

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Dallas Regional Office  
1301 Young Street, Suite 833  
Dallas, Texas 75202



**DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI**

January 28, 2014

Our Reference: SPA LA 13-30

Ms. Ruth Kennedy, State Medicaid Director  
Department of Health and Hospitals  
Bienville Building  
628 North 4<sup>th</sup> Street  
Post Office Box 91030  
Baton Rouge, LA 70821-9030

Attn: Darlene Adams  
Jodie Hebert

Dear Ms. Kennedy:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 13-30. The state plan amendment changes the criteria and reimbursement methodology for outpatient hospital services in order to make Terrebonne General Hospital qualify for the supplemental payment that West Jefferson is currently receiving.

Transmittal Number 13-30 is approved with an effective date of July 1, 2013 as requested. A copy of the HCFA-179, Transmittal No. 13-30 dated August 27, 2013 is enclosed along with the approved plan pages.

If you have any questions, please contact Ford Blunt III at [ford.blunt@cms.hhs.gov](mailto:ford.blunt@cms.hhs.gov) or by phone at (214) 767-6381.

Sincerely,

A handwritten signature in black ink, appearing to read "Bill Brooks", is positioned above the printed name.

Bill Brooks  
Associate Regional Administrator

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

**13-30**

2. STATE

**Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

**July 1, 2013**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 F**

7. FEDERAL BUDGET IMPACT:

a. FFY **2013**

**\$9,963.94**

b. FFY **2014**

**\$7,557.44**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 4.19-B, Item 2a, Page 5**

**Attachment 4.19-B, Item 2a, Page 5a**

9. PAGE NUMBER OF THE SUPERSEDED PLAN  
SECTION OR ATTACHMENT (If Applicable):

**Same (TN 12-60)**

**None (New Page)**

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the provisions governing the reimbursement methodology for outpatient hospital services in order to revise the qualifying criteria and reimbursement methodology for non-rural, non-state public hospitals.**

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:

**August 23, 2013**

16. RETURN TO:

**J. Ruth Kennedy, Medicaid Director**

**State of Louisiana**

**Department of Health and Hospitals**

**628 N. 4<sup>th</sup> Street**

**PO Box 91030**

**Baton Rouge, LA 70821-9030**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: **27 August, 2013**

18. DATE APPROVED: **28 January, 2014**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
**1 July, 2013**

20. SIGNATURE OF REGIONAL OFFICIAL:

*Bill Brooks*

21. TYPED NAME: **Bill Brooks**

22. TITLE: **Associate Regional Administrator**  
**Division of Medicaid & Children's Health**

23. REMARKS: **Please make a pen and ink change to form 179 box 7, 8, and 9 as noted above.**

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

**Supplemental Payments for Non-Rural, Non-State Government Hospitals**

Effective for dates of service on or after October 1, 2012 through June 30, 2013 quarterly supplemental payments shall be issued to qualifying non-rural, non-state government hospitals for outpatient hospital services.

- a) **Qualifying criteria** – Effective October 1, 2012, the quarterly supplemental payment will be made to West Jefferson Medical Center for SFY 2013.
- b) **Payment Methodology** – Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. For SFY 2013, this payment shall be \$7,060,008 not to exceed the upper payment limits pursuant to 42 CFR 447.321. Maximum payments shall not exceed the upper payment limit pursuant to 42CFR 447.321.

Effective for dates of service on or after July 1, 2013, quarterly supplemental payments shall be issued to the following qualifying non-rural, non-state government hospitals for outpatient hospital services.

- a) **Qualifying criteria** – Effective July 1, 2013, the quarterly supplemental payment will be made to Terrebonne General Hospital.
- b) **Payment Methodology** – Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year not to exceed the upper payment limits pursuant to 42 CFR 447.321. The UPL calculation methodology for outpatient non-state hospitals (governmental and private) is as follows:

- 1. Accumulate Medicaid claims data for outpatient services for each non-state hospital from the previous state fiscal year.
- 2. Separate charges and payments from paid claims between services reimbursed on a percentage of cost basis from services reimbursed at a fee-for-service rate.
- 3. Compile cost to charge ratios for Medicaid outpatient services from latest filed Medicare/Medicaid cost report (Form CMS 2552).
- 4. For services reimbursed at a fee-for-service rate (other than outpatient clinical laboratory services):
  - a. Multiply cost to charge ratio by Medicaid outpatient charges (except for outpatient clinical laboratory services) to determine Medicaid outpatient costs.
  - b. Subtract claims payments from costs.
- 5. For Medicaid outpatient services reimbursed at a percentage of cost:
  - a. Multiply cost to charge ratio by Medicaid outpatient claims charges to determine Medicaid outpatient costs.
  - b. Multiply Medicaid costs by the applicable percentage of allowable cost reimbursed for a period to determine Medicaid payment which would be calculated upon cost settlement.
  - c. Subtract calculated payment from costs.

State: Lousiana  
Date Rec'd: 8/27/13  
Date Apprd: 1/28/14  
Date Eff: 7/1/13  
TN #: 13-30

TN# 13-30  
Supersedes  
TN# 12-60

Approval Date 1/28/14

Effective Date 7/1/13

**PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES**

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

6. For each hospital, add the differences of the Medicaid costs less Medicaid payments for the cost-based services and the fee-for-service rate services.
7. Trend the difference forward to the midpoint of the current state fiscal year using the CMS Market Basket Index for PPS hospitals.
8. The sum of the difference for each hospital for all hospitals in the group is the upper payment limit for that group of hospitals.

Maximum payments shall not exceed the upper payment limit pursuant to 42CFR 447.321.

**Reimbursement for In-State Outpatient Children's Specialty Hospitals**

a. Qualifications

In order to qualify to receive Medicaid reimbursement as an in-state children's specialty hospital, a non-rural, non-state acute care hospital must meet the following criteria. The hospital must:

- (1) be recognized by Medicare as a prospective payment system (PPS) exempt children's specialty hospital;

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