

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



MAY 23 2017

Mrs. Jen Steele, Director
Bureau of Health Services Financing
Department of Health
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 17-0012

Dear Mrs. Steele:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 17-0012. The Louisiana Department of Health submitted this amendment to revise the reimbursement methodology for disproportionate share hospital (DSH) payments to Louisiana low-income academic hospitals in order to revise the reimbursement schedule from annual to quarterly payments.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A.

Based upon your assurances, Medicaid State plan amendment 17-0012 is approved effective July 1, 2017. We are enclosing the CMS-179 and the new plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

A handwritten signature in blue ink that reads 'Kristin Fan'. The signature is fluid and cursive, with the first name 'Kristin' and last name 'Fan' clearly distinguishable.

Kristin Fan
Director

Enclosures

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

1. TRANSMITTAL NUMBER:

17-0012

2. STATE

Louisiana

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

4. PROPOSED EFFECTIVE DATE

July 1, 2017

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 2017 **\$0**

b. FFY 2018 **\$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Item 1, Page 10 k (5)

Attachment 4.19-A, Item 1, Page 10 k (5)a

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 PAGE NUMBER OF THE SUPERSEDED PLAN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

Same (TN 16-0014)

Same (TN 16-0014)

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to revise the provisions governing the reimbursement methodology for disproportionate share hospital (DSH) payments to Louisiana low-income academic hospitals in order to revise the reimbursement schedule from annual to quarterly payments.**

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:

Rebekah E. Gee MD, MPH

14. TITLE:

Secretary

15. DATE SUBMITTED:

March 29, 2017

16. RETURN TO:

Jen Steele, Medicaid Director

State of Louisiana

Department of Health

628 North 4th Street

P.O. Box 91030

Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

March 29, 2017

18. DATE APPROVED:

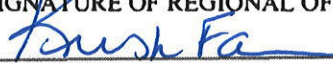
MAY 23 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Kristin Fan

22. TITLE:

Director, FMC

23. REMARKS: **The State requests to replace the Form 179 with this final version.**

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

2. having Medicaid inpatient days utilization, greater than 45 percent. Qualification shall be calculated by dividing the Medicaid inpatient days by the total inpatient days reported on the Medicaid as filed cost report ending during SFY 2015, received by April 30, 2016, and shall include traditional, shared, and managed care Medicaid days per the worksheet S-3 part I, lines 1 through 18. Column 7 shall be used to determine allowable Medicaid days and column 8 shall be used to determine total inpatient days; and
3. having a ratio of intern and resident FTEs to total inpatient beds that is greater than 1.25. Qualification shall be based on total inpatient beds and intern and resident FTEs reported on the Medicare/Medicaid cost report ending during SFY 2015. The ratio of interns and resident FTEs shall be calculated by dividing the unweighted intern and resident FTEs as reported on the Medicare Cost Report Worksheet E-4, Line 6 by the total inpatient beds, excluding nursery and Medicare designated distinct part psychiatric unit beds, reported on worksheet S-3, column 2, lines 1 through 18.

Payment Methodology

- A. Each qualifying hospital shall be paid DSH adjustment payments equal to 100 percent of allowable hospital specific uncompensated care costs.
 1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the Department.
 2. The Department shall review cost data, charge data, lengths of stay and Medicaid claims data per the Medicaid Management and Information Systems for reasonableness before payments are made.
- B. Effective for dates of service on or after July 1, 2017, for payment calculations, the most recent Medicaid filed cost report, along with actual Medicaid and uninsured patient charge data from the most recently filed Medicaid cost report with Medicaid and uninsured charge data from the same time period, is utilized to calculate hospital specific uncompensated care costs. Costs and patient utilization from a more current time period may be considered in the calculation of the DSH payment if significant changes in costs, services, or utilization can be documented. This change in the time period utilized must receive prior approval by the Department.
- C. Effective for dates of service on or after July 1, 2017, the first payment of each fiscal year will be made by October 30 and will be 25 percent of the annual calculated uncompensated care costs. The remainder of the payment will be made by January 30, April 30 and June 30 of each year.
 1. Reconciliation of these payments to actual hospital specific uncompensated care costs will be made when the cost report(s) covering the actual dates of service from the state fiscal year are filed and reviewed.
 2. If additional payments or recoupments are needed based on the results of the mandated DSH audit report, they shall be made within one year after the final report for the state fiscal year is submitted to the Centers for Medicare and Medicaid Services (CMS).

State: Louisiana
Date Received: March 29, 2017
Date Approved: **MAY 23 2017**
Date Effective: July 1, 2017
Transmittal Number: 17-0012

TN 17-0012

Approval Date **MAY 23 2017** Effective Date 7-1-2017

Supersedes

TN 16-0014

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-A
Item 1, Page 10k (5)a

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

- D. 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.
- E. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit.

State: Louisiana
Date Received: March 29, 2017
Date Approved: MAY 23 2017
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TN 17-0012
Supersedes
TN 16-0014

Approval Date **MAY 23 2017** Effective Date 7-1-2017