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

July 29, 2014

Our Reference: SPA LA 14-20

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

Attn: Darlene Budgewater
Jodie Hebert

Dear Ms. Kennedy:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 14-20. The SPA proposes to amend the provisions governing the reimbursement methodology for physician services to adopt a manual pricing methodology for covered services that do not have Medicare established rates.

Transmittal Number 14-20 is approved with an effective date of May 20, 2014 as requested. A copy of the HCFA-179, Transmittal No. 14-20 dated June 9, 2014 is enclosed along with the approved plan pages.

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

Sincerely,

Bill Brooks
Associate Regional Administrator

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: **14-20**

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
May 20, 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 447.201

7. FEDERAL BUDGET IMPACT:
a. FFY **2014** **$0**
b. FFY **2015** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Item 5, Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 87-09)

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to amend the provisions governing the reimbursement methodology for physician services to adopt a manual pricing payment methodology for covered services that do not have Medicare established rates.**

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:
June 9, 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: June 9, 2014

18. DATE APPROVED: July 29, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
May 20, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Bill Brooks

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

23. REMARKS:

FORM HCFA-179 (07-92)

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

State: Louisiana
Date Received: 9 June, 2014
Date Approved: 29 July, 2014
Date Effective: 20 May, 2014
Transmittal Number: 14-20

CITATION
42 CFR 447.201

Medical and Remedial Care and Services- Item 5

I. Method of Payment

Effective February 1, 1987, the Medicaid Program began implementation of a statewide flat fee-for-service reimbursement methodology for services provided by professional services providers such as, but not limited to physicians, osteopaths, optometrists, dentists, and nurse-midwives. In order to determine flat-fee amounts, we compared billed charges, maximum allowable prices on file, and average amounts paid for the full service aspect of all payable CPT procedure codes for calendar year 1984. This review was conducted by Medicaid Program staff and consultant physicians. Prices for full service were adjusted only when the maximum allowable payment for a given procedure was found to be out of line with the difficulty of the procedure. Other types of service prices were calculated using the same percentage formula as that used by Medicare (20% of full service for assistant surgeon, 40% of full service for professional component only). For services added as newly payable, Medicare state-wide prevailing fees were obtained and reduced by 30%. For items of care, services and procedure not covered by Medicare Part B, and no reasonable charges were set by the Medicare contractor, prices were based on review of statewide billed charges for that service in comparison with set charges for similar services or, if no similar services, based upon consultant physicians' review and recommendations of reasonable charges. National Medicare Laboratory Fee Schedules were adopted for those laboratory services covered by the Fee Schedule.

Changes in the established flat rate which are found to be necessary for any item of care, service or procedure shall be reviewed as follows:

The Medicaid Program shall review and make changes based on statewide billed charges for that service in comparison with set charges for similar services, and consultant physicians' review and recommendations of reasonable charges. For items of care, services, and procedures that do not have charges set by the Medicare contractor, the Medicaid Program shall make changes based upon review of statewide billed charges for that service in comparison with set charges for similar services or, if no similar services, based upon consultant physician' review and recommendations of reasonable charges.

The reimbursement fee for items of care, services and procedures then becomes the maximum allowable payable under the Medicaid Program. Each item of care, service, and procedure has assigned to it a Health Care Procedure Code (HCPC). For each HCPC a maximum reimbursement (flat-fee) is assigned and automated payment is made based on the flat-fee amount assigned to each HCPC, not to exceed billed charges.

Effective May 20, 2014, the reimbursement for newly payable services not covered by Medicare, when there is no established rate set by Medicare, shall be based on review of statewide billed charges for that service in comparison with set charges of similar services.

1. If there is no similar procedure or service, the reimbursement shall be based upon a consultant physicians' review and recommendations.
2. For procedures which do not have established Medicare fees, the Department of Health and Hospitals, or its designee, shall make determinations based upon a review of statewide billed charges for that service in comparison with set charges for similar services.
3. Reimbursement shall be the lesser of the billed charges or the Medicaid fee on file.