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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: 17-0027

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved Page

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



DEC 13 2017

Mrs. Jen Steele, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 17-0027

Dear Mrs. Steele:

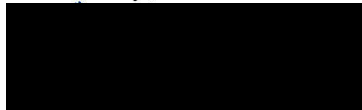
We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 17-0027. The purpose of this SPA is to extend the period of transitional rates for one large public Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) that provide continuous nursing coverage to medically fragile populations for an additional year.

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.

We are pleased to inform you that Medicaid State plan amendment 17-0027 is approved effective October 1, 2017. We are enclosing the CMS-179 and the amended plan pages.

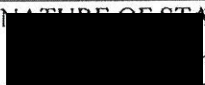
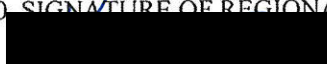
If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,



Kristin Fan
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 17-0027	2. STATE Louisiana
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE October 1, 2017	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> 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): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED The Governor does not review State Plan material. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		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	
13. TYPED NAME: Rebekah E. Gee MD, MPH			
14. TITLE: Secretary			
15. DATE SUBMITTED: October 23, 2017			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: October 23, 2017		18. DATE APPROVED: DEC 18 2017	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2017		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Kristin Fan		22. TITLE: Director, FMC	
23. REMARKS:			

STATE OF LOUISIANA

- 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.

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. 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.

State: Louisiana
Date Received: October 23, 2017
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TN 17-0027
Supersedes
TN 14-0036

Approval Date DEC 13 2017

Effective Date 10-01-2017

STATE OF LOUISIANA

Effective October 1, 2017, the Department may extend the period of transition for ARC of Acadiana (Bossier) for an additional year, if deemed necessary.

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.

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

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.

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 (SFY) 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.

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TN 17-0027
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TN 12-33

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