DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

APR 10 2015

Ms. Ruth Kennedy, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 14-0036

Dear Ms. Kennedy:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 14-0036. This amendment proposes to increase the transitional Medicaid per diem rate in effect on September 30, 2014, by $1.85, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

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. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-D.

Based upon the information provided by the State, Medicaid State plan amendment 14-0036 is approved effective October 1, 2014. We are enclosing the CMS-179 and the new plan page.

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

Sincerely,

Timothy Hill
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-0036**

2. STATE: **Louisiana**

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2014

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 C

7. FEDERAL BUDGET IMPACT:
a. FFY **2015** **$178.67**
b. FFY **2016** **$184.03**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Page 11

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~SAME (IN 12-33)~~
**Plan page is #13-43 not 12-33. Pen and ink change requested by the State

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to amend the provisions governing the transitional rates for public facilities in order to increase the Medicaid reimbursement rate.**

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:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
December 1, 2014

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12-01-2014

18. DATE APPROVED:
APR 10 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10-01-2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Kristin Fan

22. TITLE:
Deputy Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

d. Each state-owned and operated facility's capital and ancillary costs will be paid on a "pass-through" basis.

The sum of the calculations for routine service costs and the capital and ancillary costs "pass-through" shall be the per diem rate for each state-owned and operated ICF/MR. The base year cost reports to be used for the initial calculations shall be the cost reports for the fiscal year ended June 30, 2002.

Effective for the dates on or after October 1, 2012, a transitional Medicaid reimbursement rate of $302.08 per day per individual shall be established for a public ICF/DD facility over 50 beds that is transitioning to a private provider, as long as the provider meets the following criteria:

a. shall have a fully executed) agreement with the Office for Citizens with Developmental Disabilities for the private operation of the facility;

b. shall have a high concentration of medically fragile individuals being served, as determined by DHH. For the purposes of these provisions, a medically fragile individual shall refer to an individual who has a medically complex condition characterized by multiple, significant medical problems that require extended care;

c. incurs or will incur higher existing costs not currently captured in the private ICF/DD rate methodology; and

d. shall agree to downsizing and implement a pre-approved OCDD plan.

Any ICF/DD home to which individuals transition to satisfy downsizing requirements, shall not exceed 6-8 beds.

Effective for the dates on or after October 1, 2013, the transitional Medicaid reimbursement rate shall only be for the period of transition, which is defined as the term of the agreement or a period of four years, whichever is shorter. The transitional Medicaid reimbursement rate is all inclusive and incorporates the following cost components:

a. direct care staffing;
b. medical/nursing staff, up to 23 hours per day;
c. medical supplies;
d. transportation costs;
e. administrative and operating costs; and
f. the provider fee.

State: Louisiana
Date Received: December 1, 2014
Date Approved:
Date Effective: October 1, 2014
Transmittal Number: 14-0036

If the community home meets the above criteria and the individuals served require that the community home has a licensed nurse at the facility 24 hours per day, seven days per week, the community home may apply for a supplement to the transitional rate. The supplement to the rate shall not exceed $25.33 per day per individual. The total transitional Medicaid reimbursement rate, including the supplement, shall not exceed $327.41 per day per individual.

Effective for dates of service on or after October 1, 2014, the transitional Medicaid reimbursement rate shall be increased by $1.85 of the rate in effect on September 30, 2014.

No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.