Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

VIA ELECTRONIC MAIL ONLY

November 9, 2015

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

RE: Louisiana Title XIX State Plan
Transmittal No. 15-0033

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan.

Sincerely,

Kathy H. Kliebert
Secretary

Attachments (3)

KHK:WJR:JH

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: **15-0033**

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
January 20 , 2016

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 **2016** **$ 545.75**
b. FFY **2017** **$1,225.74**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Page 10
Attachment 4.19-D, Page 11

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
NONE – New Page
NONE – New Page

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to amend the provisions governing the reimbursement methodology for nursing facilities in order to establish supplemental Medicaid payments for qualifying nursing facilities, owned or operated by a non-state governmental organization (NSGO), that have entered into an agreement with the Department to participate.**

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:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
November 9, 2015

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

LOUISIANA TITLE XIX STATE PLAN
TRANSMITTAL #: **15-0033**
TITLE: **Non-State Government Organization Nursing Facilities - Supplemental Payme**
EFFECTIVE DATE: **January 20, 2016**

FISCAL IMPACT:
Increase

	year	% inc.	fed. match	*# mos	range of mos.	dollars
1st SFY	2016		0.00%	5.33	January 20, 2016 - June 30,2016	$384,134
2nd SFY	2017	3.0%	0.00%	12	July 2016- June 2017	$1,974,775
3rd SFY	2018	3.0%	0.00%	12	July 2017 - June 2018	$1,974,775

*#mos-Months remaining in fiscal year

Total Increase in Cost FFY **2016**

SFY	2016	$384,134	for	5.33	months	January 20, 2016 - June 30,2016			$384,134
SFY	2017	$1,974,775	for	12	months	July 2016- June 2017			
		$1,974,775	/	12 X 3		July 2016 - September 2016	=		$493,694
									$877,828
			FFP (FFY 2016) =			**$877,828**	**X**	**62.17%** =	**$545,746**

Total Increase in Cost FFY **2017**

SFY	2017	$1,974,775	for	12	months	July 2016- June 2017			
		$1,974,775	/	12 X 9		October 2016 - June 2016	=		$1,481,081
SFY	2018	$1,974,775	for	12	months	July 2017 - June 2018			
		$1,974,775	/	12 X 3		July 2017 - September 2017	=		$493,694
									$1,974,775
			FFP (FFY 2017)=			**$1,974,775**	**X**	**62.07%** =	**$1,225,743**

F. Non-State Governmental Organization Nursing Facilities

Supplemental Payments

1. Effective for dates of service on or after January 20, 2016, any nursing facility that is owned or operated by a non-state governmental organization (NSGO) and has entered into an agreement with the Department to participate, shall qualify for a Medicaid supplemental payment adjustment, in addition to the uniform Medicaid rates paid to nursing facilities. The only qualifying nursing facilities effective for January 20, 2016 are:
   a. Gueydan Memorial Guest Home;
   b. Lane Memorial Hospital Geriatric Long-Term Care (LTC);
   c. LaSalle Nursing Home;
   d. Natchitoches Parish Hospital LTC Unit; and
   e. St. Helena Parish Nursing Home.

2. The supplemental Medicaid payment to a non-state, government-owned or operated nursing facility shall not exceed the facility's upper payment limit (UPL) pursuant to 42 CFR 447.272.

3. Payment Calculations. The Medicaid supplemental payment adjustment shall be calculated as follows. For each state fiscal year (SFY), the Medicaid supplemental payment shall be calculated as the difference between:
   a. the amount that the Department reasonably estimates would have been paid to nursing facilities that are owned or operated by a NSGO using the Medicare Resource Utilization Groups (RUGs) prospective payment system. For each Medicaid resident that is in a nursing facility on the last day of a calendar quarter, the minimum data set (MDS) assessment that is in effect on that date is classified using the Medicare RUGs system. The Medicare rate applicable to the Medicare RUG, adjusted by the Medicare geographic wage index, equals the Medicaid resident's estimated Medicare rate. A simple average Medicare rate is determined for each nursing facility by summing the estimated Medicare rate for each Medicaid resident in the facility and dividing by total Medicaid residents in the facility; and

b. the Medicaid per diem rate for nursing facilities that are owned or operated by a NSGO. The Medicaid rate shall be adjusted to include laboratory, radiology, and pharmacy services to account for program differences in services between Medicaid and Medicare. The statewide average of laboratory, radiology, and pharmacy services is calculated using Medicaid cost report data.

4. Each participating nursing facility's upper payment limit (UPL) gap shall be determined as the difference between the estimated Medicare rate and the adjusted Medicaid rate.
   a. Each facility's UPL gap is multiplied by the Medicaid days to arrive at its supplemental payment amount. Medicaid days are taken from the Medicaid cost report.

5. Frequency of Payments and Calculations
   a. For each calendar quarter, an estimated interim supplemental payment will be calculated as described in this section utilizing the latest Medicare RUGs and payment rates and Medicaid cost reports and available Medicaid payment rates. Payments will be made to each nursing facility that is owned or operated by a NSGO and that has entered into an agreement with the Department to participate in the supplemental payment program.
   b. Following the completion of the SFY, the final supplemental payment amount for the SFY just ended will be calculated. These calculations will be based on the final Medicare RUGs and payment rates and the most recently reviewed Medicaid cost reports and Medicaid payment rates that cover the just ended state fiscal year period. The final supplemental payment calculations will be compared to the estimated interim supplemental payments, and the difference, if positive, will be paid to the NSGO, and if negative, collected from the NSGO.

6. No payment under this section is dependent on any agreement or arrangement for provider or related entities to donate money or services to a governmental entity.

deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Wednesday, November 25, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Home and Community-Based Services Waivers—Residential Options Waiver Reserved Capacity Group

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund net programmatic costs of $63,092 for FY 15-16, $676,871 for FY 16-17 and $815,384 for FY 17-18. It is anticipated that $756 ($378 SGF and $378 FED) will be expendend in FY 15-16 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16 and 62.07 percent in FY 16-17 and FY 17-18.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have a net increase in federal revenue collections by approximately $103,443 for FY 15-16, $1,107,657 for FY 16-17 and $1,334,324 for FY 17-18. It is anticipated that $378 will be expended in FY 15-16 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.17 percent in FY 15-16 and 62.07 percent in FY 16-17 and FY 17-18.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule amends the provisions governing the Residential Options Waiver (ROW) in order to create a reserved capacity group to allow individuals with developmental disabilities who receive services in the Community Choices Waiver or the Adult Day Health Care Waiver programs to transition into the ROW. It is anticipated that implementation of this proposed rule will have a net increase in programmatic expenditures in the Medicaid program for ROW services by approximately $165,779 for FY 15-16, $1,784,528 for FY 16-17 and $2,149,708 for FY 17-18, but no correlating savings in the Adult Day Health Care and Community Choices Waivers as the vacated slots are anticipated to be filled at a later time.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1510#081

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Nursing Facilities
Non-State Governmental Organizations
Supplemental Payments
(LAC 50:II.20029)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt LAC 50:II.20029 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing provides Medicaid reimbursement to non-state, government-owned or operated nursing facilities for long-term care services provided to Medicaid recipients.

The department now proposes to amend the provisions governing the reimbursement methodology for nursing facilities in order to establish supplemental Medicaid payments for qualifying nursing facilities, owned or operated by a non-state governmental organization (NSGO), that have entered into an agreement with the department to participate. This action is being taken to promote the health and welfare of Medicaid recipients, ensure sufficient provider participation in the Nursing Facilities Program, and maintain adequate recipient access to nursing facility services.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement
Chapter 200. Reimbursement Methodology
§20029. Supplemental Payments

A. Non-State Governmental Organization Nursing Facilities

1. Effective for dates of service on or after January 20, 2016, any nursing facility that is owned or operated by a non-state governmental organization (NSGO), and that has entered into an agreement with the department to participate, shall qualify for a Medicaid supplemental payment adjustment, in addition to the uniform Medicaid rates paid to nursing facilities. The only qualifying nursing facilities effective for January 20, 2016 are:

a. Gueydan Memorial Guest Home;

b. Lane Memorial Hospital Geriatric Long-Term Care (LTC);

c. LaSalle Nursing Home;

d. Natchitoches Parish Hospital LTC Unit; and

e. St. Helena Parish Nursing Home.

2. The supplemental Medicaid payment to a non-state, government-owned or operated nursing facility shall not exceed the facility's upper payment limit (UPL) pursuant to 42 CFR 447.272.

3. Payment Calculations. The Medicaid supplemental payment adjustment shall be calculated as follows. For each state fiscal year (SFY), the Medicaid supplemental payment shall be calculated as the difference between:

a. the amount that the department reasonably estimates would have been paid to nursing facilities that are owned or operated by a NSGO using the Medicare resource utilization groups (RUGs) prospective payment system. For each Medicaid resident that is in a nursing facility on the last day of a calendar quarter, the minimum data set (MDS) assessment that is in effect on that date is classified using the Medicare RUGs system. The Medicare rate applicable to the Medicare RUG, adjusted by the Medicare geographic wage index, equals the Medicaid resident's estimated Medicare rate. A simple average Medicare rate is determined for each nursing facility by summing the estimated Medicare rate for each Medicaid resident in the facility and dividing by total Medicaid residents in the facility; and

b. the Medicaid per diem rate for nursing facilities that are owned or operated by a NSGO. The Medicaid rate shall be adjusted to include laboratory, radiology, and pharmacy services to account for program differences in services between Medicaid and Medicare. The statewide average of laboratory, radiology, and pharmacy services is calculated using Medicaid cost report data.

4. Each participating nursing facility's upper payment limit (UPL) gap shall be determined as the difference between the estimated Medicare rate calculated in §20029.A.3.a and the adjusted Medicaid rate calculated in §20029.A.3.b.

a. Each facility's UPL gap is multiplied by the Medicaid days to arrive at its supplemental payment amount. Medicaid days are taken from the Medicaid cost report.

5. Frequency of Payments and Calculations

a. For each calendar quarter, an estimated interim supplemental payment will be calculated as described in this Section utilizing the latest Medicare RUGs and payment rates and Medicaid cost reports and available Medicaid payment rates. Payments will be made to each nursing facility that is owned or operated by a NSGO and that has entered into an agreement with the department to participate in the supplemental payment program.

b. Following the completion of the state's fiscal year, the final supplemental payment amount for the state fiscal year just ended will be calculated. These calculations will be based on the final Medicare RUGs and payment rates and the most recently reviewed Medicaid cost reports and Medicaid payment rates that cover the just ended state fiscal year period. The final supplemental payment calculations will be compared to the estimated interim supplemental payments, and the difference, if positive, will be paid to the NSGO, and if negative, collected from the NSGO.

6. No payment under this Section is dependent on any agreement or arrangement for provider or related entities to donate money or services to a governmental entity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may reduce the total direct and indirect cost to the provider to provide the same level of service and enhance the provider's ability to provide the same level of service since this proposed Rule establishes supplemental payments to providers for the same services they already render.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Wednesday, November 25, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Nursing Facilities Non-State Governmental Organizations Supplemental Payments

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic costs of $145,642 for FY 15-16, $749,032 for FY 16-17 and $749,032 for FY 17-18; however the state match shall be met through an IGT financing arrangement whereby qualifying providers shall transfer to the department funds to secure federal match in order to fund the payments for these nursing facility services. It is anticipated that $648 ($324 SGF and $324

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

October 8, 2015

Karen Matthews, Health Director
Chitimacha Health Clinic
3231 Chitimacha Trail
Jeanerette, LA 70544

Angela Martin
Chitimacha Tribe of Louisiana
P. O. Box 640
Jeanerette, LA 70544

Anita Molo
Chitimacha Tribe of Louisiana
P. O. Box 640
Jeanerette, LA 70544

Marshall Pierite, Chairman
Misty Hutchby, Health Director
Tunica-Biloxi Tribe of Louisiana
P. O. Box 1589
Marksville, LA 71351-1589

Lovelin Poncho, Chairman
Paula Manuel, Health Director
Coushatta Tribe of Louisiana
P. O. Box 818
Elton, LA 70532

Chief Beverly Cheryl Smith
Holly Vanhoozen, Health Director
The Jena Band of Choctaw Indians
P. O. Box 14
Jena, LA 71342

Dear Louisiana Tribal Contact:

RE: Notification of Louisiana Medicaid State Plan Amendments

In compliance with the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009, the Department of Health and Hospitals, Bureau of Health Services Financing is taking the opportunity to notify you of State Plan amendments (SPAs) that may have an impact on your tribe.

Attached for your review and comments is a summary of the proposed State Plan amendments. Please provide any comments you may have by November 7, 2015 to Mrs. Darlene Budgewater via email to Darlene.Budgewater@la.gov or by postal mail to:

Department of Health and Hospitals
Bureau of Health Services Financing
Medicaid Policy and Compliance
P.O. Box 91030
Baton Rouge, LA 70821-9030

Should you have additional questions about Medicaid policy, Mrs. Budgewater will be glad to assist you. You may reach her by email or telephone at (225) 342-3881. Thanks for your continued support of the tribal consultation process.

Sincerely,

Darlene A. Budgewater

for J. Ruth Kennedy
Medicaid Director

Attachment (1)

JRK/DB/KS

c: Ford J. Blunt, III
Stacey Shuman

State Plan Amendment for submittal to CMS

Request for Tribal Comments

October 8, 2015

Federally Qualified Health Centers - Service Limits (Remove Visit Limit)

The SPA proposes to revise the provisions governing Federally Qualified Health Centers service limits in order to remove the 12 visits per year limit for Medicaid recipients 21 years of age and older.

Outpatient Hospital Services - Outpatient Clinics - Service Limits (Remove Visit Limit)

The SPA proposes to revise the provisions governing outpatient hospital services in order to remove the 12 visits per year limit on physician services provided in a clinic in an outpatient hospital setting.

Professional Services- Physician Services - OP Physician Visits - Service Limits (Remove Visit Limit)

The SPA proposes to revise the provisions in the Professional Services Program governing physician services in order to remove the limits from outpatient physician visits.

Rural Health Clinics- Service Limits (Remove Visit Limit)

The SPA proposes to revise the provisions governing Rural Health Clinics service limits in order to remove the 12 visits per year limit for Medicaid recipients 21 years of age and older.

Nursing Facilities- Non-State Governmental Organizations- Supplemental Payments

The SPA proposes to revise the provisions governing the reimbursement methodology for nursing facilities in order to establish supplemental Medicaid payments for qualifying nursing facilities, owned or operated by a non-state governmental organization (NSGO), that have entered into an agreement with the Department to participate.