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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: 14-10

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

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

JUN 30 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 14-10

Dear Ms. Kennedy:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 14-10. This amendment increases the allowable cost of the provider tax that can be recognized for reimbursement purposes from $14.30 to $16.15 per day, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

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 14-10 is approved effective April 1, 2014. 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,

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: **14-10**

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: **April 1, 2014**

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 F

7. FEDERAL BUDGET IMPACT:

FFY 2014	$ 660.60
FFY 2015	$1,349.47

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Page 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 06-26)

10. SUBJECT OF AMENDMENT: **The SPA proposes to revise the reimbursement methodology for intermediate care facilities for persons with intellectual disabilities (ICFs/ID) by increasing the provider fee to $16.15 per day.**

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:
May 15, 2014

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: 14 May, 2014

18. DATE APPROVED: JUN 30 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Penny Thompson

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

23. REMARKS:
The State requests a pen and ink change to box 10. Please change the provider fee from $16.25 to $16.15.

FORM HCFA-179 (07-92)

Direct Care Floor

A facility wide direct care floor may be enforced upon deficiencies related to direct care staffing requirements noted during the Health Standards Section (HSS) annual review or during a complaint investigation in accordance with LAC 50:I.5501 et seq.

For providers receiving pervasive plus supplements and other client specific adjustments to the rate in accordance with Section 5b., the facility wide direct care floor is established at 94 percent of the per diem direct care payment, the pervasive plus supplement, and other client specific adjustments to the rate. The direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or client specific rate adjustment. In no case shall a facility receiving a pervasive plus supplement and/or client specific rate adjustment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

For facilities for which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to the Bureau the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to the Bureau upon submission of the cost report.

Upon completion of desk reviews or audits, facilities will be notified by the Bureau of any changes in amounts due based on audit or desk review adjustments.

3. Rate Determination

Resident specific per diem rates are calculated based on information reported on the cost report. The rates are based on cost components appropriate for an economic and efficient ICF/ID providing quality service. The resident per diem rates represent the best judgment of the State to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ICFs/ID.

The cost data used in setting base rates will be from the latest available audited or desk reviewed cost reports. The initial rates will be adjusted to maintain budget neutrality upon transition to the ICAP reimbursement methodology. To adjust to budget neutrality, at implementation, the Direct Care component is multiplied by 105% of the previously stated calculation. For rate periods between rebasing, the rates will be trended forward using the index factor.

For dates of service on or after October 1, 2005 a resident's per diem will be the sum of:

a. direct care per diem rate;
b. care related per diem rate;
c. administrative and operating per diem rate;
d. capital rate; and
e. provider fee.

Effective for dates of service on or after April 1, 2014, the add-on amount to each ICF/ID's per diem rate for the provider fee shall be increased to $16.15 per day.