Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

June 27, 2013

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

Dear Mr. Cooley:

RE: Louisiana Title XIX State Plan
Transmittal No. 13-23

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,

for

Kathy Kliebert
Secretary

Attachments

Bienville Building • 628 North 4th Street • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
Phone #: 225/342-9509 • Fax #: 225/342-5568 • *WWW.DHH.LA.GOV*
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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: **13-23**

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: **June 24, 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 $0
b. FFY 2014 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Item 1, Page 8c(5)
Attachment 4.19-A, Item 1, Page 8c(6)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None (New Page)
None (New Page)

10. SUBJECT OF AMENDMENT: **The SPA proposes to implement supplemental Medicaid payments for inpatient hospital services provided by non-state owned hospitals participating in public-private partnership CEAs in New Orleans and Lafayette.**

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: for

13. TYPED NAME: **Kathy H. Kliebert**

14. TITLE: **Secretary**

15. DATE SUBMITTED: **June 27, 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:

1. New Orleans Area CEA

Qualifying Criteria

The Department of Health and Hospitals shall enter into a cooperative endeavor agreement with Louisiana Children's Medical Center to increase its provision of inpatient Medicaid hospital services by assuming the management and operation of services at a facility in New Orleans where such services were previously provided by a state owned and operated facility.

Reimbursement Methodology

Effective for dates of service on or after June 24, 2013, a quarterly supplemental payment shall be made to this qualifying hospital for inpatient services. Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. Payments shall not exceed the allowable Medicaid charge differential. The Medicaid inpatient charge differential is the Medicaid inpatient charges less the Medicaid inpatient payments (which includes both the base payments and supplemental payments).

The qualifying hospital will provide quarterly reports to DHH that will demonstrate that, upon implementation, the annual Medicaid inpatient quarterly payments do not exceed the annual Medicaid inpatient charges per 42CFR 447.271. Before the final quarterly payment for each state fiscal year the quarterly reports will be reviewed and verified with Medicaid claims data. The final quarterly payment for each state fiscal year will be reconciled and will be adjusted to assure that the annual payment does not exceed the allowable Medicaid inpatient charge differential. Maximum payments shall not exceed the upper payment limit per 42CFR 447.272.

2. Lafayette Area CEA

Qualifying Criteria

The Department of Health and Hospitals shall enter into a cooperative endeavor agreement with the Lafayette General Health System, Inc. to increase its provision of inpatient Medicaid hospital services by assuming

the management and operation of services at a facility in Lafayette where such services were previously provided by a state-owned and operated facility.

Reimbursement Methodology

Effective for dates of service on or after June 24, 2013, a quarterly supplemental payment shall be made to this qualifying hospital for inpatient services. Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. Payments shall not exceed the allowable Medicaid charge differential. The Medicaid inpatient charge differential is the Medicaid inpatient charges less the Medicaid inpatient payments (which includes both the base payments and supplemental payments).

The qualifying hospital shall provide quarterly reports to DHH that will demonstrate that, upon implementation, the annual Medicaid inpatient quarterly payments do not exceed the annual Medicaid inpatient charges per 42 CFR 447.271. Before the final quarterly payment for each state fiscal year the quarterly reports will be reviewed and verified with Medicaid claims data. The final quarterly payment for each state fiscal year will be reconciled and will be adjusted to assure that the annual payment does not exceed the allowable Medicaid inpatient charge differential.