John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

December 15, 2023

James G. Scott, Director
Division of Program Operations
Medicaid & CHIP Operations Group
601 East 12th Street, Room 0300
Kansas City, Missouri 64106-2898

RE: Louisiana Title XIX State Plan
Transmittal No. 23-0034

Dear Mr. Scott:

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. Should you have any questions or concerns regarding this matter, please contact Karen Barnes at (225) 342-3881 or via email at Karen.Barnes@la.gov.

Sincerely,

_____ for
Stephen R. Russo, JD
Secretary

Attachments (2)

SRR:KS:KC

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **23-0034**

2. STATE: **LA**

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION

42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY **2023** $ **0**
b. FFY **2024** $ **0**

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, Item 1, Pages 8
Attachment 4.19-A, Item 1, Page 10 l (1)(c)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same (TN 11-08)
Same (TN 20-0017)

9. SUBJECT OF AMENDMENT
The purpose of this SPA is to amend the provisions governing payments for well baby and transplant services, within the inpatient hospital services program, in order to align with current practices.

10. 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.

11. SIGNATURE OF STATE AGENCY OFFICIAL
Pam Diez

12. TYPED NAME
Pam Diez, designee for Stephen R. Russo, JD

13. TITLE
Secretary

14. DATE SUBMITTED
December 15, 2023

15. RETURN TO

Kimberly Sullivan, J.D.
Interim Medicaid Executive Director
Louisiana Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

The following payments shall be made in addition to the prospective rate described above:

a. Infant Care

(1) Nursery Boarder Infants Payment

On some occasions a newborn remains in a hospital nursery after the mother has been discharged. Reimbursement is established at the weighted median for all hospitals providing maternity care, based on 1991 cost inflated to the implementation year as described in "Inflation Factor" above, and annually thereafter.

(2) Well Baby Care

A separate prospective per diem rate shall be paid to qualifying hospitals for well baby care rendered to infants who are discharged at the same time that the mother is discharged. The per diem rate for well baby care shall be the same prospective rate that is paid for nursery boarder baby service.

Qualifying Criteria

Non-state, non-rural hospitals that perform more than 1,500 Medicaid deliveries per year shall be eligible for this payment. The Department will verify that qualifying hospitals meet the required delivery threshold each state fiscal year. Well baby payments shall be discontinued should a hospital fail to meet the qualifying criteria.

b. Outlier Payments

In compliance with the requirement of §1902(s)(1) of the Social Security Act, additional payment shall be made for catastrophic costs associated with services provided to 1) children under age six who received inpatient services in a disproportionate share hospital setting, and 2) infants who have not attained the age of one year who received inpatient services in any acute care setting.

Cost is defined as the hospital-specific cost to charge ratio based on the hospital's cost report period ending in state fiscal year (SFY) 2000 (July 1, 1999 through June 30, 2000).

For new hospitals and hospitals that did not provide Medicaid Neonatal Intensive Care Unit (NICU) services in SFY 2010, the hospital-specific cost to charge ratio will be calculated based on the first full year cost reporting period that the hospital was open or that Medicaid NICU services were provided.

The hospital specific cost to charge ratio will be reviewed bi-annually to determine the need for adjustment to the outlier payment.

A deadline of six months subsequent to the date that the final claim is paid shall be established for receipt of the written request filing for outlier payments. In addition, effective March 1, 2011, outlier claims for dates of service on or before February 28, 2011 must be received by the Department on or before May 31, 2011 in order to qualify for payment. Claims for this time period received by the Department after May 31, 2011 shall not qualify for payment.

G. Transplant Services

Reimbursement Methodology

Reimbursement shall be limited to the lesser of allowable cost, net of capital and medical education cost, or the hospital-specific per diem limitation calculated for each type of transplant.

1. Allowable cost is defined as the ratio of cost to charges from the annual filed cost report multiplied by the covered charges, net of capital and medical education cost, for the specific transplant type.

2. The per diem limitation is calculated by deriving the hospital's per diem for the transplant type from the hospital's base period trended forward using the Medicare target rate inflation percentage for prospective payment system (PPS)-exempt hospitals.

3. The base period is the cost reporting period for the hospital's fiscal year ending September 30, 1983 through August 31, 1984. The base period for types of transplants that were not performed in the base period shall be the first subsequently filed cost report that includes costs for that type of transplant.

4. Reasonable capital and medical education costs as calculated per the annual filed cost report shall be paid as a pass through cost and included in cost report settlement amounts.

Qualifying Criteria

The hospital must be a Medicare approved transplant center for each type of organ transplant to qualify for reimbursement of Medicaid transplant services. Bone marrow transplant, stem cell transplant, and certain autologous immunotherapies (such as CAR T-cell therapy) services shall only be allowable for payment to hospitals that are accredited by the Foundation for the Accreditation of Cellular Therapy (FACT).