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: **09-43**

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
September 1, 2009

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 Part 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 **$209.52**
b. FFY 2010 **$2,533.06**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Page 18

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 09-11)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to increase the per diem rate for non-state intermediate care facilities for persons with developmental disabilities.**

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 [redacted]

13. TYPED NAME:
Alan Levine

14. TITLE:
Secretary

15. DATE SUBMITTED:
September 8, 2009

16. RETURN TO:
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:

18. DATE APPROVED:
10-29-09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
SEP - 1 2009

20. [redacted] OFFICIAL:
RC CM

21. TYPED NAME:
William Lasowski

22. TITLE:
Deputy Director CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

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.

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 DHH 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 DHH ICAP Review Committee.

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.