



**State of Louisiana**  
Louisiana Department of Health  
Office of the Secretary

July 2, 2024

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

RE: Louisiana Title XIX State Plan  
Transmittal No. 24-0016

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,

  
Michael Harrington, MBA, MA  
Secretary

Attachments (3)

MH:KS:KC

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <b>24-0016</b>	2. STATE <b>LA</b>
		3. PROGRAM IDENTIFICATION: TITLE <u>XIX</u> OF THE SOCIAL SECURITY ACT	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>July 1, 2024</b>	
5. FEDERAL STATUTE/REGULATION CITATION  <b>42 CFR 440.20(a)</b> <b>42 CFR 447.321</b>		6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2024</u> <b><u>\$3,689,803</u></b> b. FFY <u>2025</u> <b><u>\$15,787,045</u></b>	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  <b>Attachment 4.19-B, Item 2.a., Page 14</b> <b>Attachment 4.19-B, Item 2.a., Page 15 (New Page)</b>		8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <b>Same (TN 22-0034)</b>	
9. SUBJECT OF AMENDMENT <b>The purpose of this SPA is to adopt provisions governing qualifying criteria and reimbursement methodology for high Medicaid utilization academic hospitals in order to increase payments for outpatient hospital services.</b>			
10. GOVERNOR'S REVIEW (Check One) <div><input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL</div> <div><input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor does not review State Plan material.</div>			
11. SIGNATURE OF STATE AGENCY OFFICIAL 		15. RETURN TO  <b>Kimberly Sullivan, J.D.</b> <b>Medicaid Executive Director</b> <b>Louisiana Department of Health</b> <b>628 North 4<sup>th</sup> Street</b> <b>P.O. Box 91030</b> <b>Baton Rouge, LA 70821-9030</b>	
12. TYPED NAME <b>Michael Harrington, MBA, MA</b>			
13. TITLE <b>Secretary</b>			
14. DATE SUBMITTED <b>July 2, 2024</b>			
<b>FOR CMS USE ONLY</b>			
16. DATE RECEIVED		17. DATE APPROVED	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
18. EFFECTIVE DATE OF APPROVED MATERIAL		19. SIGNATURE OF APPROVING OFFICIAL	
20. TYPED NAME OF APPROVING OFFICIAL		21. TITLE OF APPROVING OFFICIAL	
22. REMARKS			

LA TITLE XIX SPA  
TRANSMITTAL #: 24-0016  
TITLE: Outpatient Hospital Services - High Medicaid Utilization Academic Hospitals  
EFFECTIVE DATE: July 1, 2024

FISCAL IMPACT:  
Increase

	year			*# mos	range of mos.	dollars
1st SFY	2025			12	July 2024 - June 2025	\$21,810,567
2nd SFY	2026			12	July 2025 - June 2026	\$27,351,401
3rd SFY						

\*#mos-months remaining in fiscal year

Total increase or decrease cost FFY 2024  
\$21,810,567 / 12 X 3 months July 2024 - September 2024 = \$5,452,642  
\$5,452,642 X 67.67% \$3,689,803

FFP (FFY 2024 ) = \$3,689,803

Total increase or decrease cost FFY 2025  
\$21,810,567 / 12 X 9 months October 2024 - June 2025 = \$16,357,925  
\$16,357,925 X 68.06% = \$11,133,204

\$27,351,401 / 12 X 3 months July 2025 - September 2025 = \$6,837,850  
\$6,837,850 X 68.06% \$4,653,841

FFP (FFY 2025 )= \$15,787,045

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

1. **Rehabilitation Services:** An interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.
2. **Other Outpatient Hospital Services:** For outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees, reimbursement shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

The above payment rates are contingent on the hospital continuing to meet all qualifying criteria set forth above. The addition of any off-site campus, beyond an outpatient primary care clinic, to the license of this hospital will invalidate the provisions of this reimbursement methodology.

**High Medicaid Utilization Academic Hospitals**

**Qualifying Criteria**

Effective for dates of service on or after July 1, 2024, the hospital shall meet the following criteria per the Medicare/Medicaid as filed cost report for their fiscal year ended in state fiscal year 2023:

1. have a Medicaid inpatient utilization of at least 39 percent; and
2. have an approved graduate medical education program with at least 400 intern and resident full time equivalents (FTEs). The intern and resident FTE count must be included on the Medicare/Medicaid cost report on worksheet E-4, line 6 plus worksheet E-3, Part II, line 6.

Qualifying hospitals shall not add additional locations under their license, without prior written approval of the Department. The addition of any off-site campus, beyond an outpatient primary care clinic, to the license of the hospital will invalidate the provisions of this reimbursement methodology.

**Reimbursement Methodology**

Reimbursement for outpatient hospital services to qualifying high Medicaid academic hospitals that meet all of the criteria above shall be made as follows:

1. **Outpatient Surgery:** The reimbursement amount for outpatient hospital surgery services shall be an interim payment equal to the Medicaid fee schedule amount on file for each

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service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

2. **Clinic Services:** The reimbursement amount for outpatient clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.
3. **Laboratory Services:** The reimbursement amount for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.
4. **Rehabilitation Services:** The reimbursement amount for outpatient rehabilitation services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.
5. **Other Outpatient Hospital Services:** The reimbursement amount for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

These rates are conditional on the hospital continuing to meet all qualifying criteria listed above. If the hospital no longer qualifies, payments will revert back to appropriate non-rural, non-state hospital assigned rates effective on the date that the qualification(s) in the criteria listed above are no longer met.

The Department may review all above provisions every three years, at a minimum, to evaluate continuation of these enhanced reimbursements.