



State of Louisiana
Louisiana Department of Health
Office of the Secretary

VIA ELECTRONIC MAIL ONLY

September 27, 2016

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. 16-0019

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.

Warmly,

A handwritten signature in blue ink, appearing to read "Rebekah E. Gee", with a stylized flourish.

Rebekah E. Gee MD, MPH
Secretary

Attachments (2)

REG:JS:JH

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

16-0019

2. STATE

Louisiana

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

4. PROPOSED EFFECTIVE DATE

August 1, 2016

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 E

7. FEDERAL BUDGET IMPACT:

a. FFY 2016

\$2,763,921

b. FFY 2017

\$2,451,767

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Item 24a, Page 1b (3) – 1b (6)

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 PAGE NUMBER OF THE SUPERSEDED PLAN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

None – New pages

10. SUBJECT OF AMENDMENT **The SPA adopts the provisions to establish enhanced Medicaid reimbursements through the Supplemental Payment program for qualifying emergency ground ambulance service providers.**

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:

Rebekah E. Gee MD, MPH

14. TITLE:

Secretary

15. DATE SUBMITTED:

September 27, 2016

16. RETURN TO:

Jen Steele, Medicaid Director

State of Louisiana

Department of Health

628 N. 4th Street

P.O. 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:

LA TITLE XIX SPA

TRANSMITTAL #: 16-0019

TITLE: Medical Transportation- Emergency Ambulance Services- Enhanced R

EFFECTIVE DATE: August 1, 2016

FISCAL IMPACT:
Increase

Year	% Inc.	fed. match	* # mos	range of mos.	dollars
1st SFY 2016				11 August 2016- June 2017	\$3,464,645
2nd SFY 2017	3.0%			12 July 2017- June 2018	\$3,893,001
3rd SFY 2018	3.0%			12 July 2018 - June 2019	\$4,009,791

*#mos-Months remaining in fiscal year

Total Increase in Cost FFY 2016

SFY 2016 \$3,464,645 for 11 months August 2016- June 2017 \$3,464,645

SFY 2017 \$3,893,001 for 12 months
\$3,893,001 / 12 X 3

= \$973,250
\$4,437,895

FFP (FFY 2016) =

\$2,763,921

Total Increase in Cost FFY 2017

SFY 2017 \$3,893,001 for 12 months
\$3,893,001 / 12 X 9

= \$2,919,751

SFY 2018 \$4,009,791 for 12 months
\$4,009,791 / 12 X 3

= \$1,002,448
\$3,922,199

FFP (FFY 2017)=

\$2,451,767

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

Enhanced Reimbursements for Qualifying Emergency Ground Ambulance Service Providers

A. Reimbursements

Effective for dates of service on or after August 1, 2016, qualifying emergency ambulance service providers assessed a fee shall receive enhanced reimbursement for emergency ground ambulance transportation services rendered during the quarter through the Supplemental Payment Program (refer to Attachment 4.19-B, Item 24a, Page 1b).

B. Calculation of Average Commercial Rate

1. The enhanced reimbursement shall be determined in a manner to bring the payments for these services up to the average commercial rate level as described in Subparagraph C.3.h. The average commercial rate level is defined as the average amount payable by the commercial payers for the same service.
2. The Department shall align the paid Medicaid claims with the Medicare fees for each healthcare common procedure coding system (HCPCS) or current procedure terminology (CPT) code for the ambulance provider and calculate the Medicare payment for those claims.
3. The Department shall calculate an overall Medicare to commercial conversion factor for each ambulance provider by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.
4. The commercial to Medicare ratio for each provider will be re-determined at least every three years.

TN _____
Supersedes
TN _____

Approval Date _____

Effective Date _____

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C. Payment Methodology

1. The enhanced reimbursement to each qualifying emergency ground ambulance service provider shall not exceed the sum of the difference between the Medicaid payments otherwise made to these providers for the provision of emergency ground ambulance transportation services and the average amount that would have been paid at the equivalent community rate.
2. The enhanced reimbursement shall be determined in a manner to bring payments for these services up to the community rate level. Community Rate-the average amount payable by commercial insurers for the same services.
3. The specific methodology to be used in establishing the enhanced reimbursement payment for ambulance providers is as follows:
 - a. The Department shall identify Medicaid ambulance service providers that qualify to receive enhanced reimbursement Medicaid payments for the provision of emergency ground ambulance transportation services.
 - b. For each Medicaid ambulance service provider identified to receive enhanced reimbursement Medicaid payments, the Department shall identify the emergency ground ambulance transportation services for which the provider is eligible to be reimbursed.
 - c. For each Medicaid ambulance service provider described in Subparagraph C.3.a., the Department shall calculate the reimbursement paid to the provider for the provision of emergency ground ambulance transportation services identified under Subparagraph C.3.b.
 - d. For each Medicaid ambulance service provider described in Subparagraph C.3.a., the Department shall calculate the

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provider's equivalent community rate for each of the provider's services identified under Subparagraph C.3.b.

- e. For each Medicaid ambulance service provider described in Subparagraph C.3.a., the Department shall subtract an amount equal to the reimbursement calculation for each of the emergency ground ambulance transportation services under Subparagraph C.3.c. from an amount equal to the amount calculated for each of the emergency ground ambulance transportation services under Subparagraph C.3.d.
- f. For each Medicaid ambulance service provider described in Subparagraph C.3.a., the Department shall calculate the sum of each of the amounts calculated for emergency ground ambulance transportation services under Subparagraph C.3.e.
- g. For each Medicaid ambulance service provider described in Subparagraph C.3.a., the Department shall calculate each provider's upper payment limit by totaling the provider's total Medicaid payment differential from Subparagraph C.3.f.
- h. The Department shall reimburse providers identified in Subparagraph C.3.a. up to 100 percent of the provider's average commercial rate.

D. Effective Date of Payment

- 1. The enhanced reimbursement payment shall be made effective for emergency ground ambulance transportation services provided on or after August 1, 2016. This payment is based on the average amount that would have been paid at the equivalent community rate.
- 2. After the initial calculation for fiscal year 2015-2016, the Department will rebase the equivalent community rate using adjudicated claims data for services from the most recently completed fiscal year. This calculation may be made annually but shall be made no less than every three years.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

E. Maximum Payment

1. The total maximum amount to be paid by the Department to any individually qualified Medicaid ambulance service provider for enhanced reimbursement Medicaid payments shall not exceed the total of the Medicaid payment differentials calculated under Subparagraph C.3.f.

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Effective Date _____