



**State of Louisiana**  
Louisiana Department of Health  
Office of the Secretary

**VIA ELECTRONIC MAIL ONLY**

August 13, 2019

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

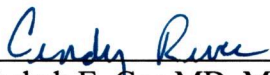
RE: Louisiana Title XIX State Plan  
Transmittal No. 19-0021

Dear Mr. Brooks:

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.  
Should you have any questions or concerns regarding this matter, please contact Karen Barnes at (225) 342-3881 or via email at [Karen.Barnes@la.gov](mailto:Karen.Barnes@la.gov).

Warmly,

  
\_\_\_\_\_, for  
Rebekah E. Gee MD, MPH  
Secretary

Attachments (3)

REG:JS:SSJ

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <b>19-0021</b>	2. STATE <b>Louisiana</b>
		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 <b>July 1, 2019</b>	
5. TYPE OF PLAN MATERIAL (Check One)			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION  <b>42 CFR 447 Subpart C</b>		7. FEDERAL BUDGET IMPACT a. FFY <b>2019</b> <b>\$ 9,012,396</b> b. FFY <b>2020</b> <b>\$ 7,416,231</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  <b>Attachment 4.19-A, Item 1, Page 8a (1)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <b>Same (TN 11-34)</b>	
10. SUBJECT OF AMENDMENT <b>The purpose of this SPA is to amend the provisions governing the reimbursement methodology for inpatient hospital services to increase outlier pool payments.</b>			
11. GOVERNOR'S REVIEW (Check One)			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED              The Governor does not review State Plan material. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL		16. RETURN TO <b>Jen Steele, Medicaid Director State of Louisiana Department of Health 628 North 4<sup>th</sup> Street P.O. Box 91030 Baton Rouge, LA 70821-9030</b>	
13. TYPED NAME <b>Cindy Rives, designee for Rebekah E. Gee MD, MPH</b>			
14. TITLE <b>Secretary</b> <i>Cindy Rives</i>			
15. DATE SUBMITTED <b>August 13, 2019</b>			
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			

	year	% inc.		fed. match		# mos		range of mos.		dollars
1st SFY	2020			%		12	July 2019- June 2020			\$11,092,179
2nd SFY	2021					12	July 2020- June 2021			\$11,092,179
3rd SFY	2022					12	July 2021 - June 2022			\$11,092,179

\*#mos-Months remaining in fiscal year

Total Increase or Decrease Cost FFY 2020

SFY 2020 \$11,092,179 for 12 months July 2019- June 2020 \$11,092,179

SFY 2021 \$11,092,179 for 12 months July 2020- June 2021

SFY 2021 \$11,092,179 / 12 X 3 months July 2020 - September 2020 = \$2,773,045

\$13,865,224

FFP (FFY 2020 ) = \$13,865,224 X 65.00% = \$9,012,396

Total Increase or Decrease Cost FFY 2021

SFY 2021 \$11,092,179 for 12 months July 2020- June 2021

SFY 2021 \$11,092,179 / 12 X 9 months October 2020 - June 2021 = \$8,319,134

SFY 2022 \$11,092,179 for 12 months July 2021 - June 2022

SFY 2022 \$11,092,179 / 12 X 3 months July 2021 - September 2021 = \$2,773,045

\$11,092,179

FFP (FFY 2021 )= \$11,092,179 X 66.86% = \$7,416,231



STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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METHODS AND STANDARDS FOR ESTABLISHING RATES - IN-PATIENT HOSPITAL CARE

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Effective on or after July 1, 2019, the outlier pool for admissions during SFY 2019 and subsequent SFYs, shall cover eligible claims and shall not exceed \$21,092,179 annually. Payment shall be the costs of each hospital's eligible claims, less the prospective payment, divided by the sum of all eligible claims costs in excess of payments, multiplied by \$21,092,179.

**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 to 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.

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TN: \_\_\_\_\_

Approval Date \_\_\_\_\_

Effective Date: \_\_\_\_\_

Supersedes

TN: \_\_\_\_\_