

STATE OF LOUISIANA
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this State Plan.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:

Effective for dates of service on or after July 1, 2012, the Medicaid Program will not provide reimbursement for healthcare-acquired or provider preventable condition which result in medical procedures performed in error and have a serious adverse impact to the health of the Medicaid recipient as defined in 42 CFR 447.26 in the following:

- Ambulatory Surgical Centers (ASCs);
- Outpatient hospital setting; and
- Professional Services Program,

Provider Preventable conditions are defined in two distinct categories:

- Healthcare Acquired Conditions (HCACs) and
- Other Provider Preventable Conditions (OPPCs).

No payment shall be made for Other Provider Preventable Conditions (OPPCs). OPPCs include the three Medicare National Coverage Determinations:

- Wrong surgical or other invasive procedure performed on a patient;
- Surgical or other invasive procedure performed on the wrong body part; and
- Surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for provider preventable condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

STATE <u>Louisiana</u>	A
DATE REC'D <u>5-17-2012</u>	
DATE APPV'D <u>AUG 26 2013</u>	
DATE EFF <u>7-1-2012</u>	
UNFA 179 <u>12-10</u>	

TN# 12-10
Supersedes

Approval Date AUG 26 2013

Effective Date 7-1-2012

SUPERSEDES: NONE - NEW PAGE

TN# _____

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:

Reductions in provider payment may be limited to the extent that the following apply:

- i. The identified provider-preventable conditions would otherwise result in an increase in payment.
- ii. The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

STATE <u>Louisiana</u>	A
DATE REC'D <u>5-17-2012</u>	
DATE APPV'D <u>AUG 26 2013</u>	
DATE EFF <u>7-1-2012</u>	
INDEX 179 <u>12-10</u>	

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

CITATION Medical and OUTPATIENT HOSPITAL SERVICES

42 CFR Remedial

447.321 Care and Services
Item 2.a.

Clinical diagnostic laboratory services are reimbursed at the lower of:

- 1) billed charges;
- 2) the State maximum amount for CPT codes based on the 2008 Medicare fee schedule. These amounts are published on the Medicaid provider website at www.lamedicaid.com; or
- 3) Medicare Fee Schedule amount.

State: Louisiana
Date Received: 2/7/13
Date Approved: 9/20/13
Date Effective: 2/1/13
Transmittal #: LA 13-03

Reimbursement for clinical diagnostic laboratory services complies with UPL requirements for these services.

Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 5.65 percent of the fee schedule on file as of August 3, 2009.

Effective for the dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 5 percent of the fee schedule on file as of February 2, 2010.

Effective for the dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

Effective for the dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

Effective for dates of service on or after August 1, 2012, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 3.7 percent of the fee schedule on file as of July 31, 2012.

Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.

TN# 13-03
Supersedes
TN# 12-51

Approval Date 9/20/13

Effective Date 2/1/13

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

State-owned Hospitals

Effective for dates of services on or after July 1, 2008, state-owned hospitals shall be reimbursed for outpatient clinical laboratory services at 100 per cent of the current Medicare Clinical Laboratory Fee Schedule.

Outpatient hospital facility fees for office/outpatient visits are reimbursed at the lower of:

State: Louisiana
Date Received: 2/7/13
Date Approved: 9/20/13
Date Effective: 2/1/13
Transmittal #: LA 13-03

- 1) billed charges; or
- 2) the State maximum amount (70% of the Medicare APC payment rates as published in the 8/9/02 Federal Register). The fee schedule is published on the Medicaid provider website at www.lamedicaid.com.

Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital facility fees shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital facility fees for office/outpatient visits shall be reduced by 5.65 percent of the fee schedule on file as of August 3, 2009.

Effective for the dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital facility fees for office/outpatient visits shall be reduced by 5 percent of the fee schedule on file as of February 2, 2010.

Effective for the dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital facility fees for office/outpatient visits shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

Effective for the dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital facility fees for office/outpatient visits shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital facility fees for office/outpatient visits shall be reduced by 3.7 percent of the fee schedule on file as of July 31, 2012.

Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital facility fees for office/outpatient visits shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.

TN# 13-03
Supersedes
TN# 12-51

Approval Date 9/20/13

Effective Date 2/1/13

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:

Outpatient hospital surgery facility fees are reimbursed at the lower of:

- 1) billed charges; or
- 2) established Medicaid payment rates assigned to each Healthcare Common Procedure Coding System (HCPCS) code based on the Medicare payment rates for ambulatory surgery center services. These rates are published on the Medicaid provider website at www.lamedicaid.com.

Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital facility surgery fees shall be reduced by 5.65 percent of the fee schedule on file as of August 3, 2009.

Effective for the dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital surgery facility fees shall be reduced by 5 percent of the fee schedule on file as of February 2, 2010.

Effective for the dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery facility fees shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

Effective for the dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery facility fees shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery facility fees shall be reduced by 3.7 percent of the fee schedule on file as of July 31, 2012.

Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery facility fees shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.

Current HCPCS codes and modifiers shall be used to bill for all outpatient hospital surgery services.

TN# 13-03 Approval Date 9/20/13
Supersedes Effective Date: 2/1/13
TN# 12-51

State: Louisiana
Date Received: 2/7/13
Date Approved: 9/20/13
Date Effective: 2/1/13
Transmittal #: LA 13-03

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:

Rehabilitation services (physical, occupational, and speech therapy). Rates for rehabilitation services are calculated using the base rate from fees on file in 1997. The maximum rates for outpatient rehabilitation services are set using the State maximum rates for rehabilitation services plus an additional 10%. Effective September 16, 2002 the reimbursement rates for services rendered to Medicaid recipients over the age of 3 years are increased by 15% for outpatient hospital rehabilitation services.

Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient rehabilitation services provided to recipients over the age of 3 years shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009. The fee schedule is published on the Medicaid provider website at www.lamedicaid.com.

Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be reduced by 5.65 percent of the fee schedule on file as of August 3, 2009.

Effective for dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be reduced by 5 percent of the fee schedule on file as of February 2 2010.

Rates for outpatient rehabilitation services provided to recipients up to the age of three are as follows:

Initial Speech/Language Evaluation	\$70.00
Initial Hearing Evaluation	\$70.00
Speech/Language/Hearing Therapy 60 minutes	\$56.00
Visit with Procedure(s) 45 minutes	\$56.00
Visit with Procedure(s) 60 minutes	\$74.00
Visit with Procedure(s) 90 minutes	\$112.00
Procedures and Modalities 60 minutes	\$74.00
PT and Rehab Evaluation	\$75.00
Initial OT Evaluation	\$70.00
OT 45 minutes	\$45.00
OT 60 minutes	\$60.00

A	
STATE <u>Louisiana</u>	
DATE RECD <u>9-30-10</u>	
DATE APPVD <u>12-16-10</u>	
DATE EFF <u>8-1-10</u>	
HCFA 179 <u>10-52</u>	

TN# 10-52
Supersedes
TN# 10-12

Approval Date 12-16-10

Effective Date 8-1-10

SUPERSEDES: TN- 10-12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

ATTACHMENT 4.19-B
Item 2.a., Page 1.b(1)

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Effective for services provided on or after July 21, 2010 for physical therapy, occupational therapy or speech-language therapy services provided in conjunction with the Pediatric Day Health Program, reimbursement is made pursuant to the methodology described on page 4.19-B, Item 4b, Page 5 under EPSDT- Pediatric Day Health Program.

STATE	<u>Louisiana</u>	A
DATE REC'D	<u>9-30-10</u>	
DATE APP'D	<u>11-18-11</u>	
DATE EFF	<u>7-21-10</u>	
HCFA 179	<u>10-48</u>	

SUPERSEDES: NONE - NEW PAGE

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Diabetes Education Services Reimbursement

Effective for dates of service on or after February 21, 2011, the Medicaid Program shall provide reimbursement for diabetes self-management training services rendered by qualified health care professionals in an outpatient hospital setting.

Reimbursement for DSMT services shall be a flat fee based on the appropriate Healthcare Common Procedure Coding (HCPC) code.

Payment is uniform for both governmental and private providers. The fee schedule is published on the Louisiana Medicaid provider website, lamedicaid.com.

STATE <u>Louisiana</u>	A
DATE REC'D <u>3-27-11</u>	
DATE APPV'D <u>6-6-11</u>	
DATE EFF <u>2-21-11</u>	
HCFA 179 <u>11-05</u>	

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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Outpatient hospital services other than clinical diagnostic laboratory, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees for office/outpatient visits are paid as follows:

In-state private hospital outpatient services are reimbursed on a hospital specific cost to charge ratio calculation based on the latest filed cost reports. Updated cost to charge ratios will be calculated as filed cost reports are received. Cost to charge ratios for the hospitals on which a filed cost report was received will be adjusted at the beginning of the next quarter. Final reimbursement is adjusted to 83% of allowable cost through the cost report settlement process. The allowable costs are determined from the Medicare/Medicaid cost report for each hospital. The costs and charges on these cost reports are reported in accordance with the instructions in the HIM-15 (Medicare Reimbursement Manual).

Effective for dates of services on or after August 1, 2006, the outpatient rates paid to private hospitals for cost-based services are increased by 3.85% of the rates in effect on July 31, 2006. Final reimbursement will be 86.2% of allowable cost through the cost report settlement process.

Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, facility fees for outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 3.5 percent of the rates effective as of February 19, 2009. Final reimbursement will be 83.18% of allowable cost through the cost settlement process.

Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, facility fees for outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 5.65 percent of the rates effective as of August 3, 2009. Final reimbursement shall be at 78.48 percent of allowable cost through the cost settlement process.

Effective for dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, facility fees for outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 5 percent of the rates effective as of February 2, 2010. Final reimbursement shall be at 74.56 percent of allowable cost through the cost settlement process.

Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, facility fees for outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 4.6 percent of the rates effective as of July 31, 2010. Final reimbursement shall be at 71.13 percent of allowable cost through the cost settlement process.

Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, facility fees for outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 2 percent of the rates effective as of November 30, 2010. Final reimbursement shall be at 69.71 percent of allowable cost through the cost settlement process.

Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 3.7 percent of the rates in effect on July 31, 2012. Final reimbursement shall be at 67.13 percent of allowable cost through the cost settlement process.

Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 1 percent of the fee schedule in effect on January 31, 2013. Final reimbursement shall be at 66.46 percent of allowable cost through the cost settlement process.

TN# 13-03 Approval Date 9/20/13
Supersedes Effective Date: 2/1/13
TN# 12-51

State: Louisiana
Date Received: 2/7/13
Date Approved: 9/20/13
Date Effective: 2/1/13
Transmittal #: LA 13-03

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In-state state-owned hospital outpatient services. Interim payment shall be one hundred percent of each hospital's cost to charge ratio as calculated from the latest filed cost report. Final reimbursement shall be one hundred percent of allowable cost as calculated through the cost report settlement process. Final cost is identified by mapping outpatient charges to individual cost centers on the Medicare Hospital Cost Report then multiplying such charges by the cost centers' individual cost to charge ratios. Dates of service associated with the charges match the rate year on the Medicare Hospital Cost Report.

Effective for dates of services on or after August 1, 2012, the reimbursement rate paid to state-owned hospitals for outpatient surgery, outpatient clinic services, outpatient laboratory services and outpatient hospital services, other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 10 percent of the fee schedule on file as of July 31, 2012. Final reimbursement shall be at 90 percent of allowable cost through the cost settlement process.

Out-of-state hospital outpatient services. Effective for dates of services on or after April 1, 2003, services shall be reimbursed at 31.04% of billed charges.

Medical Education Payments (State-Owned Hospitals)

A. Outpatient Surgery

Effective for dates of service on or after February 10, 2012, medical education payments for outpatient surgery services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be reimbursed by Medicaid annually through the cost report settlement process.

1. For purposes of these provisions, qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.
2. Final payment shall be determined based on the actual MCO covered outpatient surgery services and Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

B. Clinic Services

Effective for dates of service on or after February 10, 2012, medical education payments for outpatient clinic services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be reimbursed by Medicaid annually through the cost report settlement process.

1. For purposes of these provisions, qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.
2. Final payment shall be determined based on the actual MCO covered outpatient clinic services and Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

TN# 12-49 Approval Date 8/22/13
Supersedes
TN# 12-07 Effective Date: 8/1/12

State: Louisiana
Date Received: 12-12-12
Date Approved: 8-22-13
Effective Date: 8-1-12
Transmittal Number: LA 12-49

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:

C. **Rehabilitation Services**

Effective for dates of service on or after February 10, 2012, medical education payments for outpatient rehabilitation services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be reimbursed by Medicaid annually through the cost report settlement process

1. For purposes of these provisions, qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.
2. Final payment shall be determined based on the actual MCO covered outpatient rehabilitation services and Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

D. **Other Outpatient Hospital Services**

Effective for dates of service on or after February 10, 2012, medical education payments which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be reimbursed by Medicaid annually through the cost report settlement process to state-owned hospitals for outpatient hospital services other than outpatient surgery services, clinic services, laboratory services, and rehabilitation services.

1. For purposes of these provisions, qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.
2. Final payment shall be determined based on the actual MCO covered outpatient services and Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

State: Louisiana
Date Received: 12-12-12
Date Approved: 8-22-13
Effective Date: 8-1-12
Transmittal Number: LA 12-49

TN# 12-49 Approval Date 8/22/13 Effective Date 8/1/12
Supersedes
TN# 12-07

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:

Enhancement Pool For Public Hospitals

- a. Reserved
- b. Reserved
- c. Reserved
- d. Reserved
- e. Reserved

SUPERSEDES: TN- 09-13

STATE	<u>Louisiana</u>	A
DATE REC'D	<u>2-16-12</u>	
DATE APPV'D	<u>5-3-12</u>	
DATE EFF	<u>2-10-12</u>	
HIDEA 179	<u>12-07</u>	

TN# 12-07 Approval Date 5-3-12 Effective Date 2-10-12
Supersedes

TN# 09-13

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

f. Supplemental Payment for State Hospitals

A supplemental payment shall be issued to state owned and operated hospitals for outpatient hospital services subject to the payment limits of 42 CFR §447.321. The outpatient upper payment limit for state hospitals will be determined using the latest available cost report and corresponding claims data to determine the reasonable costs in accordance with the Medicare principles of reimbursement. The supplemental payment calculation shall be the difference between outpatient costs using the Medicare principles of reimbursement less the Medicaid reimbursement for outpatient services for each state hospital. This amount shall be trended forward to the mid-point of the current state fiscal year based on the Centers for Medicare and Medicaid Services (CMS) Hospital Market Basket Index for PPS hospitals. This supplemental payment calculation is an annual calculation of which a fourth will be distributed on a quarterly basis. Payments are made at the beginning of the quarter.

Reimbursement for Outpatient Services in Small Rural Hospital

Effective for dates of service on or after July 1, 2008, small rural hospitals as defined in D.3.b. shall be reimbursed for **outpatient clinical diagnostic laboratory services** at a fee schedule amount which will be equal to 100% of the Medicare Clinical Laboratory Services Fee Schedule amount. The fee schedule is published on the Medicaid provider website at www.lamedicaid.com.

Effective for dates of service on or after July 1, 2008, small rural hospitals as defined in D.3.b. shall be reimbursed for **outpatient surgeries, rehabilitation services, and outpatient hospital facility fees** as follows:

Interim payment for claims shall be the Medicaid fee schedule payment currently in effect for each service. A quarterly interim cost settlement payment shall be made to each small rural hospital to estimate a payment of one hundred ten percent of allowable cost for fee schedule services. The interim cost settlement payment shall be calculated by subtracting the actual quarterly payments for dates of services from one hundred ten percent of the allowable costs of the quarterly claims. The cost to charge ratio from the latest filed cost report shall be applied to quarterly charges for the outpatient claims paid by fee schedule and multiplied by one hundred ten percent to determine allowable cost. Final reimbursement shall be one hundred ten percent of allowable cost as calculated through the cost report settlement process.

Effective for the dates of service on or after August 1, 2010, small rural hospitals as defined below shall be reimbursed for **outpatient hospital surgery services, rehabilitation services, and outpatient hospital facility fees** up to the Medicare outpatient upper payment limit.

SUPERSEDES: TN- 07-20

TN# 10-54
Supersedes
TN# 07-20

Approval Date 4-28-11
Effective Date: 8-1-10

STATE <u>Louisiana</u>	A
DATE REC'D <u>9-28-10</u>	
DATE APP'VD <u>4-28-11</u>	
DATE EFF <u>8-1-10</u>	
HCFA 179 <u>10-54</u>	

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

Qualifying Criteria:

- a. Public (non-state) small rural hospital – a small rural hospital as defined in Attachment 4.19-A, Section D.3.b.(1) which is owned by a local government and as of August 1, 2010 has a certified neonatal intensive care unit.
- b. Private small rural hospital- a small rural hospital as defined in Attachment 4.19-A, Section D.3.b.(1)(i)

Effective for dates of service on or after July 1, 2008, small rural hospitals as defined in D.3.b. shall be reimbursed for **outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees as follows:**

Interim payment shall be one hundred ten percent of each hospital's cost to charge ratio as calculated from the latest filed cost report. Final reimbursement shall be one hundred ten percent of allowable cost as calculated through the cost report settlement process. Final cost is identified by mapping outpatient charges to individual cost centers on the Medicare Hospital Cost Report then multiplying such charges by the cost centers' individual cost to charge ratios. Dates of service associated with the charges match the rate year on the Medicare Hospital Cost Report.

Effective for the dates of service on or after August 1, 2010, small rural hospitals as defined below shall be reimbursed for **outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees** up to the Medicare outpatient upper payment limit.

Qualifying Criteria:

- a. Public (non-state) small rural hospital – a small rural hospital as defined in Attachment 4.19-A, Section D.3.b.(1) which is owned by a local government and as of August 1, 2010 has a certified neonatal intensive care unit.
- b. Private small rural hospital- a small rural hospital as defined in Attachment 4.19-A, Section D.3.b.(1)(i)

SUPERSEDES: NONE - NEW PAGE

STATE <u>Louisiana</u>	A
DATE REC'D <u>9-28-10</u>	
DATE APP'D <u>4-28-11</u>	
DATE EFF <u>8-1-10</u>	
HCFA 179 <u>10-54</u>	

TN# 10-54

Approval Date 4-28-11

Effective Date 8-1-10

Supersedes

TN# SUPERSEDES: NONE - NEW PAGE

MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

Supplemental Payments for Low Income and Needy Care Collaboration Hospitals (Small Rural Hospitals)

- A. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for **outpatient surgery services** rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.
 - 1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement as of October 31, 2011.
 - a) A non-state hospital is defined as a hospital which is owned or operated by a private entity.
 - b). A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.
 - 2. Payment Methodology. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on Medicaid paid claims for service dates from the previous state fiscal year not to exceed the maximum allowable cap. Payment to a hospital shall be proportional to the hospital's percentage of paid claims relative to the total paid claims for all eligible hospitals.

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STATE	Louisiana
DATE REC'D	11-29-11
DATE APP'VD	7-11-12
DATE EFF	10-20-11
HCP#	179

Payments to hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

Aggregate outpatient hospital service supplemental payments to all qualifying small rural hospitals (includes outpatient surgery services, hospital clinic services, rehabilitation services, and services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient facility fees) shall not exceed the maximum allowable cap of \$4,500,000 for each state fiscal year.

TN# 11-35

Approval Date 7-11-12

Effective Date 10-20-11

Supersedes

TN# **SUPERSEDES: NONE - NEW PAGE**

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

- B. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for **outpatient hospital clinic services** rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.
1. **Qualifying Criteria.** In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement as of October 31, 2011.
 - a) A non-state hospital is defined as a hospital which is owned or operated by a private entity.
 - b) A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.
 2. **Payment Methodology.** Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on Medicaid paid claims for service dates from the previous state fiscal year not to exceed the maximum allowable cap. Payment to a hospital shall be proportional to the hospital's percentage of paid claims relative to the total paid claims for all eligible hospitals.

Payments to hospitals participating in the Medicaid Disproportionate Share Hospital Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

Aggregate outpatient hospital service supplemental payments to all qualifying small rural hospitals (includes outpatient surgery services, hospital clinic services, rehabilitation services, and services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient facility fees) shall not exceed the maximum allowable cap of \$4,500,000 for each state fiscal year.

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DATE REC'D <u>11-29-11</u>	
DATE APPV'D <u>7-11-12</u>	
DATE EFF <u>10-20-11</u>	
HCFA 179 <u>11-35</u>	

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

C. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for **outpatient rehabilitation services** rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement as of October 31, 2011.
 - a) A non-state hospital is defined as a hospital which is owned or operated by a private entity.
 - b) A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.
2. Payment Methodology. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on Medicaid paid claims for service dates from the previous state fiscal year not to exceed the maximum allowable cap. Payment to a hospital shall be proportional its percentage of paid claims relative to the total paid claims for all eligible hospitals.

Payments to hospitals participating in the Medicaid Disproportionate Share Hospital Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

Aggregate outpatient hospital service supplemental payments to all qualifying small rural hospitals (includes outpatient surgery services, hospital clinic services, rehabilitation services, and services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient facility fees) shall not exceed the maximum allowable cap of \$4,500,000 for each state fiscal year.

STATE <u>Louisiana</u>	A
DATE REC'D <u>11-29-11</u>	
DATE APPV'D <u>7-11-12</u>	
DATE EFF <u>10-20-11</u>	
NOFA 179 <u>11-35</u>	

TN# 11-35 Approval Date 7-11-12 Effective Date 10-20-11

Supersedes

TN# SUPERSEDES: NONE - NEW PAGE

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

- E. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for **services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient facility fees** during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.
1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement as of October 31, 2011.
 - a) A non-state hospital is defined as a hospital which is owned or operated by a private entity.
 - b) A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.
 2. Payment Methodology. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on Medicaid paid claims for service dates from the previous state fiscal year not to exceed the maximum allowable cap. Payment to a hospital shall be proportional its percentage of paid claims relative to the total paid claims for all eligible hospitals.

Payment to hospitals participating in the Medicaid Disproportionate Share Hospital Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

Aggregate outpatient hospital service supplemental payments to all qualifying small rural hospitals (includes outpatient surgery services, hospital clinic services, rehabilitation services, and services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient facility fees) shall not exceed the maximum allowable cap of \$4,500,000 for each state fiscal year.

STATE	<u>Louisiana</u>
DATE REC'D	<u>11-29-11</u>
DATE APPV'D	<u>7-11-12</u>
DATE EFF	<u>10-20-11</u>
HCFA 179	<u>11-35</u>

A

TN# 11-35 Approval Date 7-11-12

Effective Date 10-20-11

Supersedes
TN# SUPERSEDES: NONE - NEW PAGE

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

Supplemental Payments for Non-Rural, Non-State Government Hospitals

Effective for dates of service on or after October 1, 2012 through June 30, 2013 quarterly supplemental payments shall be issued to qualifying non-rural, non-state government hospitals for outpatient hospital services.

- a) **Qualifying criteria** – Effective October 1, 2012, the quarterly supplemental payment will be made to West Jefferson Medical Center for SFY 2013.
- b) **Payment Methodology** – Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. For SFY 2013, this payment shall be \$7,060,008 not to exceed the upper payment limits pursuant to 42 CFR 447.321. Maximum payments shall not exceed the upper payment limit pursuant to 42CFR 447.321.

Effective for dates of service on or after July 1, 2013, quarterly supplemental payments shall be issued to the following qualifying non-rural, non-state government hospitals for outpatient hospital services.

- a) **Qualifying criteria** – Effective July 1, 2013, the quarterly supplemental payment will be made to Terrebonne General Hospital.
- b) **Payment Methodology** – Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year not to exceed the upper payment limits pursuant to 42 CFR 447.321. The UPL calculation methodology for outpatient non-state hospitals (governmental and private) is as follows:

- 1. Accumulate Medicaid claims data for outpatient services for each non-state hospital from the previous state fiscal year.
- 2. Separate charges and payments from paid claims between services reimbursed on a percentage of cost basis from services reimbursed at a fee-for-service rate.
- 3. Compile cost to charge ratios for Medicaid outpatient services from latest filed Medicare/Medicaid cost report (Form CMS 2552).
- 4. For services reimbursed at a fee-for-service rate (other than outpatient clinical laboratory services):
 - a. Multiply cost to charge ratio by Medicaid outpatient charges (except for outpatient clinical laboratory services) to determine Medicaid outpatient costs.
 - b. Subtract claims payments from costs.
- 5. For Medicaid outpatient services reimbursed at a percentage of cost:
 - a. Multiply cost to charge ratio by Medicaid outpatient claims charges to determine Medicaid outpatient costs.
 - b. Multiply Medicaid costs by the applicable percentage of allowable cost reimbursed for a period to determine Medicaid payment which would be calculated upon cost settlement.
 - c. Subtract calculated payment from costs.

State: Louisiana
Date Rec'd: 8/27/13
Date Apprd: 1/28/14
Date Eff: 7/1/13
TN #: 13-30

TN# 13-30
Supersedes
TN# 12-60

Approval Date 1/28/14

Effective Date 7/1/13

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

6. For each hospital, add the differences of the Medicaid costs less Medicaid payments for the cost-based services and the fee-for-service rate services.
7. Trend the difference forward to the midpoint of the current state fiscal year using the CMS Market Basket Index for PPS hospitals.
8. The sum of the difference for each hospital for all hospitals in the group is the upper payment limit for that group of hospitals.

Maximum payments shall not exceed the upper payment limit pursuant to 42CFR 447.321.

Reimbursement for In-State Outpatient Children’s Specialty Hospitals

a. Qualifications

In order to qualify to receive Medicaid reimbursement as an in-state children’s specialty hospital, a non-rural, non-state acute care hospital must meet the following criteria. The hospital must:

- (1) be recognized by Medicare as a prospective payment system (PPS) exempt children’s specialty hospital;

State: Louisiana
Date Rec'd: 8/27/13
Date Apprd: 1/28/14
Date Eff: 7/1/13
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- (2) not qualify for Medicare disproportionate share hospital payments; and
- (3) have a Louisiana Medicaid inpatient days utilization rate greater than the mean plus two standard deviations of the Medicaid utilization rates for all hospitals in the state receiving Medicaid payments.

b. Reimbursement Methodology

- (1) Effective for the dates of service on or after September 1, 2009, the reimbursement amount paid to children's specialty hospitals that meet the above qualifications shall be reimbursed as follows for **outpatient surgeries and rehabilitation services (physical, occupational, and speech therapy)**:

Initial payments shall be equal to the Medicaid fee schedule payments per Item 2.a., Page 1. After the fiscal year end cost report is filed, final annual payment for these services will be 97 percent of cost as calculated per the cost report.

- (2) Effective for the dates of service on or after September 1, 2009, the reimbursement amount paid to children's specialty hospitals that meet the above qualifications shall be reimbursed as follows for **outpatient hospital services other than clinical diagnostic laboratory, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees**:

Initial payments shall be 97 percent of the hospital's interim cost to charge ratio as calculated from the latest filed cost report. After the fiscal year end cost report is filed, final annual payment for these services will be 97 percent of cost as calculated per the cost report.

- (3) Effective for the dates of service on or after February 3, 2010, the reimbursement paid to children's specialty hospitals for outpatient surgery services, rehabilitation services provided to recipients over the age of 3, and outpatient hospital services other than clinical diagnostic laboratory services, facility fees for outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be reduced by 5 percent of the fee schedule on file as of February 2, 2010. Final reimbursement shall be 92.15 percent of allowable cost as calculated through the cost report settlement process.

Effective for the dates of service on or after February 3, 2010, the reimbursement paid to children's specialty hospitals for outpatient hospital clinic services, and clinical diagnostic laboratory services shall be reduced by 5 percent of the fee schedule on file as of February 2, 2010.

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STATE	Louisiana
DATE REC'D	8-30-10
DATE APP'D	12-13-10
DATE EFF	8-1-10
HCFA 179	10-12

TN# 10-12
Supersedes
TN# 09-44

Approval Date 12-13-10

Effective Date 2-3-10

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:

- (4) Effective for the dates of service on or after August 1, 2010, the reimbursement paid to children's specialty hospitals for outpatient surgery services, and outpatient hospital services other than clinical diagnostic laboratory services, facility fees for outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010. Final reimbursement shall be 87.91 percent of allowable cost as calculated through the cost report settlement process.

Effective for the dates of service on or after August 1, 2010, the reimbursement paid to children's specialty hospitals for outpatient hospital clinic services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

- (5) Effective for the dates of service on or after January 1, 2011, the reimbursement paid to children's specialty hospitals for outpatient hospital services other than clinical diagnostic laboratory services, rehabilitation services, and outpatient hospital facility fees shall be reduced by 2 percent of the fee schedule on file as of November 30, 2010. Final reimbursement shall be 86.15 percent of allowable cost as calculated through the cost report settlement process.
- (6) Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to children's specialty hospitals for outpatient surgery, outpatient clinic services and outpatient clinical diagnostic laboratory services shall be reduced by 3.7 percent of the fee on file as of July 31, 2012.
- (7) Effective for dates of service on or after August 1, 2012, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services other than rehabilitation services and outpatient hospital facility fees shall be reduced by 3.7 percent of the rates in effect on July 31, 2012. Final reimbursement shall be 82.96 percent of the allowable cost as calculated through the cost report settlement process.
- (8) Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to children's specialty hospitals for outpatient surgery, outpatient hospital clinic services, outpatient clinical diagnostic laboratory services shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.
- (9) Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to children's specialty hospitals for outpatient hospital services other than rehabilitation services and outpatient hospital facility fees shall be reduced by 1 percent of the fee schedule in effect on January 31, 2013. Final reimbursement shall be 82.13 percent of allowable cost as calculated though the cost report settlement process.

TN# 13-03
Supersedes
TN# 12-51

Approval Date 9/20/13
Effective Date: 2/1/13

State: Louisiana
Date Received: 2/7/13
Date Approved: 9/20/13
Date Effective: 2/1/13
Transmittal #: LA 13-03

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

Supplemental Payments for Major Teaching Hospitals

i. Qualifying Criteria

In order to qualify for the supplemental payment, a non-rural, non-state acute care hospital must:

1. be designated as a major teaching hospital by the department in state fiscal year 2009;
2. have provided at least 25,000 Medicaid acute care paid days for state fiscal year 2008 dates of service;
3. have provided at least 4,000 Medicaid distinct part psychiatric unit paid days for the state fiscal year 2008 dates of service; and
4. provided at least 20,000 Medicaid outpatient paid visits for state fiscal year 2008 dates of service.

ii. Reimbursement Methodology

Effective for the dates of service on or after October 1, 2009, a quarterly supplemental payment shall be issued to qualifying non-rural, non-state acute care hospitals for outpatient services rendered during the quarter. These payments shall be used to facilitate the development of public-private partnerships to preserve access to medically necessary services for Medicaid enrollees. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable cap for the state fiscal year.

Payments shall be distributed quarterly based on Medicaid paid claims data from service dates in state fiscal year 2009.

Payments are applicable to Medicaid service dates provided during each quarter and shall be discontinued for the remainder of the state fiscal year in the event that the maximum allowable payment caps of \$25,185,636 for SFY 2010 and \$29,886,955 for SFY 2011 is reached or by June 30, 2011, whichever occurs first.

SUPERSEDES: NONE - NEW PAGE

STATE	<u>Louisiana</u>	A
DATE REC'D	<u>12-21-09</u>	
DATE APP'VD	<u>03-18-10</u>	
DATE EFF	<u>10-1-09</u>	
HCFA 179	<u>09-48</u>	

TN# 09-48

Approval Date 03-18-10

Effective Date 10-1-09

Supersedes

TN# SUPERSEDES: NONE - NEW PAGE

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

Supplemental Payments for Low Income and Needy Care Collaboration Hospitals

Effective for dates of service on or after January 1, 2010, quarterly supplemental payments will be issued to qualifying non-rural, non-state hospitals for outpatient services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement
 - a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.
 - b. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.
2. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:
 - a. the difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for covered outpatient 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; or
 - b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

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DATE REC'D	<u>12-30-09</u>	
DATE APP'D	<u>10-29-10</u>	
DATE EFF	<u>1-1-10</u>	
HCFA 179	<u>09-56</u>	

SUPERSEDES: NONE - NEW PAGE

TN# 09-56
Supersedes
TN# SUPERSEDES: NONE - NEW PAGE

Approval Date 10-29-10

Effective Date 1-1-10

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

Supplemental Payments for Private Hospitals

A. Baton Rouge Area

Qualifying Criteria

Effective for dates of service on or after April 15, 2013, a quarterly supplemental payment shall be made to Our Lady of the Lake Hospital, Inc.

Reimbursement Methodology

Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. For SFY 2013, this payment shall be \$2,109,589, and for each state fiscal year starting with SFY 2014, this payment shall be \$10,000,000, not to exceed the upper payment limits pursuant to 42 CFR 447.321. Maximum payments shall not exceed the upper payment limit pursuant to 42CFR 447.321.

STATE	<u>LOUISIANA</u>	A
DATE REC'D	<u>11-2-12</u>	
DATE APPV'D	<u>7-23-13</u>	
DATE EFF	<u>4-15-13</u>	
ISSA 179	<u>12-64</u>	

TN# 12-64 Approval Date 7-23-13 Effective Date 4-15-13
Supersedes
TN# NONE - NEW PAGE SUPERSEDES: NONE - NEW PAGE

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

Reimbursement for Our Lady of the Lake Hospital, Inc.

Effective for dates of service on or after April 15, 2013, Our Lady of the Lake Hospital, Inc. shall be reimbursed as follows:

1. **Outpatient Surgery:** The reimbursement amount for outpatient hospital surgery services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement will be cost settled using the final audited cost report CMS-2552-10 to 95 percent of allowable Medicaid costs.
2. **Clinic Services:** The reimbursement amount for outpatient clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement will be cost settled using the final audited cost report CMS-2552-10 to 95 percent of allowable Medicaid costs.
3. **Laboratory Services:** The reimbursement amount for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.
4. **Rehabilitative Services:** The reimbursement amount for outpatient clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement will be cost settled using the final audited cost report CMS-2552-10 to 95 percent of allowable Medicaid costs.
5. **Other Outpatient Hospital Services:** Outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reimbursed a hospital specific cost to charge ratio calculation based on the latest filed cost report. The final reimbursement will be cost settled using the final audited cost report CMS-2552-10 to 95 percent of allowable Medicaid costs.

STATE	<u>LOUISIANA</u>
DATE REC'D	<u>5-22-13</u>
DATE APPV'D	<u>7-23-13</u>
DATE EFF	<u>4-15-13</u>
NOFA 179	<u>13-21</u>

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SUPERSEDES: NONE - NEW PAGE

TN# 13-21 Approval Date 7-23-13 Effective Date 4-15-13
Supersedes
TN# NONE - NEW PAGE