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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: 11-19

This file contains the following documents in the order listed:

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

Mr. Don Gregory, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

JAN 26 2012

Attention: Darlene York

RE: Louisiana 11-19

Dear Mr. Gregory:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-19. The purpose of this amendment is to increase the direct care and care related price multiplier and to increase the fair rental value minimum occupancy percentage for the calculation of nursing facilities payments.

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 your assurances, Medicaid State plan amendment 11-19 is approved effective October 1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Sandra Dasheiff, CPA at (214) 767-6490.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid and CHIP Services

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: **11-19**

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 *
~~July 1, 2011~~ October 1, 2011

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 ~~2011~~ 2012 ~~($33,170)~~ ($137,092)
b. FFY ~~2012~~ 2013 ~~($137,092)~~ ($145,535)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, Page 6
Attachment 4.19-D, Page 7
Attachment 4.19-D, Page 9
Attachment 4.19-D, Page 9a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same (TN-06-33)
Same (TN 09-26)
Same (TN 06-33)
Same (TN 08-23)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to increase the direct care and care related price multiplier, ~~provide for the exclusion of certain costs from the direct care and care related median cost~~, and to increase the fair rental value minimum occupancy percentage.** *

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:
[redacted]

13. TYPED NAME:
Bruce Greenstein

14. TITLE:
Secretary

15. DATE SUBMITTED:
August 24, 2011

16. RETURN TO:

Don Gregory, 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:
6 December, 2011

18. DATE APPROVED:
JAN 26 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Penny Thompson

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

* Pen and ink changes requested by Kaydra Singleton, Medicaid Program Manager, on 1/11/12.

iii. each facility's capital rate component;
iv. each facility's pass-through rate component;
v. adjustments to the rate; and
vi the statewide durable medical equipment price.

c. Determination of Rate Components

i. Facility Specific Direct Care and Care Related Component. This portion of a facility's rate shall be determined as follows.

(1). The per diem direct care cost for each nursing facility is determined by dividing the facility's direct care cost during the base year cost reporting period by the facility's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The per diem neutralized direct care cost is calculated by dividing each facility's direct care per diem cost by the facility cost report period case-mix index.

(2). The per diem care related cost for each nursing facility is determined by dividing the facility's care related cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

(3). The per diem neutralized direct care cost and the per diem care related cost is summed for each nursing facility. Each facility's per diem result is arrayed from low to high and the resident-day-weighted median cost is determined. Also for each facility, the percentage that each of these components represents of the total is determined.

(4). The statewide direct care and care related price is established at 110 percent of the direct care and care related resident-day-weighted median cost.

For the dates of service on or after July 1, 2011, the statewide direct care and care related price is established at 112.40 percent of the direct care and care related resident-day-weighted median cost.

(5). The statewide direct care and care related floor is established at 94 percent of the direct care and care related resident-day-weighted median cost. For periods prior to January 1, 2007, the statewide direct care and care related floor shall be reduced to 90 percent of the direct care and care related resident-day-weighted median cost in the event that the nursing wage and staffing enhancement add-on is removed. Effective January 1, 2007, the statewide direct care and care related floor shall be reduced by one percentage point for each 30 cent reduction in the average Medicaid rate due to a budget reduction implemented by the Department. The floor cannot be reduced

below 90 percent of the direct care and care related resident-day-weighted median cost.

(6). For each nursing facility, the statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in section C.2.c.i.(3). On a quarterly basis, each facility's specific direct care component of the statewide price shall be multiplied by each nursing facility's average case-mix index for the prior quarter. The direct care component of the statewide price will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related price is the sum of each facility's case mix adjusted direct care component of the statewide price plus each facility's specific care related component of the statewide price.

(7). For each nursing facility, the statewide direct care and care related floor shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in section C.2.c.i.(3). On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each facility's average case-mix index for the prior quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related floor is the sum of each facility's case mix adjusted direct care component of the statewide floor plus each facility's specific care related component of the statewide floor.

(8). Effective with cost reporting periods beginning on or after January 1, 2003, a comparison will be made between each facility's direct care and care related per diem cost and the direct care and care related cost report period per diem floor. If the total direct care and care related per diem cost the facility incurred is less than the cost report period per diem floor, the facility shall remit to the Bureau the difference between these two amounts times the number of Medicaid days paid during the cost reporting period. The cost report period per diem floor shall be calculated using the calendar day-weighted average of the quarterly per diem floor calculations for the facility's cost reporting period.

(9). For dates of service on or after February 9, 2007, the facility-specific direct care rate will be increased by a $4.70 per diem wage enhancement for direct care staff prior to the case-mix adjustment. The $4.70 wage enhancement will be included in the direct care component of the floor calculations.

For dates of service on or after July 3, 2009, the facility-specific direct care rate will be adjusted in order to reduce the $4.70 wage enhancement to a $1.30 wage enhancement prior to the case-mix adjustment for direct care staff. The $1.30 wage enhancement will be included in the direct care component of the floor calculations. Effective with the next rebase, on or after July 1, 2010, the wage enhancement will be eliminated.

(c). The nursing facility's annual fair rental value shall be divided by the greater of the facility's annualized actual resident days during the cost reporting period or 70 percent of the annualized licensed capacity of the facility to determine the FRV per diem or capital component of the rate. Annualized total patient days will be adjusted to reflect any increase or decrease in the number of licensed beds as of the date of rebase by applying to the increase or decrease the greater of the facility's actual occupancy rate during the base year cost report period or 70 percent of the annualized licensed capacity of the facility.

As of July 1, 2011, the nursing facility's annual fair rental value shall be divided by the greater of the facility's annualized actual resident days during the cost reporting period or 85 percent of the annualized licensed capacity of the facility to determine the FRV per diem or capital component of the rate. Annualized total patient days will be adjusted to reflect any increase or decrease in the number of licensed beds as of the date of rebase by applying to the increase or decrease the greater of the facility's actual occupancy rate during the base year cost report period or 85 percent of the annualized licensed capacity of the facility.

(d). The initial age of each nursing facility used in the FRV calculation shall be determined as of January 1, 2003, using each facility's year of construction. This age will be reduced for replacements, renovations and/or additions that have occurred since the facility was built provided there is sufficient documentation to support the historical changes. The age of each facility will be further adjusted each July 1 to make the facility one year older, up to the maximum age of 30 years. Beginning January 1, 2007 and the first day of every calendar quarter thereafter, the age of each facility will be reduced for those facilities that have completed and placed into service major renovation or bed additions. This age of a facility will be reduced to reflect the completion of major renovations and/or additions of new beds. If a facility adds new beds, these new beds will be averaged in with the age of the original beds and the weighted average age for all beds will be used as the facility's age. Changes in licensed beds are only recognized, for rate purposes, at July 1 of a rebase year unless the change in licensed beds is related to a change in square footage. The occupancy rate applied to a facility's licensed beds will be based on the base year occupancy.

(e). If a facility performed a major renovation/improvement project (defined as a project with capitalized cost equal to or greater than $500 per bed), the cost of the renovation project will be used to determine the equivalent number of new beds that project represents. The equivalent-number of new beds from a renovation/improvement

project will be determined by dividing the cost of the renovation/improvement project by the accumulated depreciation per bed of the facility's existing beds immediately before the renovation/improvement project. The equivalent number of new beds will be used to determine the weighted average age of all beds for this facility.

Major renovation/improvement costs must be documented through cost reports, depreciation schedules, construction receipts or other auditable records. Costs must be capitalized in compliance with the Medicare provider reimbursement manual in order to be considered in a major renovation/improvement project. The cost of the project shall only include the cost of items placed into service during a time period not to exceed the previous 24 months prior to a re-aging. Entities that also provide non-nursing facility services or conduct other non-nursing facility business activities must allocate their renovation cost between the nursing facility and non-nursing facility business activities. Documentation must be provided to the Department or its designee to substantiate the accuracy of the allocation of cost. If sufficient documentation is not provided, the renovation/improvement project will not be used to re-age the nursing facility.

Weighted average age changes as a result of replacements/ improvements and/or new bed additions must be requested by written notification to the Department prior to the rate effective date of the change and separate from the annual cost report. The written notification must include sufficient documentation as determined the Department. All valid requests will become part of the quarterly case-mix FRV rate calculation beginning January 1, 2007.

iv. Pass-Through Component of the Rate.

The nursing facility's per diem property tax and property insurance cost is determined by dividing the facility's property tax and property insurance cost during the base year cost reporting period by the facility's actual total resident days. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The pass through rate is the sum of the facility's per diem property tax and property insurance cost trended forward plus the provider fee determined by the Department of Health and Hospitals.

Effective July 1, 2007, an add-on amount of $8.02 shall be added to each facility's per diem rate in order to reimburse providers for Medicaid's share of the costs associated with payment of provider fees.