



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>09-44</b>	2. STATE <b>Louisiana</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		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 <b>September 1, 2009</b>	
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: <b>42 CFR Part 447 Subpart F</b>		7. FEDERAL BUDGET IMPACT: a. FFY <u>2009</u> <u>\$291.17</u> b. FFY <u>2010</u> <u>\$3,520.27</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-B, Item 2.a, Page 5</b> <b>Attachment 4.19-B, Item 2.a, Page 6</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Same (Pending TN 09-24)</b> <b>None (New Page)</b>	
10. SUBJECT OF AMENDMENT: <b>The purpose of this amendment is to revise the reimbursement methodology for outpatient hospital services rendered by in-state children's specialty hospitals.</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 <b>The Governor does not review state plan material.</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE: 		16. RETURN TO: <b>State of Louisiana</b> <b>Department of Health and Hospitals</b> <b>628 N. 4<sup>th</sup> Street</b> <b>PO Box 91030</b> <b>Baton Rouge, LA 70821-9030</b>	
13. TYPED NAME: <b>Alan Levine</b>			
14. TITLE: <b>Secretary</b>			
15. DATE SUBMITTED: <b>September 25, 2009</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>29 September, 2009</b>		18. DATE APPROVED: <b>14 December, 2009</b>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>1 September, 2009</b>		20. SIGNATURE: 	
21. TYPED NAME: <b>Bill Brooks</b>		22. TITLE: <b>Associate Regional Administrator</b> <b>Div of Medicaid &amp; Children's Health</b>	
23. REMARKS:			

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

**diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees as follows:**

Interim payment shall be one hundred ten percent of each hospital's cost to charge ratio as calculated from the latest filed cost report. Final reimbursement shall be one hundred ten percent of allowable cost as calculated through the cost report settlement process. Final cost is identified by mapping outpatient charges to individual cost centers on the Medicare Hospital Cost Report then multiplying such charges by the cost centers' individual cost to charge ratios. Dates of service associated with the charges match the rate year on the Medicare Hospital Cost Report.

**Supplemental Payments for Non-Rural, Non-State Hospitals**

Effective for dates of service on or after July 1, 2009, Medicaid Supplemental payments will be made to qualifying non-rural non-state public hospitals for dates of service from July 1, 2009 through December 31, 2010 as follows.

A	
STATE	LOUISIANA
DATE REC'D.	9-29-09
DATE APP'D	12-14-09
DATE EFF.	9-1-09
HCFA 179	09-44

1) Hospitals impacted by Hurricane Katrina

Maximum aggregate payments to all qualifying hospitals in this group (which includes inpatient supplemental payments described in Attachment 4.19-A, Item 1, Section I.B.9.b.1) will not exceed \$170,000,000.

- a) Qualifying criteria – Non-rural non-state public or private hospital which is located in DHH Administrative Region 1 and identified in the July 17, 2008 United States Governmental Accountability Office report as a hospital that has demonstrated substantial financial and operational challenges in the aftermath of Hurricane Katrina.
- b) Payment Methodology – Each eligible qualifying hospital shall receive quarterly supplemental payments which in total do not exceed a specified individualized hospital limit. Payments will be distributed based on Medicaid paid claims data from service dates from SFY 2008. Payments will end when the hospital specific cap is reached or December 31, 2010 whichever occurs first.

**Reimbursement for In-State Outpatient Children's Specialty Hospitals**

a. Qualifications

In order to qualify to receive Medicaid reimbursement as an in-state children's specialty hospital, a non-rural, non-state acute care hospital must meet the following criteria. The hospital must:

- (1) be recognized by Medicare as a prospective payment system (PPS) exempt children's specialty hospital;

TN# 09-44  
Supersedes  
TN# 09-24

Approval Date 12-14-09

Effective Date 9-1-09

SUPERSEDES: TN- 09-24

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

- (2) not qualify for Medicare disproportionate share hospital payments; and
  - (3) have a Louisiana Medicaid inpatient days utilization rate greater than the mean plus two standard deviations of the Medicaid utilization rates for all hospitals in the state receiving Medicaid payments.
- b. Reimbursement Methodology
- (1) Effective for the dates of service on or after September 1, 2009, the reimbursement amount paid to children's specialty hospitals that meet the above qualifications shall be reimbursed as follows for **outpatient surgeries and rehabilitation services (physical, occupational, and speech therapy)**:

Initial payments shall be equal to the Medicaid fee schedule payments per Item 2.a., Page 1. After the fiscal year end cost report is filed, final annual payment for these services will be 97 percent of cost as calculated per the cost report.

- (2) Effective for the dates of service on or after September 1, 2009, the reimbursement amount paid to children's specialty hospitals that meet the above qualifications shall be reimbursed as follows for **outpatient hospital services other than clinical diagnostic laboratory, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees**:

Initial payments shall be 97 percent of the hospital's interim cost to charge ratio as calculated from the latest filed cost report. After the fiscal year end cost report is filed, final annual payment for these services will be 97 percent of cost as calculated per the cost report.

SUPERSEDES: NONE - NEW PAGE

STATE	<u>Louisiana</u>	A
DATE REC'D	<u>9-29-09</u>	
DATE APPV'D	<u>12-14-09</u>	
DATE EFF	<u>9-1-09</u>	
HCFA 179	<u>09-14</u>	

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**

December 14, 2009

Our Reference: SPA-LA-09-44

Mr. Jerry Phillips, State Medicaid Director  
Department of Health and Hospitals  
Bienville Building  
628 North 4<sup>th</sup> Street  
Post Office Box 91030  
Baton Rouge, LA 70821-9030

Dear Mr. Phillips:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 09-44. This amendment revises the reimbursement methodology for outpatient hospital services rendered by in-state children's specialty hospitals.

Transmittal Number 09-44 is approved with an effective date of September 1, 2009 as requested. A copy of the HCFA-179, Transmittal No. 09-44 dated September 25, 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

**Marks, Marsha L. (CMS/SC)**

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**From:** Marks, Marsha L. (CMS/SC)  
**Sent:** Thursday, January 21, 2010 1:11 PM  
**To:** CMS SPA  
**Cc:** Rupley, Cheryl A. (CMS/SC); Cieslicki, Mary E. (CMS/CMO); Carter, Demetria (CMS/SC); Sampson, Tamara L. (CMS/CMCHO)  
**Subject:** Approval Pkg for LA 09-44  
**Attachments:** SPA-LA-09-44.doc; Final Approval Pkg for LA 09-44.pdf

See Attached.

State: Louisiana

**Brief Description:** This amendment revises reimbursement for outpatient hospital services rendered by in-state children's specialty hospitals, The payment did not exceed the hospital UPL and indicated that the payment is uniform for governmental and private providers.

**Approval Date:** 14 December, 2009

**Effective Date:** 1 September, 2009

**Marsha Marks** // Dept of Health & Human Services // Centers for Medicare & Medicaid Services // Dallas Regional Office // Division of Medicaid & Children's Health // Dallas Texas 75202 // 214-767-6280 // Fax 214-767-0322 // [marsha.marks@cms.hhs.gov](mailto:marsha.marks@cms.hhs.gov)