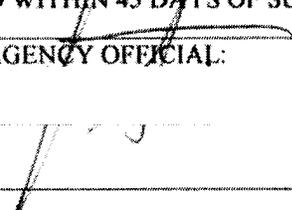


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-54	2. STATE Louisiana
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE August 1, 2010	
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: 42 CFR Part 447 Subpart F		7. FEDERAL BUDGET IMPACT: * a. FFY 2009 2010 \$1,530.17 * b. FFY 2010 2011 \$7,286.48	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Item 2.a, Page 4 Attachment 4.19-B, Item 2.a, Page 5 * Attachment 4.19-B, Item 2a, Page 4a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same (TN 07-20) Same (TN 09-44) *None (New Page)	
10. SUBJECT OF AMENDMENT: The purpose of this amendment is to revise the reimbursement methodology for small rural hospitals to reimburse outpatient hospital services up to the Medicare inpatient upper payment limit. (up to the Medicare outpatient upper payment limit (UPL).)			
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: State of Louisiana Department of Health and Hospitals 628 N. 4th Street PO Box 91030 Baton Rouge, LA 70821-9030	
13. TYPED NAME: Bruce D. Greenstein			
14. TITLE: Secretary			
15. DATE SUBMITTED: September 28, 2010			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 28 September, 2010		18. DATE APPROVED: 28 April, 2011	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 August, 2010		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS: * Pen and Ink change made per State's Letter Dated 24 February, requesting change to Block 10. * Pen and Ink change made per State's Letter Dated 24 February, requesting change to Blocks 8 & 9 adding Attachment 4.19-B, Item 2a, page 4a. * Pen and Ink change made per State's E-mail Dated 25 April, 2011 changed the Fiscal Year Impact Date			

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 APPVD <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>	

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 Hospitals

Effective for dates of service on or after July 1, 2009, Medicaid Supplemental payments will be made to qualifying non-rural non-state public hospitals for dates of service from July 1, 2009 through December 31, 2010 as follows.

- 1) Hospitals impacted by Hurricane Katrina
Maximum aggregate payments to all qualifying hospitals in this group (which includes inpatient supplemental payments described in Attachment 4.19-A, Item 1, Section I.B.9.b.1) will not exceed \$170,000,000.
 - a) Qualifying criteria – Non-rural non-state public or private hospital which is located in DHH Administrative Region 1 and identified in the July 17, 2008 United States Governmental Accountability Office report as a hospital that has demonstrated substantial financial and operational challenges in the aftermath of Hurricane Katrina.
 - b) Payment Methodology – Each eligible qualifying hospital shall receive quarterly supplemental payments which in total do not exceed a specified individualized hospital limit. Payments will be distributed based on Medicaid paid claims data from service dates from SFY 2008. Payments will end when the hospital specific cap is reached or December 31, 2010 whichever occurs first.

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 <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>	

SUPERSEDES: TN- 09-44

TN# 10-54
Supersedes
TN# 09-44

Approval Date 4-28-11

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