



State of Louisiana
Department of Health and Hospitals
Office of the Secretary

May 16, 2013

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMSO
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

Dear Mr. Mark Cooley:

RE: Louisiana Title XIX State Plan
Transmittal No. 13-20

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.

Sincerely,

A handwritten signature in blue ink, appearing to read "Kathy Kliebert".

Kathy Kliebert
Interim Secretary

Attachments

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:
13-20

2. STATE
Louisiana

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
April 15, 2013

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 B & C

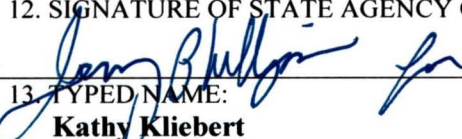
7. FEDERAL BUDGET IMPACT:
a. FFY 2013 **\$4,910.47**
b. FFY 2014 **\$10,099.86**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Item 1, Page 8g
Attachment 4.19-A, Item 1, Page 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN
SECTION OR ATTACHMENT (*If Applicable*):
None (New Page TN 13-20)
Supersedes (TN# 10-50)

10. SUBJECT OF AMENDMENT: **The SPA proposes to provide Medicaid payments for inpatient services rendered by private major teaching hospitals participating in public-private partnerships which assume the provision of services that were previously delivered and terminated, reduced, by a state-owned and operated facility.**

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:
Kathy Kliebert
14. TITLE:
Interim Secretary
15. DATE SUBMITTED:
May 15, 2013

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

LOUISIANA TITLE XIX STATE PLAN

TRANSMITTAL #: 13-20
 TITLE: Inpatient Hospitals Public Private Partnership Rate for OLOL
 EFFECTIVE DATE: April 15, 2013

FISCAL IMPACT:
Increase

	year		*# mos	range of mos.	state fiscal year years
1st SFY	2013		2.5	April 15, 2013-June 2013	\$3,430,453
2nd SFY	2014		12	July 2013 - June 2014	\$16,261,238
3rd SFY	2015		12	July 2014 - June 2015	\$16,261,238

*#mos-Months remaining in fiscal year

Total Increase in Cost FFY 2013

State Fiscal Year 2013 \$3,430,453 for 2.5 months April 15, 2013-June 2013 \$3,430,453
 Federal Fiscal Year

State Fiscal Year 2014 \$16,261,238 for 12 months July 2013 - June 2014
 Federal Fiscal Year \$16,261,238 / 12 X 3 July 2013 - September 2013 = \$4,065,310
\$7,495,763

FFP (FFY 2013) = \$7,495,763 X 65.51% = \$4,910,474

Total Increase in Cost FFY 2014

State Fiscal Year 2014 \$16,261,238 for 12 months July 2013 - June 2014
 Federal Fiscal Year \$16,261,238 / 12 X 9 October 2013 - June 2014 = \$12,195,929

State Fiscal Year 2015 \$16,261,238 for 12 months July 2014 - June 2015
 Federal Fiscal Year \$16,261,238 / 12 X 3 July 2014 - September 2014 = \$4,065,310
\$16,261,239

FFP (FFY 2014) = \$16,261,239 X 62.11% = \$10,099,856

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

12. Reimbursement for Public-Private Partnership Hospitals

The Department shall provide Medicaid payments for inpatient hospital services rendered by private owned hospitals that enter into public-private partnership cooperative endeavor agreements (CEA) with the Department as follows:

a. Baton Rouge Area CEA

Qualifying Criteria

Effective for dates of service on or after April 15, 2013, a major teaching hospital that enters into a CEA with the Department of Health and Hospital to provide acute care hospital services to Medicaid and uninsured patients and which assumes providing services that were previously delivered and terminated or reduced by a state owned and operated facility will qualify for reimbursement as a Public-Private Partnership Hospital.

Reimbursement Methodology

The inpatient reimbursement shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid costs.

TN# _____ Approval Date _____ Effective _____
Date _____
Supersedes _____
TN# _____

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

13. Qualifying Loss Review Process

Any hospital seeking an adjustment to the operations, movable, fixed capital, or education component of its rate shall submit a written request for administrative review within 30 days after receipt of the letter notifying the hospital of its rate. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later.

The time period for requesting an administrative review may be extended upon written agreement between the Department and the hospital.

The Department will acknowledge receipt of the written request within 30 days after actual receipt. Additional documentation may be requested from the hospital as may be necessary to render a decision. A written decision will be rendered within 90 days after receipt of all additional documentation or information requested.

a. Definitions

"Qualifying loss" in this context refers to that amount by which the hospital's operating costs, movable equipment costs, fixed capital costs, or education costs (excluding disproportionate share payment adjustments) exceeds the Medicaid reimbursement for each component.

"Costs" when used in the context of operating costs, movable equipment costs, fixed capital costs, and education costs, means a hospital's costs incurred in providing covered inpatient services to Medicaid and indigent clients as allowed by the *Medicare Provider Reimbursement Manual*.

"Uninsured Patient" in this context is defined as a patient that is not eligible for Medicare and Medicaid and does not have insurance.

"Uninsured Care Costs" in this context means uninsured care charges multiplied by the cost to charge ratios by revenue code per the last filed cost report, net of payments received from uninsured patients.

b. Permissible Basis

Consideration for qualifying loss review is available only if one of the following conditions exists:

TN# _____ Approval Date _____ Effective _____
Date _____
Supersedes _____
TN# _____