

Table of Contents

State/Territory Name: Louisiana

State Plan Amendment (SPA) #: LA 22-0011

This file contains the following documents in the order listed:

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

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



Financial Management Group

July 26, 2022

Patrick Gillies, Medicaid Executive Director
Louisiana Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

RE: Louisiana State Plan Amendment (SPA) 22-0011

Dear Mr. Gillies:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 22-0011. Effective for services on or after July 1, 2022, this SPA is to amend the provisions governing reimbursement to non-state intermediate care facilities for persons with intellectual disabilities in order to implement administrative penalties related to noncompliance with the direct care floor requirements.

We conducted our review of your submittal according to the statutory requirements at Sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act. We hereby inform you that Medicaid State plan amendment 22-0011 is approved effective July 1, 2022. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,



Rory Howe
Director

Enclosure

| | | |
|--|---|-----------------------|
| <p align="center">TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES</p> | 1. TRANSMITTAL NUMBER 22-0011 | 2. STATE LA |
| | 3. PROGRAM IDENTIFICATION: TITLE <u>XIX</u> OF THE SOCIAL SECURITY ACT | |
| TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE July 1, 2022 | |
| 5. FEDERAL STATUTE/REGULATION CITATION 42 CFR 447, Subpart F | 6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2023</u> \$ 0 b. FFY <u>2024</u> \$ 0 | |
| 7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19D, Pages 15 and 15a | 8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if Applicable) Same (TN 18-0011) | |

9. SUBJECT OF AMENDMENT
The purpose of this SPA is to amend the provisions governing reimbursement to non-state intermediate care facilities for persons with intellectual disabilities in order to implement administrative penalties related to noncompliance with the direct care floor requirements.

10. GOVERNOR'S REVIEW (Check One)

| | |
|---|---|
| <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor does not review State Plan material. |
|---|---|

| | |
|--|---|
| 11. SIGNATURE OF STATE AGENCY OFFICIAL | 15. RETURN TO Patrick Gillies, Medicaid Executive Director Louisiana Department of Health 628 North 4th Street P.O. Box 91030 Baton Rouge, LA 70821-9030 |
| 12. TYPED NAME Ruth Johnson, designee for Dr. Courtney N. Phillips | |
| 13. TITLE Secretary | |
| 14. DATE SUBMITTED May 4, 2022 | |

FOR CMS USE ONLY

| | |
|----------------------------------|------------------------------------|
| 16. DATE RECEIVED May 4, 2022 | 17. DATE APPROVED July 26, 2022 |
|----------------------------------|------------------------------------|

PLAN APPROVED - ONE COPY ATTACHED

| | |
|---|--|
| 18. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2022 | 19. SIGNATURE OF APPROVING OFFICIAL |
| 20. TYPED NAME OF APPROVING OFFICIAL Rory Howe | 21. TITLE OF APPROVING OFFICIAL Director, FMG |

22. REMARKS

STATE OF LOUISIANA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

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.

For providers receiving pervasive plus supplements, the facility wide direct care floor is established at 94 percent of the per diem direct care payment and at 100 percent of any rate supplements or add-on payments received by the provider, including the pervasive plus supplement, the complex care add-on payment 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 a client-specific rate adjustment. In no case, however, shall a facility receiving a pervasive plus supplement and/or client-specific rate adjustment, have total facility payments reduced to less than a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except in connection with an administrative penalty as noted below for repeat non-compliance with direct care floor requirements.

For providers receiving complex care add-on payment, but not receiving pervasive plus supplements or other client-specific adjustments to the rate, the facility wide direct care floor is established at 85 percent of the per diem direct care payment and at 100 percent of the complex care add-on payment. The direct care floor will be applied to the cost-reporting year in which the facility receives a complex care add-on payment. In no case shall a facility receiving a complex care add-on payment, have total facility payments reduced to less than a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except in connection with an administrative penalty as noted below for repeat non-compliance with direct care floor requirements.

For facilities to 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 Department, 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.

Effective for dates of service on or after July 1, 2022, if a provider receiving complex care or pervasive plus add-on payments has facility payments reduced as a result of imposition of the direct care floor, the Department may, at its discretion, levy a non-refundable administrative penalty separate from any other reduction in facility payments. The administrative penalty is not subject to any facility specific safe harbor percentage and is calculated solely on the final reduced payment amount for the cost report period in question.

STATE OF LOUISIANA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

The Department may impose sanctions for noncompliance with Medicaid laws, regulations, rules, and policies. Facilities that have payments reduced as a result of the imposition of the direct care floor with consecutive subsequent years of reduced payments, shall incur the following safe harbor and administrative penalties:

| Consecutive Cost Report Period with Reduced Payments | Administrative Penalty Levied on Reduced Payments | Safe Harbor Percentages |
|--|---|-------------------------|
| 1st Year | 0% | 104% |
| 2 nd Year | 0% | 102% |
| 3 rd Year | 5% | 100% |
| 4 th Year and Onwards | 10% | 100% |

At its discretion, the Department may terminate provider participation in the complex care or pervasive plus add-on payment programs, as a result of imposition of the direct care floor.

Upon completion of desk reviews or audits, facilities will be notified by the Department 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 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 budget neutrality, at implementation, the direct care component is multiplied by 105 percent of the previously stated calculation. For rate periods between rebasing, the rates will be trended forward using the Skilled Nursing Facility without Capital Market Basket Index, published by IHS Global Insight, Inc. (IGI), formerly Data Resources Inc. (DRI), for December 2018, divided by the index for December 2017.

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.