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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: 19-021

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

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,

[redacted]

Kristin Fan
Director

cc:
Tia Lyles
Tamara Sampson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS 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: **19-0021**
2. STATE: **Louisiana**
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **July 1, 2019**

5. TYPE OF PLAN MATERIAL (Check One)
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT
a. FFY **2019** $ ~~9,012,396~~ $138,852
b. FFY **2020** $ ~~7,416,231~~ $112,161

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, Item 1, Page 8a (1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)
Same (TN 11-34)

10. SUBJECT OF AMENDMENT **The purpose of this SPA is to amend the provisions governing the reimbursement methodology for inpatient hospital services to increase outlier pool payments.**

11. 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.

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Cindy Rives, designee for Rebekah E. Gee MD, MPH

14. TITLE
Secretary [redacted]

15. DATE SUBMITTED
August 13, 2019

16. RETURN TO
Jen Steele, Medicaid Director
State of Louisiana
Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
August 13, 2019

18. DATE APPROVED
OCT 21 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL [redacted]

21. TYPED NAME Kristin Fan

22. TITLE Director, FMG

23. REMARKS The State requests a pen and ink change to box 7.

FORM CMS-179 (07/92)

Instructions on Back

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