

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202



Division of Medicaid & Children's Health, Region VI

March 29, 2010

Our Reference: SPA-LA-09-29

Mr. Don Gregory, Interim State Medicaid Director
Department of Health and Hospitals
Bienville Building
628 North 4th Street
Post Office Box 91030
Baton Rouge, LA 70821-9030

Dear Mr. Gregory:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 09-29. This state plan amendment reduces reimbursement for medical equipment and supplies for recipients over the age of 21 by 4 percent.

In the future, when the State submits a State Plan Amendment (SPA) that may impact Indians or Indian health providers, CMS will look for evidence of the State's tribal consultation process for that SPA. Pursuant to section 1902 (a) (73) of the Act added by section 5006 (e) of the Recovery and Reinvestment Act of 2009, the State must submit evidence to CMS regarding the solicitation of advice prior to submission of the SPA. This consultation must include all federally recognized tribes, Indian Health Service and Urban Indian Organizations within the state.

Transmittal Number 09-29 is approved with an effective date of August 4, 2009 as requested. A copy of the HCFA-179, Transmittal No. 09-29 dated September 3, 2009 is enclosed along with the approved plan pages.

If you have any questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,



Bill Brooks
Associate Regional Administrator

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: <p style="text-align: center;">09-29</p>	2. STATE <p style="text-align: center;">Louisiana</p>
FOR: HEALTH CARE FINANCING ADMINISTRATION		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 <p style="text-align: center;">August 4, 2009</p>	
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 COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <p style="text-align: center;">42 CFR 477 Subpart B</p>		7. FEDERAL BUDGET IMPACT: a. FFY <u>2009</u> (\$48.94) b. FFY <u>2010</u> (\$311.41)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Item 7, Page 2 * Attachment 4.19-B, Item 7, Page 2a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same (TN 09-05) Same (TN 09-05)	

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to reduce the reimbursement rates for medical equipment, supplies, and appliances under the Home Health Program.**

11. GOVERNOR'S REVIEW (Check One): <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		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <p style="text-align: center;">The Governor does not review state plan material.</p>	
12. SIGNATURE OF [Redacted]		16. RETURN TO: State of Louisiana Department of Health and Hospitals 628 N. 4 th Street PO Box 91030 Baton Rouge, LA 70821-9030	
13. TYPED NAME: Alan Levine			
14. TITLE: Secretary			
15. DATE SUBMITTED: August 28, 2009			

FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: <p style="text-align: center;">3 September, 2009</p>		18. DATE APPROVED: <p style="text-align: center;">29 MARCH 2010</p>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <p style="text-align: center;">4 August, 2009</p>		20. SIGNATURE OF OFFICIAL: [Redacted]	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator DWO of Medicaid & Children's Health	
23. REMARKS: <p style="text-align: center;">* Pen + Ink Change made to add page "Attachment 4.19-B, Item 7, Page 2a, per e-mail dated 23 Feb, 2010.</p>			

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM, UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

2. seventy percent (70%) of the Medicare fee schedule under which the procedure code first appeared; or
3. seventy percent (70%) of the manufacturer's suggested retail price (MSRP) amount; or
4. billed charges, whichever is the lesser amount; or
5. if an item is not available at the rate of seventy percent (70%) of the applicable established flat fee or seventy percent (70%) of the MSRP, the flat fee that will be utilized is the lowest cost at which the item has been determined to be widely available by analyzing usual and customary fees charged in the community.

Effective for dates of service on or after February 1, 2009, the reimbursement paid for the following medical equipment, supplies, appliances and repairs shall be reduced by 3.5 percent of the rate on file as of January 31, 2009:

1. ambulatory equipment;
2. bathroom equipment;
3. hospital beds, mattresses and related equipment; and
4. the cost for parts used in the repair of medical equipment, including parts used in the repair of wheelchairs.

A	
STATE	Louisiana
DATE REC'D	9-3-09
DATE APP'D	3-27-10
DATE EFF	8-7-09
HCFA 179	09-29

Effective for dates of service on or after August 4, 2009, the reimbursement paid for medical equipment, supplies and appliances for recipients 21 years of age and older shall be reduced by 4 percent of the rates on file as of August 3, 2009. The following medical equipment, supplies and appliances are excluded from this rate reduction:

- a. enteral therapy pumps and related supplies;
- b. intravenous therapy and administrative supplies;
- c. apnea monitor and accessories;
- d. nebulizers;
- e. hearing aids and related supplies;
- f. respiratory care (other than ventilators and oxygen);
- g. tracheostomy and suction equipment and related supplies;
- h. ventilator equipment;
- i. oxygen equipment and related supplies;
- j. vagus nerve stimulator and related supplies; and
- k. augmentative and alternative communication devices.

TN# 09-29

Approval Date 3-29-10

Effective Date 8-7-09

Supersedes
TN# 09-05

SUPERSEDES: TN- 09-05

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM, UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

- B. Continuous subcutaneous insulin external infusion pumps shall be reimbursed the lesser of 5 percent over the provider's actual cost or the provider's usual and customary charge, not to exceed \$5,745. Related diabetic supplies shall be reimbursed the lesser of 10 percent over the provider's actual cost or the provider's usual and customary charge.
- C. Ostomy supplies are reimbursed at the lesser of:
- billed charges; or
 - eighty percent (80%) of 2000 Medicare fee schedule for the procedure codes that were listed on the 2000 Medicare fee schedule and at the same amount for the HIPAA compliant codes which replaced them or 80 % of the Medicare fee schedule under which the procedure code first appeared; or
 - eighty percent (80%) of the Manufacturer's Suggested Retail Price (MSRP)
- D. Tracheostomy tubes and care kits are reimbursed at ninety percent (90%) of the 2000 Medicare fee schedule for the procedure codes that were listed on the 2000 Medicare fee schedule and at the same amount for the HIPAA compliant codes which replaced them or 80 % of the Medicare fee schedule under which the procedure code first appeared.
- E. Enteral formulas are reimbursed at the lesser of:
- billed charges; or
 - eighty percent (80%) of the 2000 Medicare fee schedule for the procedure codes that were listed on the 2000 Medicare fee schedule and at the same amount for the HIPAA compliant codes which replaced them or 80 % of the Medicare fee schedule under which the procedure code first appeared.
- F. Enteral infusion pumps, standard type wheelchairs, hospital beds, commode chairs, and stationary suction machines are reimbursed at the Medicaid established flat fee amount.

SUPERSEDES: TN- 09-05

STATE <u>Louisiana</u>	A
DATE REC'D. <u>9-3-09</u>	
DATE APPV'D <u>3-29-10</u>	
DATE EFF. <u>8-4-09</u>	
HCFA 179 <u>09-29</u>	

TN# 09-29 Approval Date 3-29-10 Effective 8-4-09
Supersedes
TN# 09-05