

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



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**Financial Management Group**

October 21, 2019

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

RE: Louisiana 19-0021

Dear Mrs. Steele:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 19-0021. This amendment proposes to amend the provisions governing the reimbursement methodology for inpatient hospital services to increase outlier pool 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.

We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2019. We are enclosing the CMS-179 and the amended approved plan page.

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

Sincerely,

A handwritten signature in blue ink, appearing to read "Kristin Fan", with a small "for" written below it.

Kristin Fan  
Director

cc:

Tia Lyles  
Tamara Sampson

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <b>19-0021</b>	2. STATE <b>Louisiana</b>
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE <b>July 1, 2019</b>	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION  <b>42 CFR 447 Subpart C</b>		7. FEDERAL BUDGET IMPACT a. FFY <b>2019</b> \$ <del>9,012,396</del> <b>\$138,852</b> b. FFY <b>2020</b> \$ <del>7,416,231</del> <b>\$112,161</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  <b>Attachment 4.19-A, Item 1, Page 8a (1)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <b>Same (TN 11-34)</b>	
10. SUBJECT OF AMENDMENT <b>The purpose of this SPA is to amend the provisions governing the reimbursement methodology for inpatient hospital services to increase outlier pool payments.</b>			
11. GOVERNOR'S REVIEW (Check One) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      The Governor does not review State Plan material. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL		16. RETURN TO <b>Jen Steele, Medicaid Director State of Louisiana Department of Health 628 North 4<sup>th</sup> Street P.O. Box 91030 Baton Rouge, LA 70821-9030</b>	
13. TYPED NAME <b>Cindy Rives, designee for Rebekah E. Gee MD, MPH</b>			
14. TITLE <b>Secretary</b> <i>Cindy Rives</i>			
15. DATE SUBMITTED <b>August 13, 2019</b>			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED <b>August 13, 2019</b>		18. DATE APPROVED <b>OCT 21 2019</b>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL <b>July 1, 2019</b>		20. SIGNATURE OF REGIONAL OFFICIAL <i>[Signature]</i> for	
21. TYPED NAME <b>Kristin Fan</b>		22. TITLE <b>Director, FMG</b>	
23. REMARKS <b>The State requests a pen and ink change to box 7.</b>			

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

Effective on or after July 1, 2019, the outlier pool for admissions during SFY 2019 and subsequent SFYs, shall cover eligible Medicaid fee-for-service (FFS) and managed care organization claims and payments and shall not exceed \$21,092,179 annually. Outlier payments shall be calculated as follows: (costs of each hospital's eligible FFS claims less prospective payment divided by sum of all eligible outlier claims less prospective payment) multiplied by annual outlier pool amount.

**8. Reimbursement for Small Rural Hospitals**

- a. Effective for dates of service on or after July 1, 2008, small rural hospitals as defined in D.3.b. shall be reimbursed at a prospective per diem rate. The per diem rate shall be the median cost plus ten percent which shall be calculated based on each hospital's year-end cost report period ending in calendar year 2006. If the cost reporting period is not a full period (twelve months), the latest filed full period cost report shall be used. The Medicaid cost per inpatient day for each small rural hospital shall be inflated from their applicable cost reporting period to the midpoint of the implementation year (December 31, 2008) by the Medicare market basket inflation factor for PPS hospitals, then arrayed from high too low to determine the median inpatient acute cost per day for all small rural hospitals. The payment rate for inpatient acute services in small rural hospitals shall be the median cost amount plus ten percent. The median cost and rates shall be rebased at least every other year using the latest filed full period cost reports as filed in accordance with Medicare timely filing guidelines.
- b. Effective for dates of service on or after August 1, 2010, quarterly supplemental payments will be issued to qualifying small rural hospitals for inpatient services rendered during the quarter.
  1. Qualifying criteria
    - a. Public (non-state) small rural hospital – a small rural hospital as defined in D.3.b.(1) which is owned by a local government and as of August 1, 2010 and has a certified neonatal intensive care unit.
    - b. Private small rural hospital- a small rural hospital as defined in D.3.b.(1)(i)
  2. Reimbursement methodology - each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payments shall be the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the Department. In the event that the above supplemental payments exceed state appropriated amounts, payment amounts to qualifying hospitals shall be reduced on a pro rata basis to equal the state appropriated level of funding.

State: Louisiana

Date Received: August 13, 2019

Date Approved: OCT 21 2019

Date Effective: July 1, 2019

Transmittal Number: 19-0021

TN: 19-0021

Approval Date OCT 21 2019

Effective Date: 7-1-2019

Supersedes

TN: 11-34