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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: 13-43

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 S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

JUL 23 2014

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 13-43

Dear Ms. Kennedy:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 13-43. This amendment redefines the period of transitional rates from three to four years for public Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) that are transitioning to a private provider.

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 access to care issues and the funding of the State share of expenditures under Attachment 4.19-D.

Based upon your assurances, Medicaid State plan amendment 13-43 is approved effective October 1, 2013. We are enclosing the HCFA-179 and the new plan page.

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

Sincerely,

[redacted]

Cindy Mann
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: **13-43**

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
October 1, 2013

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 F

7. FEDERAL BUDGET IMPACT:
a. FFY **2014** **$0**
b. FFY **2015** **$0**

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 (TN 12-33)

10. SUBJECT OF AMENDMENT: The SPA proposes to revise the reimbursement methodology for public intermediate care facilities for persons with developmental disabilities (ICF/DDs) to redefine the period of transition governing transitional rates.

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:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
October 31, 2013

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: 1 November, 2013

18. DATE APPROVED: JUL 23 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 October, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Penny Thompson

22. TITLE:
Deputy Director, Policy & Financial Mgt. CMCS

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 that is a (agreement 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: 1 November, 2013
Date Approved: JUL 23 2014
Date Effective: 1 October, 2013
Transmittal Number: 13-43

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.

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.