for bereavement of close family members as outlined below:

    a. Parent;

    b. Stepparent;

    c. Stepsister;

    d. Stepbrother;

    e. Child;

    f. Stepchild;

g. Grandchild;

h. Grandparent;

i. Spouse;

j. Mother-in-law;

k. Father-in-law;

l. Brother; and

m. Sister.

The ICF/IID shall **promptly notify** LDH of absences beyond the applicable 30 or seven-day hospital limitations. Payment to the ICF/IID shall be terminated from the 31st or the 8th day, depending upon the type of absence. **Payment will commence after the individual has been determined eligible for Medicaid benefits and has remained in the ICF/IID for 30 consecutive days.**

NOTE: Elopements and unauthorized absences count against allowable leave days; however, Title XIX eligibility is not affected if the absence does not exceed 30 days and if the ICF/IID has not discharged the beneficiary.

The period of absence shall be determined by counting the first day of absence as the day on which the first 24-hour time period is used.

Only a period of 24 continuous hours or more shall be considered an absence. Likewise, a temporary leave of absence for hospitalization or a home visit is broken only if the beneficiary returns to the ICF/IID for 24 hours or longer.

Upon admission, a beneficiary must remain in the ICF/IID at least 24 continuous hours in order for the ICF/IID to submit a payment claim for a day of service or reserve a bed. A beneficiary admitted to an ICF/IID in the morning and transferred to the hospital that afternoon would not be eligible for any vendor payment for ICF/IID services.

Examples in Calculating Leave Days

The following are examples in how to calculate leave days:

Reason for Leave	Left Facility	Returned to Facility	How Leave is Reported	
Hospital or Home Leave	Jan 3rd at 9:00 am	Jan 10th at **8:00** am	Jan 4th – Jan **9th**	Leave days
Hospital or Home Leave	Jan 3rd at 9:00 am	Jan 10th at **10:00** am	Jan 4th – Jan **10th**	Leave days
Hospital	Jan 3rd at 9:00 am	Jan 21st at **8:00** am	Jan 4th – Jan 10th	Leave days
			Jan 11th – Jan **20th**	Paid or unpaid bed hold days
Hospital	Jan 3rd at 9:00 am	Jan 21st at **10:00** am	Jan 4th – Jan 10th	Leave days
			Jan 11th – Jan **21st**	Paid or unpaid bed hold days
Home Leave with State Holiday	July 3rd at 9:00 am	July 5th at **8:00** am	No Home Leave Reported	
Home Leave with State Holiday*	July 3rd at 9:00 am	July 5th at **1:00** pm	July 5th	Home Leave Day

*Do not report official or declared state holidays as home leave on the claim form; however, this should be noted in the beneficiary's record.

Paid bed hold days are claimed when payment is received from the beneficiary or family for leave days over the LDH allowable leave days, or payment is received for a non-Medicaid resident when the resident is not in the facility.

Unpaid bed hold days are claimed when no payment is received, but the facility is holding the bed for the beneficiary. Related days should not be reported on the cost report.

The limit on Title XIX payment for leave days does not mean that further leave days are prohibited when provided for in the IHP. After the payment limit is met, further leave days may be arranged between the ICF/IID and the beneficiary, family or responsible party. Such arrangements may include the following options:

1. The ICF/IID may charge the beneficiary, family or responsible party an amount not to exceed the Title XIX daily rate;

2. The ICF/IID may charge the beneficiary, family or responsible party a portion of the daily rate; or

3. The ICF/IID may absorb the cost into its operating costs.

If a beneficiary transfers from one facility to another, the unused leave days for the fiscal year also transfers. No additional leave days are allocated.

Temporary Absences Due to Evacuations

When local conditions require beneficiary evacuation, the following payment procedures apply:

1. When beneficiaries are evacuated for less than 24 hours, the monthly vendor payment is not interrupted;

2. When staff is sent with beneficiaries to the evacuation site, the monthly vendor payment is not interrupted;

3. When beneficiaries are evacuated to a family's or friend's home, the ICF/IID shall not submit a claim for a day of service or leave day, and the beneficiary's liability shall not be collected;

4. When beneficiaries go home at the family's request or on their own initiative, a leave day shall be charged; and

5. When beneficiaries are admitted to the hospital for the purpose of evacuation of the ICF/IID, Medicaid payment shall not be made for hospital charges.

Evacuating and Temporary Sheltering Provisions

Certified, licensed intermediate care facilities for persons with intellectual disabilities (ICF's/IID) required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

ICFs/IID must first apply for evacuation or sheltering reimbursement from all other sources and request that the Department apply for FEMA assistance on their behalf. This request must be submitted in writing along with expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid residents to the Department.

Eligible Expenses

Eligible expenses for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the Department's discretion and may include the following:

Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another ICF/IID. Evacuation expenses include:

1. Resident transportation expenses during travel;

2. Nursing staff expenses when accompanying residents, including:

    a. Transportation; and

    b. Additional direct care expenses, when a direct care expense increase of ten percent or more is documented. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the Department; and

3. Any additional allowable costs that are directly related to the evacuation and that would normally be allowed under the ICF/IID rate methodology.

Temporary Sheltering Expenses

Non-ICF/IID facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-ICF/IID facility temporary shelter to the date all Medicaid residents leave the shelter. A non-ICF/IID facility temporary shelter includes both Medicare/Medicaid –licensed facilities and non-licensed facilities that are not part of a licensed ICF/IID and are not billing for the residents under the ICF/IID reimbursement methodology for any other Medicaid reimbursement system. Non-ICF/IID facility temporary sheltering expenses may include:

1. Additional nursing staff expenses including:

a. Additional direct care expenses, when a direct care expense increase of ten percent or more is documented. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or period comparisons determined acceptable by the Department;

b. Care-related expenses incurred in excess of care-related expenses prior to the evacuation;

c. Additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents in accordance with the following:

i. These expenses will be capped at a daily rental fee not to exceed the total purchase price of the item; and

ii. The allowable daily rental fee will be determined by the Department; and

d. Any additional allowable costs as determined by the Department and that are directly related to the temporary sheltering and that would normally be allowed under the ICF/IID reimbursement methodology.

NOTE: Reimbursement for room and board costs is not available when beneficiaries are sheltered at facilities not licensed as Medicare/Medicaid providers.

Host Temporary Sheltering Expenses

Host ICF/IID temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed ICF/IID to the date all temporary sheltered Medicaid residents are discharged from the ICF/IID, not to exceed a six-month period.

The host ICF/IID shall bill for the residents under Medicaid's ICF/IID reimbursement methodology. Additional direct care expenses may be submitted when a direct care expense increase of ten percent or more is documented. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the Department.

Payment of Eligible Expenses for Medicare and/or Medicaid Licensed Facilities

For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the Department by the end of each calendar quarter.

All eligible expenses documented and allowed will be removed from allowable expenses when the ICF/IID's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set ICF/IID reimbursement rates in future years.

Equipment purchases that are reimbursed on a rental rate may have their remaining basis included as allowable cost on future cost reports provided that the equipment is in the ICF/IID and being used. If the remaining basis requires capitalization, then depreciation will be recognized.

Payments shall remain under the upper payment limit cap for ICF/IID.

ICFs/IID may also be entitled to reimbursement in accordance with the Medicaid leave day provisions.

Admission

Medicaid payments become effective as of the admission date provided the beneficiary is medically certified as of that date and either of the following conditions is met:

1. The beneficiary is eligible for Medicaid benefits in the ICF/IID (excluding the medically needy); **or**

2. The beneficiary was in a continuous institutional living arrangement (nursing home, hospital, ICF/IID, or a combination of these institutional living arrangements) for 30 consecutive days. The beneficiary must also be determined financially eligible for Medical Assistance.

Continuous Stay

The continuous stay requirement is met if:

1. The beneficiary dies during the first 30 consecutive days; or

2. The stay is not interrupted by the beneficiary's absence from the ICF/IID when the absence is for hospitalization or leave of absence and is in the written IHP.

Discharge and Death

ICF/IIDs must comply with payment criteria:

1. The beneficiary's applicable income is applied toward the ICF/IID fee effective with the date Medicaid payment is to begin;

2. Medicaid payment is not made for the date of discharge. The beneficiary, family, nor responsible party is to be billed for the date of discharge; and

3. Medicaid payment is made for the day of beneficiary's death.

NOTE: The ICF/IID shall promptly notify BHSF of all admissions, deaths, and all discharges.

Advance Deposits

An advance deposit shall not be required or accepted from an individual whose Medicaid (Title XIX) eligibility has been established.

Exception: An ICF/IID may require an advance deposit for the current month only on that part of the total payment, which is the beneficiary's liability.

If advance deposits or payments are required from the beneficiary, family, or responsible party upon admission when Medicaid (Title XIX) eligibility has not been established, then such a deposit **shall be refunded or credited** to the person upon receipt of vendor payment.

Retroactive Payment

When individuals enter an ICF/IID prior to the date Medicaid (Title XIX) eligibility has been established, payment for ICF/IID services are made retroactive to the first day of eligibility after admission.

Timely Filing for Reimbursements

Vendor payments cannot be made if more than 12 months have elapsed between the month of initial services and submittal of a claim for these services. Exceptions for payments of claims over 12 months old can be made only with authorization from BHSF.

Refunds

Refunds to Beneficiaries

When the facility receives vendor payments, it **shall** refund any fees for services collected from the beneficiary, family or responsible party by the end of the month in which vendor payment is received.

Advance payments for a beneficiary's liability (applicable income) shall be refunded promptly if he/she leaves the facility. The ICF/IID shall adhere to the following procedures for refunds:

1. The proportionate amount for the remaining days of the month shall be refunded to the beneficiary, family, or the responsible party no later than 30 days following the date of discharge. If the beneficiary has not yet been certified, any fees for services collected from the beneficiary, family or responsible party shall be refunded by the end of the month in which vendor payment is received; and

2. No penalty shall be charged to the beneficiary, family, or responsible party even if the following circumstances surrounding the discharge occur:

    a. Without prior notice;

    b. Within the initial month; or

    c. Within some other "minimum stay" period established by the ICF/IID.

Proof of refund of the unused portion of the applicable income shall be furnished to BHSF upon request.

Refunds to the Department

Participating ICF/IID

Billing or payment errors shall be corrected by using the appropriate adjustment void or Patient Liability (PLI) adjustment forms.

Non-Participating ICF/IID

Vendor payments made for services performed while an ICF/IID is in a non-participating status with the Medicaid Program must be refunded. The refund shall be made payable to "LDH - Medicaid Program."

Sitters

A sitter shall not be required or expected. However, beneficiaries, families, or responsible parties may directly employ and pay sitters when indicated, subject to the following limitations:

1. The use of sitters will be entirely at the beneficiary, family, or responsible party's discretion. However, the ICF/IID shall have the right to approve the selection of a sitter. If the ICF/IID disapproves the selection of the sitter, the ICF/IID must provide written notification to the beneficiary, family, and/or responsible party, and to the LDH stating the reasons for disapproval;

2. Payment to sitters is the direct responsibility of the beneficiary, family or responsible party, unless:

    a. The hospital's policy requires a sitter;

    b. The attending physician requires a sitter; or

    c. The IHP requires a sitter.

3. Payment to sitters is the direct responsibility of the ICF/IID facility when:

    a. The hospital's policy requires a sitter, and the beneficiary is on hospital leave days;

    b. The attending physician requires a sitter; or

c. The IHP requires a sitter.

A sitter will be expected to abide by the ICF/IID's policies and procedures in accordance with LDH rules and regulations, including the LDH Health Standards Section, and professional ethics as applicable.

The presence of a sitter does not absolve the ICF/IID of its full responsibility for the beneficiary's care.

The ICF/IID is not responsible for providing a sitter if one is required while the resident is on home leave.

NOTE: Psychiatric Hospitals are excluded from this requirement.

Tips

The ICF/IID shall not permit tips for services rendered by its employees.