John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

VIA ELECTRONIC MAIL ONLY

March 29, 2017

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. 17-0012

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.

Warmly,

Approved for

Rebekah E. Gee MD, MPH
Secretary

Attachments (2)

REG:JS: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: **17-0012**

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: **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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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) - Reserved

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:

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: **The State requests a pen and ink change to box number 9.**

FORM HCFA-179 (07-92)

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. Additional payments or recoupments, as needed, shall be made after the finalization of the Centers for Medicare and Medicaid Services (CMS) mandated DSH audit for the state fiscal year.

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.

RESERVED