**John Bel Edwards**
GOVERNOR

**Rebekah E. Gee MD, MPH**
SECRETARY

# State of Louisiana

Louisiana Department of Health
Office of the Secretary

**VIA ELECTRONIC MAIL ONLY**

March 3, 2017

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. 17-0011

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,

Rebekah E. Gee MD, MPH
Secretary

Attachments (2)

REG:JS:JH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

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

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: **17-0011**

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: **February 20, 2017**

5. TYPE OF PLAN MATERIAL *(Check One)*:

G NEW STATE PLAN G 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 **2017** **$0**
b. FFY **2018** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 4.19- B, Item 5, Page 8**
**Attachment4.19- B, Item 5, Page 8a**
**Attachment 4.19-B, Item 5, Page 9**
**Attachment 4.19-B, Item 5, Page 10**
**Attachment 4.19-B, Item 5, Page 10a**
**Attachment 4.19-B, Item 5, Page 11**
**Attachment 4.19-B, Item 5, Page 11a**

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

**Same (TN 10-0031)**
**None (New Page)**
**Same (TN 05-0005)**
**Same (TN 10-0031)**
**None (New Page)**
**Same (TN 10-0031)**
**None (New Page)**

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to amend the qualifying criteria for supplemental payments to physicians and other professional service practitioners in order to clarify these provisions.**

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:
**March 3, 2017**

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:

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:

FORM HCFA-179 (07-92)

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:

**III. Supplemental Payments for Physicians and Other Professional Service Practitioners**

**State-Owned or Operated Entities**

1. Qualifying Criteria:

Effective for dates of service on or after February 20, 2017, in order to qualify to receive supplemental payments. The physician or professional service practitioner must be:

a. licensed by the State of Louisiana;
b. enrolled as a Louisiana Medicaid provider;
c. employed by, or under contract to provide services in affiliation with, a state-owned or operated entity, such as state-operated hospital or other state entity including a state academic health system, which has been designated by the Bureau as an essential provider and which has furnished satisfactory data to LDH regarding the commercial insurance payments made to its employed physicians and other professional service practitioners. Essential providers include:
   - LSU School of Medicine – New Orleans
   - LSU School of Medicine – Shreveport
   - LSU School of Dentistry; and
   - LSU – state operated hospitals (Lallie Kemp Regional Medical Center and Villa Feliciana Geriatric Hospital);

2. Qualifying Provider Types.

For purposes of qualifying for supplemental payments under this Section, services provided by the following professional practitioners will be included:

1. physicians;
2. physician assistants;
3. certified registered nurse practitioners;
4. certified nurse anesthetists;
5. nurse midwives;
6. psychiatrists;
7. psychologists;
8. speech-language pathologists;
9. physical therapists;
10 occupational therapists;
11. podiatrists;
12. optometrists;

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:

13. social workers;
14. dentists;
15. audiologists;
16. chemical dependency counselors;
17. mental health professionals;
18. opticians;
19. nutritionists;
20. paramedics; and
21. doctors of chiropractic

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:

Payment Methodology:

a. The supplemental payment to each qualifying physician or other eligible professional services practitioner will equal the difference between the Medicaid payments otherwise made to these qualifying providers for professional services and the average amount that would have been paid at the equivalent community rate. The community rate is defined as the average amount that would have been paid by commercial insurers for the same services.

The supplemental payment to each qualifying physician or practitioner shall be calculated by applying a community rate conversion factor to actual charges for claims paid during a quarter for Medicaid services provided by the qualifying state-employed physician or practitioner. This community rate conversion factor shall be established annually for qualifying providers by determining the amount that private commercial insurance companies paid for commercial claims submitted by the state-employed providers and dividing that amount by the respective charges for these payers. The commercial payments and respective charges shall be furnished for the state fiscal year preceding the reimbursement calendar year. If the required data is not provided, the default conversion factor shall equal "1".

The actual charges for Medicaid services paid in the quarter shall then be multiplied by the conversion factor to determine the maximum allowable Medicaid reimbursement. For eligible non-physician practitioners, the maximum allowable Medicaid reimbursement shall be limited to 80 percent of this amount. Then the actual base Medicaid payments to the qualifying state-employed physician or practitioner shall be subtracted from the maximum Medicaid reimbursement amount to determine the supplemental payment amount.

b. The supplemental payment for services provided will be issued through quarterly supplemental payments to providers based on specific MMIS paid claims data. Supplemental payments will be made subsequent to the delivery of services.

c. Supplemental payments will be paid for services provided at or through a state-owned or operated entity that has been designated as an essential provider. Services provided at a non-state-owned facility will not be considered to be provided through an essential provider if the other facility bills for the service.

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:

**Non-State Owned or Operated Governmental Entities**

1. Qualifying Criteria

Effective for dates of service on or after February 20, 2017, in order to qualify to receive supplemental payments, physicians and other eligible professional service practitioners must be:

a. licensed by the State of Louisiana;
b. enrolled as a Louisiana Medicaid provider; and
c. employed by, or under contract to provide services at a non-state owned or operated governmental entity and identified by the non-state owned or operated governmental entity as a physician that is employed by, or under contract to provide services at said entity.

2. Qualifying Provider Types

For purposes of qualifying for supplemental payments under this section, services provided by the following professional practitioners will be included:

1. physicians;
2. physician assistants;
3. certified registered nurse practitioners;
4. certified nurse anesthetists;
5. nurse midwives;
6. psychiatrists;
7. psychologists;
8. speech-language pathologists;
9. physical therapists;
10 occupational therapists;
11. podiatrists;
12. optometrists:
13. social workers;

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:

14. dentists;
15. audiologists;
16. chemical dependency counselors;
17. mental health professionals;
18. opticians;
19. nutritionists;
20. paramedics; and
21. doctors of chiropractic.

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:

3. Payment Methodology

The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level. The community rate level is defined as the rates paid by commercial payers for the same service. Under this methodology the terms physician and physician services include services provided by all qualifying provider types as set forth in 2. above.

The specific methodology to be used in establishing the supplemental payment for physician services is as follows:

a. For services provided by physicians at a non-state governmental hospital, the state will collect from the hospital its current commercial physician fees by CPT code for the hospital's top three commercial payers by volume.

b. The state will calculate the average commercial fee for each CPT code for each physician practice plan or physician that provides services at the non-state governmental hospital.

c. The state will extract from its paid claims history file for the preceding fiscal year all paid claims for those physicians who will qualify for a supplemental payment. The state will align the average commercial fee for each CPT code as determined in b. above to each Medicaid claim for that physician or physician practice plan and calculate the average commercial payments for the claims.

d. The state will also align the same paid Medicaid claims with the Medicare fees for each CPT code for the physician or physician practice plan and calculate the Medicare payment amounts for those claims. The Medicare fees will be the most currently available national non-facility fees.

e. The state will then calculate an overall Medicare to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio will be re-determined every three years.

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:

f. For each quarter the state will extract paid Medicaid claims for each qualifying physician or physician practice plan for that quarter.

g. The state will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the most currently available national non-facility fees.

h. The total amount that Medicare would have paid for those claims is then multiplied by the Medicare to commercial conversion factor and the amount Medicaid actually paid for those claims is subtracted to establish the supplemental payment amount for the physician or physician practice plan for that quarter.

4. Effective Date of Payment

The supplemental payment will be made effective for services provided on or after July 1, 2010. This payment is based on the Medicare equivalent of the average commercial rate and is set using the Medicare physician fee schedule for hospital based services rendered by the qualifying providers. After the initial calculation for fiscal year 2010-2011, Louisiana will rebase the Medicare equivalent of the average commercial rate using adjudicated claims data for dates of services from the most recently completed fiscal year. This calculation will be made every three years. A link to the Medicare fee schedule used to determine the payment factor will be posted on the Louisiana Medicaid website at www.lamedicaid.com.

**TN 17-0011 Physician Services - Supplemental Payments Qualifying Criteria**

**Standard Funding Questions**

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

   **RESPONSE: Providers will receive and retain 100 percent of the payments. No portion of the payments is returned to the State.**

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,

(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

**RESPONSE: The State share is paid from the State general fund which is directly appropriated to the Medicaid agency.**

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

**RESPONSE: In SFY 16-17 $1,628,217 has been paid in supplemental payments to public hospitals for physician and certified registered nurse anesthetist (CRNA) services.**

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

**RESPONSE: Not applicable to this State Plan amendment.**

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

**RESPONSE: The State does not have any public/governmental providers receiving payments that exceed their reasonable costs of services provided.**