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, and Survey & Certification

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

DEC - 8 2010

Attention: Sandra Victor

RE: Louisiana 10-47

Dear Mr. Gregory:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 10-47. The purpose of this amendment is to establish a transitional Medicaid reimbursement rate for a public intermediate care facility for persons with developmental disabilities (ICF/DD) that is transitioning to a private facility.

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 10-47 is approved effective August 1, 2010. 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]
Director
Center for Medicaid, CHIP, and Survey & Certification

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:	2. STATE
10-47	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
August 1, 2010

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 2010 *($93,425) ~~($92.50)~~
b. FFY 2011 ($519,335) ~~($448.89)~~

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

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 05-33)
None (New Page)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to establish a transitional Medicaid reimbursement rate for a public ICF/DD community home that is transitioning to a private facility.**

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. S[redacted]IAL:

13. TYPED NAME:
Bruce D. Greenstein

14. TITLE:
Secretary

15. DATE SUBMITTED:
September 28, 2010

16. RETURN TO:
State of Louisiana
Department of Health and Hospitals
1201 Capitol Access Road
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED
12-08-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
AUG - 1 2010

20. [redacted]

21. TYPED NAME:
William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

* Pen and ink change requested by Allyson Lamy, Program Manager, on 11-19-10

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 August 1, 2010, a transitional Medicaid reimbursement rate of $302.08 per day per individual shall be established for a public ICF/DD community home that is transitioning to a private facility, provided that the community home meets the following criteria. The community home:

a. shall have a fully executed Cooperative Endeavor Agreement (CEA) 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; and

c. incurs or will incur higher existing costs not currently captured in the private ICF/DD rate methodology.

The transitional Medicaid reimbursement rate shall only be for the period of transition, which is defined as the term of the CEA or a period of three 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.

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/MR'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 DHH rate committee.

D. REIMBURSEMENT TO PRIVATE ICF/DD 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.

Marks, Marsha L. (CMS/SC)

From: Cooley, Mark S. (CMS/CMSO)
Sent: Thursday, December 09, 2010 9:50 AM
To: Dasheiff, Sandra (CMS/CMCHO)
Cc: GOLDSTEIN, STUART S. (CMS/CMSO); Brooks, Bill D. (CMS/CMCHO); Marks, Marsha L. (CMS/SC)
Subject: Approval package LA 10-047
Attachments: LA 10-047.pdf

Approval package for Louisiana 10-047