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: **09-13**

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, 2009**

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 F

7. FEDERAL BUDGET IMPACT:
a. FFY **2009** **($2,270.83)**
b. FFY **2010** **($5,345.55)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Item 2.a., Page 1
Attachment 4.19-B, Item 2.a., Page 1a
Attachment 4.19-B, Item 2.a., Page 2
Attachment 4.19-B, Item 2.a., Page 2a
* Attachment 4.19-B, Item 2a, Page 3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same (TN 08-18)
Same (TN 03-23)
Same (TN 08-18)
Same (TN 03-37)
Same (TN 02-09

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to reduce the reimbursement for non-state, non-rural outpatient hospital services by 3.5% due to a budgetary shortfall.**

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 O[redacted]

13. TYPED NAME:
Alan Levine

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 27, 2009

16. RETURN TO:

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:
30 March, 2009

18. DATE APPROVED:
2 November, 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
20 February, 2009

20. SIGNAT[redacted]ICIAL:

21. TYPED NAME:
Bill Brooks

22. TITLE:
Associate Regional Administrator
Div of Medicaid & Children's Health

23. REMARKS: * Pen + Ink Change Made per State's Letter Dated September 3, 2009

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:

CITATION	Medical and Remedial Care and Services
42 CFR 447.321	Item 2.a.

OUTPATIENT HOSPITAL SERVICES

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.

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.

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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:

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.

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

SUPERSEDES: TN- 08-18

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

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ambulatory surgery center services. These rates are published on the Medicaid provider website at www.lamedicaid.com.

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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.

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

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.

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

SUPERSEDES: TN 03-23

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 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.

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.

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.

Enhancement Pool For Public Hospitals

a. **Reserved**

SUPERSEDES: TN- 08-18

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b. **Reserved**

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SUPERSEDES: TN- 03-37

PAYMENT 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 AS DESCRIBED AS FOLLOWS:

c. Reserved

d. Reserved

e. Reserved

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SUPERSEDES: TN 02-09

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid & Children's Health, Region VI

November 2, 2009

Our Reference: SPA-LA-09-13

Mr. Jerry Phillips, State Medicaid Director
Department of Health and Hospitals
Bienville Building
628 North 4th Street
Post Office Box 91030
Baton Rouge, LA 70821-9030

Dear Mr. Phillips:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 09-13. This amendment reduces reimbursement for non-state, non-rural outpatient hospital services by 3.5%.

Transmittal Number 09-13 is approved with an effective date of February 20, 2009 as requested. A copy of the HCFA-179, Transmittal No. 09-13 dated March 27, 2009 is enclosed along with the approved plan pages.

If you have any questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

Enclosures

Marks, Marsha L. (CMS/SC)

From: Marks, Marsha L. (CMS/SC)
Sent: Wednesday, November 04, 2009 2:18 PM
To: CMS CMSO_508_SPA
Cc: Rupley, Cheryl A. (CMS/SC); 'ALLYSON LAMY'
Subject: FW: Approved SPA LA 09-13
Attachments: SPA-LA-09-13.doc; Approval Pkg for LA 09-13.pdf

See Attached.

State: Louisiana

Brief Description: The SPA reduces the reimbursement for non-state, non-rural outpatient hospital services by 3.5% . The payment does not exceed the outpatient hospital services upper payment limit. The non-Federal share of the payment will be funded through appropriations made to the Medicaid agency.

Approval Date: 11/3/09

Effective Date: 7/1/09

R/

Marsha Marks // Dept of Health & Human Services // Centers for Medicare & Medicaid Services // Dallas Regional Office // Division of Medicaid & Children's Health // Dallas Texas 75202 // 214-767-6280 // Fax 214-767-0322 // marsha.marks@cms.hhs.gov