

## **Table of Contents**

**State/Territory Name: Louisiana**

**State Plan Amendment (SPA) LA: 24-0023**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
Center for Medicaid & CHIP Services  
230 South Dearborn  
Chicago, Illinois 60604



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**Financial Management Group**

November 26, 2024

Kimberly Sullivan  
Medicaid Executive Director  
Louisiana Medicaid Program  
Louisiana Department of Health  
Bureau of Health Services  
Financing 628 North Fourth Street  
Post Office Box 91030  
Baton Rouge, Louisiana 70821-9030

RE: Louisiana TN 24-0023

Dear Medicaid Executive Director Kimberly Sullivan:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Louisiana state plan amendment (SPA) to Attachment 4.19B 24-0023 which was submitted to CMS on September 30, 2024. This plan amendment adopts provisions governing qualifying criteria and reimbursement methodology for other rural hospitals in order to increase payments for outpatient hospital services.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.



Based upon the information provided by the state, we have approved the amendment with an effective date of September 17, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Monica Neiman at via email at: [Monica.Neiman@cms.hhs.gov](mailto:Monica.Neiman@cms.hhs.gov).

Sincerely,

*Todd McMillion*

Todd McMillion  
Director  
Division of Reimbursement Review

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <b>24-0023</b>	2. STATE <b>LA</b>
		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 <del>July 1, 2024</del> <b>September 17, 2024</b>	
5. FEDERAL STATUTE/REGULATION CITATION <b>42 CFR 440.10</b> <b>42 CFR 440.20</b> <b>42 CFR 447.321</b> <b>42 CFR 447.272</b>		6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <b>2024</b> <del>\$1,760,335</del> <b>\$252,314</b> b. FFY <b>2025</b> <b>\$7,832,358</b>	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  <b>Attachment 4.19-B, Item 2a, Pages 16-17 (New Pages)</b>		8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)	
9. SUBJECT OF AMENDMENT <b>The purpose of this SPA is to adopt provisions governing qualifying criteria and reimbursement methodology for other rural hospitals in order to increase payments for outpatient hospital services.</b>			
10. GOVERNOR'S REVIEW (Check One) <div><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</div> <div><input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor does not review State Plan material.</div>			
11. SIGNATURE OF STATE AGENCY OFFICIAL 		15. RETURN TO <b>Kimberly Sullivan, J.D.</b> <b>Medicaid Executive Director</b> <b>Louisiana Department of Health</b> <b>628 North 4<sup>th</sup> Street</b> <b>P.O. Box 91030</b> <b>Baton Rouge, LA 70821-9030</b>	
12. TYPED NAME <b>Michael Harrington, MBA, MA</b>			
13. TITLE <b>Secretary</b>			
14. DATE SUBMITTED <b>September 30, 2024</b>			
FOR CMS USE ONLY			
16. DATE RECEIVED <b>September 30, 2024</b>		17. DATE APPROVED <b>November 26, 2024</b>	
PLAN APPROVED - ONE COPY ATTACHED			
18. EFFECTIVE DATE OF APPROVED MATERIAL <b>September 17, 2024</b>		19. SIGNATURE OF APPROVING OFFICIAL 	
20. TYPED NAME OF APPROVING OFFICIAL <b>Todd McMillion</b>		21. TITLE OF APPROVING OFFICIAL <b>Director, Division of Reimbursement Review</b>	
22. REMARKS <b>The State made a pen and ink change to box 5. (November 1, 2024)</b> <b>11.13.2024 The State made a pen and ink change to boxes 4 and 6.</b>			

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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:

**Other Rural Hospitals**

In order to qualify as an other rural, non-state hospital the hospital shall meet the following criteria:

- a. Is a non-state owned hospital;
- b. Has no more than sixty licensed beds as of October 1, 2024, excluding distinct part psychiatric unit beds, distinct part rehabilitation unit beds, and nursery bassinets;
- c. Does not qualify as a rural hospital as defined in Attachment 4.19-A, Section D.3.b;
- d. Is not located within one of Louisiana's metropolitan statistical areas (MSA) as delineated in OMB Bulletin No. 23-01;
- e. Has an operational emergency room; and
- f. Is located in a municipality with a population of less than 23,000 as measured by the 2020 United States Census.

**Reimbursement Methodology**

Effective for dates of service on or after September 17, 2024, reimbursement rates paid to other rural, non-state hospitals for outpatient hospital services shall be as follows:

- a. Surgery Services. The reimbursement amount for outpatient hospital surgery services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.
- b. Clinic Services. The reimbursement amount for outpatient hospital facility fees for clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.
- c. Laboratory Services. The reimbursement amount for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.
- d. Rehabilitation Services. The reimbursement amount for outpatient rehabilitation services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.



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- e. Other Outpatient Hospital Services. The reimbursement amount for outpatient hospital services other than surgery services, clinic services, clinical diagnostic laboratory services, and rehabilitation services shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated per the latest filed cost report. Final payment shall be 95 percent of allowable cost as determined through the cost report settlement process.

If a qualifying hospital's outpatient costs is greater in subsequent cost reporting periods than the initial implementation year cost report period's cost, outpatient costs shall be subjected to a cap prior to determination of cost settlement amount. Calculation of reimbursable costs shall be as follows:

- a. An average cost per Medicaid outpatient unduplicated encounter per day shall be established using Medicaid cost report and paid claims data from the initial cost report period of implementation. The average unduplicated encounter cost per day shall be calculated by dividing the total outpatient allowable costs for all Medicaid outpatient services by the number of paid unduplicated encounters per day. Clinical diagnostic laboratory services and vaccines are not included in this calculation.
- b. To determine the capped limit for each subsequent year's allowable cost settlement reimbursement, the base year outpatient unduplicated encounter per day cost shall be multiplied by the unduplicated encounters from the applicable subsequent cost reporting period's Medicaid paid claims data and then increased by three percent cumulatively for each year subsequent to the initial implementation year.
- c. Final reimbursement shall be 95 percent multiplied by the lesser of capped cost amount calculated per a.-b., or actual allowable cost for the applicable cost report.

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. In accordance with 42 CFR 447.272, 447.321, 440.20, and 440.10, there will be no duplication of costs.