



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

VIA ELECTRONIC MAIL ONLY

August 22, 2014

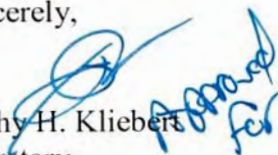
Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

**RE: Louisiana Title XIX State Plan
Transmittal No. 14-24**

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,


Kathy H. Kliebert
Secretary

Attachments (2)

KHK/JRK/DAB

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

14-24

2. STATE

Louisiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

August 20, 2014

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 F

7. FEDERAL BUDGET IMPACT:

a. FFY 2015 **\$246.15**
b. FFY 2016 **\$228.70**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Item 1, Page 15
Attachment 3.1-A, Item 1, Page 46

9. PAGE NUMBER OF THE SUPERSEDED PLAN
SECTION OR ATTACHMENT (If Applicable):

None (New Page)
None (New Page)

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to amend the provisions governing the reimbursement methodology for inpatient hospital services in order to cease reimbursement for elective deliveries performed prior to 39 weeks gestation when there is no documentation of a medical condition that would justify elective delivery.**

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 H. Kliebert

14. TITLE:

Secretary

15. DATE SUBMITTED:

August 22, 2014

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 #: 14-24

TITLE: Elective Deliveries-Inpatient Hospital Services

EFFECTIVE DATE: August 20, 2014

FISCAL IMPACT:

Increase

	year	% inc.	fed. match	*# mos	range of mos.	dollars
1st SFY	2015			10.3	August 20, 2014 - June 30, 2015	\$304,852
2nd SFY	2016	3.0%		12	July 2015 - June 2016	\$365,822
3rd SFY	2017	3.0%		12	July 2016 - June 2017	\$376,797

*#mos-Months remaining in fiscal year

Total Increase in Cost FFY 2015

SFY 2015 \$304,852 for 10.3 months August 20, 2014 - June 30, 2015 \$304,852

SFY 2016 \$365,822 for 12 months July 2015 - June 2016
 \$365,822 / 12 X 3 July 2014 - September 2014 = \$91,456
\$396,308

FFP (FFY 2015)= \$396,308 X 62.11% = \$246,147

Total Increase in Cost FFY 2016

SFY 2016 \$365,822 for 12 months July 2015 - June 2016
 \$365,822 / 12 X 9 October 2014 - June 2015 = \$274,367

SFY 2017 \$376,797 for 12 months July 2016 - June 2017
 \$376,797 / 12 X 3 July 2015 - September 2015 = \$94,199
\$368,566

FFP (FFY 2016)= \$368,566 X 62.05% = \$228,695

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING RATES - INPATIENT HOSPITAL CARE

Reimbursement for Elective Deliveries

Induced deliveries and cesarean sections shall not be reimbursed when performed prior to 39 weeks gestation. This shall not apply to deliveries when there is a documented medical condition that would justify delivery prior to 39 weeks gestation.

TN# _____
Supersedes

Approval Date _____ Effective Date _____

TN# _____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
LIMITATIONS ON THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED
MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

Reimbursement for Elective Deliveries

Induced deliveries and cesarean sections shall not be reimbursed when performed prior to 39 weeks gestation. This shall not apply to deliveries when there is a documented medical condition that would justify delivery prior to 39 weeks gestation.