John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

VIA ELECTRONIC MAIL ONLY

October 23, 2017

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

Dear Mr. Brooks:

RE: Louisiana Title XIX State Plan
Transmittal No. 17-0027

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.

Warmly,

Rebekah E. Gee MD, MPH
Secretary

Attachments (2)

REG:JS:MJ

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: **17-0027**

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, 2017**

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 **2017** **$ 0**
b. FFY **2018** **$ 0**

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

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 14-36)
Same (TN 12-33)

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to revise the provisions governing reimbursement for public facilities in order to extend the period of transitional rates for large facilities that provide continuous nursing coverage to medically fragile populations for an additional year.**

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:
Rebekah E. Gee MD, MPH

14. TITLE:
Secretary

15. DATE SUBMITTED:
October 23, 2017

16. RETURN TO:
Jen Steele, Medicaid Director
State of Louisiana
Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

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:

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/IID. 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/IID 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 (OCDD) for the private operation of the facility;
b. shall have a high concentration of medically fragile individuals being served, as determined by LDH. 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/IID rate methodology; and
d. shall agree to downsizing and implement a pre-approved OCDD plan.

Any ICF/IID 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.

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.

Effective October 1, 2017, the Department may extend the period of transition for an additional year, if deemed necessary, for an active CEA facility that:

a. is a large facility of 100 beds or more;
b. serves a medically fragile population; and
c. provides continuous (24-hour) nursing coverage.

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.

The transitional rate and supplement shall not be subject to the following:

a. inflationary factors or adjustments;
b. rebasing;
c. budgetary reductions; or
d. other rate adjustments.

2. Quasi-public facilities are reimbursed a facility specific prospective rate based on budgeted costs. Providers submit a projected budget for the state fiscal year beginning July 1. Rates are determined as follows:

   a. Determine each ICF/IID's per diem for the base year beginning July 1.
   b. Calculate the inflation factor using an average CPI index applied to each facility's per diem for the base year to determine the inflated per diem.
   c. Calculate the median per diem for the facilities' base year.
   d. Calculate the facility's routine cost per diem for the SFY beginning July 1, by using the lowest of the budgeted, inflated, or median per diem rates plus any additional allowances.
   e. Calculate the final approved per diem rate for each facility by adding routine costs plus any "pass through" amounts for ancillary services, provider fees, and grant expenses.
   f. Providers may request a final rate adjustment subject to submission of supportive documentation and approval by the LDH rate committee.

D. REIMBURSEMENT TO PRIVATE ICF/IID PROVIDERS

Private providers are reimbursed a per diem rate for each resident. Rates are calculated based on information reported on the cost report.

1. **Definitions**

   a. *Acuity Factor*—an adjustment factor which will modify the direct care portion of the Inventory for Client and Agency Planning (ICAP) rate based on the ICAP level for each resident.