REIMBURSEMENT

This chapter is an overview of inpatient hospital services' reimbursement methodology and does not address all issues or questions that a hospital may have regarding reimbursement. If a provider has a question about this chapter, or any issue regarding hospital reimbursement, the provider may e-mail the Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHFS), Rate Setting and Audit Section (see Appendix B for contact information).

Inpatient Reimbursement

For reimbursement purposes, hospitals enrolled in Louisiana Medicaid are classified as:

1. State-owned;
2. Small rural; or
3. Non-small rural/non-state.

NOTE: The three (3) types of hospitals each have separate inpatient reimbursement methodologies.

State-Owned Hospitals

State-owned hospitals are hospitals that are owned and operated by the state of Louisiana.

Small Rural Hospitals

Small rural hospitals are those hospitals which are defined as a rural hospital by the Rural Hospital Preservation Act (Act No. 327 of the 2007 Louisiana Legislative regular session, Louisiana Revised Statutes 40:1300.142 – 144). Although a hospital may in fact be located in a rural parish or area, only those hospitals meeting the requirements to qualify as a small rural hospital by the legislation noted above fall into this category.

Non-Small Rural/Non-State Hospitals

Non-small rural/non-state hospitals refer to a hospital not falling into either of the previous two designations. Therefore, it may be publicly or privately owned as a profit, or non-profit hospital.

The fact that it is not owned by the state, or that it is not a small rural hospital, makes it a non-small rural/non-state hospital for purposes of Louisiana Medicaid reimbursement.

Acute Care Hospitals Peer Group Assignment

As of October 1, 2009, existing qualifying non-small rural/non-state hospitals classified as one of the peer groups listed below, shall receive not less than a specified percentage (see below) of the peer group per diem to which they are assigned, and may receive more than the current peer group per diem (only if their September 30, 2009, per diem was more than the per diem of the peer group to which they were classified). On and after October 1, 2009, newly qualifying non-rural/non-state hospitals will be assigned the specified percentage of the peer group per diem for the peer group to which they are classified.

Reimbursement for non-small rural/non-state hospitals for inpatient acute care is a prospective per diem rate. All non-small rural/non-state hospitals enrolled in Louisiana Medicaid are classified as one of the following five peer groups, or as a specialty hospital:

1. **Peer Group 1 – Major Teaching Hospitals**
   Qualifying hospitals will receive not less than 80 percent of the current peer group rate;

2. **Peer Group 2 – Minor Teaching Hospitals**
   Qualifying hospitals will receive not less than 103 percent of the current peer group rate;

3. **Peer Group 3 – Non-Teaching Hospitals with less than 58 beds**
   Qualifying hospitals will receive not less than 103 percent of the current peer group rate;

4. **Peer Group 4 – Non-Teaching Hospitals with 59 to 138 beds**
   Qualifying hospitals will receive not less than 122 percent of the current peer group rate; or

5. **Peer Group 5 – Non-Teaching Hospitals with more than 138 beds**
   Qualifying hospitals will receive not less than 103 percent of the current peer group rate.

Changing Peer Group Status

Hospitals wishing to change their status as defined above must submit a request to Provider Enrollment within 90 days prior to the desired effective date. If the requested change is approved, the effective date will be the beginning of the next state fiscal year (SFY). In addition to notifying the FI's Provider Relations Section of its desire to change peer groups, a hospital should also notify the LDH/Rate Setting and Audit in order to be apprised of any specific issues that may affect the hospital's peer group change, and possible new acute care per diem. Refer to Appendix B for LDH/Rate Setting and Audit contact information.

Specialty Hospitals

For each specialty hospital listed below, qualifying hospitals will receive the current peer group rate:

1. Children's Hospitals;
2. Freestanding Psychiatric Hospitals;
3. Distinct Part Psychiatric (DPP) Hospitals;
4. Long Term Acute Care (LTAC) Hospitals; and
5. Rehabilitation Hospitals.

Boarder Baby per Diem

The boarder baby per diem is paid for boarder babies that remain in the regular nursery of the hospital after the mother's discharge. In these cases, this per diem is paid to hospitals billing the appropriate and covered nursery revenue codes.

Well-Baby per Diem

Private hospitals that perform more than 1,500 Louisiana Medicaid deliveries per SFY qualify to be paid a per diem for well babies that are discharged at the same time the mother is discharged. This well-baby per diem rate is the lesser of the hospital's actual costs or the boarder baby rate.

Qualification for Well-Baby Rate

In order for a hospital to qualify for the well-baby per diem, it must notify Rate Setting and Audit at any time during a SFY, or not later than six months after the end of a SFY that it indeed had more than 1,500 Medicaid deliveries in that SFY. It is the hospital's responsibility to request qualifying status in order to be paid the well-baby per diem rate. If the hospital does not inform LDH of their change in status, they will not qualify.

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The Rate Setting and Audit Section generates an annual report to determine if there are any new hospitals that may qualify. **If the Rate Setting and Audit Section cannot determine from the hospital's billing data, available at the time of the report, that it had 1,500 Medicaid deliveries, the hospital must then provide documentation satisfactory to LDH that supports the 1,500 Medicaid deliveries in that SFY.** If the hospital does not notify LDH of their change in status ***and*** provide sufficient information supporting the 1,500 Medicaid deliveries in the time frame specified above, the hospital will not be eligible for the well-baby per diem rate.

Medicaid eligibles do count as Medicaid deliveries, but must be billed to Medicaid, in order to count that delivery. **Therefore, it is the responsibility of the hospital to notify us timely (as described above) that it qualifies.** Rate Setting and Audit will then verify qualifying information. Once a hospital has qualified, it will begin receiving the well-baby per diem for dates of service on and after the beginning of the SFY following its qualification. See the following qualifying, and non-qualifying, Well-Baby Rate examples:

Well-Baby Example 1:

A hospital determines that it had 1,500 Medicaid deliveries from July 1, 2007, to June 30, 2008 (SFY 2008), and it notifies Rate Setting and Audit on December 31, 2008, that it has qualified. After verification and implementation of the rate, the hospital would receive the well-baby per diem for dates of service retroactive to July 1, 2008.

Well-Baby Example 2:

A hospital determines that it had 1,500 Medicaid deliveries from July 1, 2007 to June 30, 2008 (SFY 2008), and it notifies Rate Setting and Audit on January 1, 2009 that it has qualified. The hospital was too late in notifying Rate Setting and Audit; thus, it does not qualify to receive the well-baby per diem. The hospital can qualify later, but only after it has notified Rate Setting and Audit that it has had more than 1,500 Medicaid deliveries in SFY 2009.

Well-Baby Example 3:

A hospital determines that it had 1,500 Medicaid deliveries from July 1, 2008 to January 31, 2009 (first seven months of SFY 2009), and it notifies Rate Setting and Audit on February 1, 2009 that it has qualified. After verification and implementation of the rate, the hospital would receive the well-baby per diem for dates of service on and after July 1, 2009.

Continuing Qualification for Well-Baby Rate

After each SFY, Medicaid will run a report to determine if hospitals currently receiving the well-baby per diem continue to qualify. If the report shows that a hospital did not qualify, additional information will be requested from the hospital to determine if there will be any subsequently billed Medicaid deliveries. After determining that there is no more Medicaid deliveries to count, eligibility will be determined and LDH will either continue or discontinue paying the well-baby per diem in accordance with the number of Medicaid deliveries for that hospital.

If it is determined that a hospital does not continue to qualify, the well-baby per diem will be discontinued and retroactively recouped if necessary back to dates of service beginning July 1 of the SFY year following that hospital's failure to qualify.

Specialty Units

Certain resource intensive inpatient services have historically been recognized through a separate reimbursement methodology by Louisiana Medicaid. Separate per diems are established for the following resource intensive inpatient services: neonatal intensive care units, pediatric intensive care units, and burn units.

Neonatal Intensive Care Units

Reimbursement methodology recognizes four categories of neonatal units based on the certification of a hospital to provide neonatal intensive care services at a minimum standard for each category of Neonatal Intensive Care Units (NICUs): **NICU I; NICU II; NICU III; and NICU III Regional**.

In order for a hospital to qualify to be reimbursed for NICU services, certification must be obtained and maintained through the Health Standards Section (HSS) of LDH.

NOTE: Details regarding these NICUs can be found within the Hospital Licensing Standards. (See Appendix B for the HSS website).

If a hospital has implemented an NICU, it **must notify Rate Setting and Audit at least 90 days prior to the beginning of the subsequent SFY** in order to be compensated with an appropriate NICU rate at the beginning of the following SFY.

NICU Example

Hospital plans to have an NICU, and determines when it will begin delivering NICU services.

Hospital notifies HSS (to schedule an on-site survey for certification) and Rate Setting and Audit (for rate implementation). These **notifications must occur at least 90 days prior to the next subsequent SFY** in order to assure that the hospital may receive NICU per diem on dates of service beginning on the first day of the next SFY. The on-site survey should be completed and documented by HSS prior to the next SFY so that the rate will be implemented.

The NICU per diem may be paid only when a hospital bills the appropriate revenue code.

Per Diem Adjustments

Effective for dates of service on or after March 1, 2011, the per diem rates for Medicaid inpatient services rendered by NICU level III and NICU level III regional units, recognized by the Department as such on December 31, 2010, shall be adjusted to include an increase.

The per diem adjustment will vary based on the following five (5) tiers:

If the qualifying hospital's average percentage:	Tier	Additional Per Diem
Exceeds 10 percent	1	$601.98
Exceeds 5 percent but is less than or equal 10 percent	2	$624.66

If the qualifying hospital's average percentage:	Tier	Additional Per Diem
Exceeds 1.5 percent but is less than or equal to 5 percent	3	$419.83
Exceeds 0 percent but is less than or equal to 1.5 percent; and the Hospital received greater than .25 percent of the outlier payments for dates of service in: 1. SFY 2008; 2. SFY 2009; and 3. Calendar year 2010.	4	$263.33
If the qualifying hospital:	**Tier**	**Additional Per Diem**
Exceeds 0 percent but received less than .25 percent of outlier payments for dates of service in: 1. SFY 2008; 2. SFY 2009; and 3. Calendar year 2010.	5	$35.00

A qualifying hospital's placement into a tier will be determined by the average of its percentage of paid NICU Medicaid days for SFY 2010 dates of service to the total of all qualifying hospitals' paid NICU days for the same time period, and its percentage of NICU patient outlier payments made as of December 31, 2010 for dates of service in SFY 2008 and SFY 2009 and calendar year 2010 to the total NICU outlier payments made to all qualifying hospitals for these same time periods.

This average shall be weighted to provide that each hospital's percentage of paid NICU days will comprise 25 percent of this average, while the percentage of outlier payments will comprise 75 percent. In order to qualify for tiers 1-4, a hospital must have received at least .25 percent of outlier payments in SFY 2008, SFY 2009, and calendar year 2010.

SFY 2010 is used as the base period to determine the allocation of NICU and PICU outlier payments for hospitals having both NICU and PICU units.

If the daily paid outlier amount per paid NICU day for any hospital is greater than the mean plus one standard deviation of the same calculation for all NICU level III and NICU level III regional hospitals, then the basis for calculating the hospital's percentage of NICU patient outlier payments shall be to substitute a payment amount equal to the highest daily paid outlier amount of any hospital not exceeding this limit, multiplied by the exceeding hospital's paid NICU days for SFY 2010, to take the place of the hospital's actual paid outlier amount.

Exclusion Criteria

Children's specialty hospitals are not eligible for the tier determined per diem adjustments.

Assessment/Evaluation

The Department shall evaluate all rates and tiers two years after implementation.

Pediatric Intensive Care Units

Reimbursement methodology recognizes two categories of pediatric intensive care units (PICUs) based on the certification of a hospital to provide pediatric intensive care services at a minimum standard for each category of PICU: **PICU II; and PICU I.**

In order for a hospital to qualify to be reimbursed for PICU services, certification must be obtained and maintained through the LDH/HSS.

NOTE: Details regarding these PICU units can be found within the Hospital Licensing Standards. (See Appendix B for the HSS web site).

If a hospital has implemented a PICU, it **must notify Rate Setting and Audit at least 90 days prior to the beginning of the subsequent SFY** in order to initiate compensation with an appropriate PICU rate at the beginning of the following SFY.

PICU Example

Hospital plans to have a PICU, and determines when they will begin delivering PICU services.

Hospital notifies HSS (to schedule an on-site survey for certification) and Rate Setting and Audit (for rate implementation). These **notifications must occur at least 90 days prior to the next subsequent SFY** in order to assure that the hospital may receive PICU per diem on dates of service beginning on the first day of the next SFY. The on-site survey should be completed and documented by HSS prior to the next SFY so that the rate will be implemented.

Only when a hospital bills the appropriate and covered revenue code in accordance with the UB-04 National Billing Guidelines, will the PICU per diem be paid.

Effective for dates of service on or after March 1, 2011, the per diem rates for Medicaid inpatient services rendered by PICU level I and PICU level II units, recognized by the Department as such on December 31, 2010, shall be adjusted to include an increase.

The per diem adjustment will vary based on the following four tiers:

If the qualifying hospital's average percentage	Tier	Additional Per Diem
Exceeds 20 percent	1	$418.34
Exceeds 10 percent but is less than or equal to 20 percent	2	$278.63
Exceeds 0 percent but is less than or equal to 10 percent; and the Hospital received greater than .25 percent of the outlier payments for dates of service in: 1. SFY 2008; 2. SFY 2009; and 3. Calendar year 2010.	3	$178.27

If the qualifying hospital:	Tier	Additional Per Diem
Exceeds 0 percent but received less than .25 percent of outlier payments for dates of service in: 1. SFY 2008; 2. SFY 2009; and 3. Calendar year 2010.	4	$35.00

A qualifying hospital's placement into a tier will be determined by the average of its percentage of paid PICU Medicaid days for SFY 2010 dates of service to the total of all qualifying hospitals' paid PICU days for the same time period, and its percentage of PICU patient outlier payments made as of December 31, 2010 for dates of service in SFY 2008 and SFY 2009 and calendar year 2010 to the total PICU outlier payments made to all qualifying hospitals for these same time periods.

This average shall be weighted to provide that each hospital's percentage of paid PICU days will comprise 25 percent of this average, while the percentage of outlier payments will comprise 75 percent. In order to qualify for tiers 1-4, a hospital must have received at least .25 percent of outlier payments in SFY 2008, SFY 2009, and calendar year 2010.

SFY 2010 is used as the base period to determine the allocation of NICU and PICU outlier payments for hospitals having both NICU and PICU units.

If the daily paid outlier amount per paid PICU day for any hospital is greater than the mean plus one standard deviation of the same calculation for all PICU level I and PICU level II hospitals, then the basis for calculating the hospital's percentage of PICU patient outlier payments shall be to substitute a payment amount equal to the highest daily paid outlier amount of any hospital not exceeding this limit, multiplied by the exceeding hospital's paid PICU days for SFY 2010, to take the place of the hospital's actual paid outlier amount.

Exclusion Criteria

Children's specialty hospitals are not eligible for the tier determined per diem adjustments.

Assessment/Evaluation

The Department shall evaluate all rates and tiers two years after implementation.

Change in Level of Care in a Specialty Unit

When a hospital wishes to change the level of care in a NICU or PICU, it must notify HSS and Rate Setting and Audit. Compliance with the specialized unit criteria shall be verified via an on-site survey within 30 days after receipt of application. **The rate implementation for a change in level of care of a NICU or PICU can only occur at the beginning of the hospital's subsequent cost reporting period.**

If it is subsequently discovered that a hospital does not meet the level of care for which it has previously been certified, recoupment of any inappropriate payments shall be made.

Burn Units

Only when a hospital bills the appropriate and covered revenue code in accordance with the UB-04 National Billing Guidelines, will the burn unit per diem be paid.

Transplant Services

In-state transplant services are reimbursed at costs subject to a hospital-specific per diem limit that is based on each hospital's actual cost in the base year established for each type of approved transplant. Out of state transplant services are 40 percent of billed charges for adults and 60 percent of billed charges for children ages 0-21.

Outliers

In compliance with the requirement of §1902(s) (1) of the Social Security Act, additional payment shall be made for catastrophic costs associated with services provided to:

1. Children under age six who received inpatient services in a disproportionate share hospital setting; and

2. Infants who have not attained the age of one year who received inpatient services in any acute care setting.

Cost is defined as the hospital-specific cost to charge ratio based on the hospital's cost report period ending in SFY2000 (July 1, 1999 through June 30, 2000).

For new hospitals and hospitals that did not provide Medicaid NICU services in SFY 2010, the hospital specific cost to charge ratio will be calculated based on the first full year cost reporting period that the hospital was open or that Medicaid NICU services were provided.

The hospital specific cost to charge ratio will be reviewed bi-annually to determine the need for adjustment to the outlier payment. A deadline of six months subsequent to the date that the final claim is paid shall be established for receipt of the written request filing for outlier payments. Additionally, effective March 1, 2011, outlier claims for dates of service on or before February 28, 2011 must be received by the Department on or before May 31, 2011 in order to qualify for payment. Claims for this time period received by the Department after May 31, 2011 shall not qualify for payment.

NOTE: Outlier payments are not payable for transplant procedures, and services provided to beneficiaries with Medicaid coverage that is secondary to other payer sources.

Effective for dates of service on or after March 1, 2011, a catastrophic outlier pool shall be established with annual payments limited to $10,000,000. In order to qualify for payments from this pool, the following conditions must be met:

1. The claims must be for children less than six years of age who received inpatient services in a disproportionate share hospital setting; or infants less than one year of age who receive inpatient services in any acute care hospital setting; and

2. The costs of the case must exceed $150,000. The hospital specific cost to charge ratio utilized to calculate the claim costs shall be calculated using the Medicaid NICU or PICU costs and charge data from the most current cost report.

The initial outlier pool will cover eligible claims with admission dates from the period beginning March 1, 2011 through June 30, 2011.

1. Payment for the initial partial year pool will be $3,333,333 and shall be the costs of each hospital's qualifying claims net of claim payments divided by the sum of all qualifying claims cost in excess of payments, multiplied by $3,333,333;

2. Cases with admission dates on or before February 28, 2011 that continue beyond the March 1, 2011 effective date, and that exceed the $150,000 cost threshold, shall be eligible for payment in the initial catastrophic outlier pool; and

3. Only the costs of the cases applicable to dates of service on or after March 1, 2011, shall be allowable for determination of payment from this pool.

Beginning with SFY 2012, the outlier pool will cover eligible claims with admission dates during the SFY (July 1 through June 30) and shall not exceed $10,000,000 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 $10,000,000.

Outlier claims must be for a single continuous inpatient stay. Some hospital charges will be considered non-covered charges and will be removed from the total billed charges. For example, experimental drugs would be identified by revenue code, and removed from the total billed charges for a claim.

To submit an outlier claim, a copy of all of the UB-04s and corresponding remittance advice (RA) for a qualifying beneficiaries entire inpatient stay (along with documentation of payment from third parties on the beneficiary's behalf for the stay, if applicable) must be received in Medicaid's Rate Setting and Audit Section office no later than six months after the latest RA date on that claim. **Failure to meet this six-month deadline will result in the outlier claim being denied**. If there are unresolved payment issues from third parties, the outlier claim should still be submitted in accordance with this timely filing requirement above, along with notification of the unresolved issues.

Qualifying Loss Review Process

Any hospital seeking an adjustment to the operations, movable, fixed capital, or education component of its rate shall submit a written request for administrative review within 30 days after receipt of the letter notifying the hospital of its rate. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later.

"Qualifying loss" in this context refers to that amount by which the hospital's operating costs, movable equipment costs, fixed capital costs, or education costs (excluding disproportionate share payment adjustments) exceed the Medicaid reimbursement for each component.

"Costs" when used in the context of operating costs, movable equipment costs, fixed capital costs, and education costs, means a hospital's costs incurred in providing covered inpatient services to Medicaid beneficiaries as allowed by the *Medicare Provider Reimbursement Manual*.

Permissible Basis

Consideration for qualifying loss review is available only if one of the following conditions exists:

1. Rate-setting methodologies or principles of reimbursement are incorrectly applied;

2. Incorrect or incomplete data or erroneous calculations were used in the establishment of the hospital's rate; or

3. The amount allowed for a component in the hospital's prospective rate is 70 percent or less of the component cost it incurs in providing services that conform to the applicable state and federal laws of quality and safety standards.

Basis Not Allowable

The following matters are not subject to a qualifying loss review:

1. The use of peer group weighted medians to establish operations component of the per diem;

2. The use of peer group medians to establish movable equipment component of the per diem;

3. The use of statewide median to establish fixed capital component of the per diem;

4. The percentages used to blend peer group and hospital-specific costs during the three-year phase-in period;

5. The use of teaching and non-teaching status, specialty hospital status, and bed-size as criteria for hospital peer groups;

6. The use of Council of Teaching Hospitals full membership as criteria for major teaching status;

7. The use of fiscal year 1991 medical education costs to establish a hospital-specific medical education component;

8. The use of the DATA Resources, Inc. (DRI). DRI Type Hospital Market Basket Index as the prospective escalator;

9. The decision not to escalate fixed capital beyond the implementation year;

10. The criteria used to establish the levels of neonatal intensive care;

11. The criteria used to establish the levels of pediatric intensive care;

12. The methodology used to calculate the boarder baby rates for nursery;

13. The criteria used to identify specialty hospital peer groups; and

14. The criteria used to establish the level of burn care.

Burden of Proof

The hospital shall bear the burden of proof in establishing the facts and circumstances necessary to support a rate adjustment. Any costs that the provider cites as a basis for relief under this provision must be calculable and auditable.

Required Documentation

All requests for qualifying loss review shall specify the following:

1. The nature of the adjustment sought;

2. The amount of the adjustment sought;

3. The reasons or factors that the hospital believes justify an adjustment; and

4. An analysis demonstrating the extent to which the hospital is incurring or expects to incur a qualifying loss. However, such analysis is not required if the request is limited to a claim that:

a. The rate-setting methodology or criteria for classifying hospitals or hospital claims were incorrectly applied;

b. Incorrect or incomplete data or erroneous calculations were used in establishment of the hospital rates; or

c. The hospital has incurred additional costs because of a catastrophe.

Consideration Factors for Additional Reimbursement Requests

In determining whether to award additional reimbursement to a hospital that has made the showing required, the factors described below shall be considered.

Unreimbursed costs are generated by factors generally not shared by other hospitals in the hospital's peer group. Such factors may include, but are not limited to, extraordinary circumstances beyond the control of the hospital, and improvements required complying with licensing or accrediting standards. The request for rate adjustment may be denied where it appears from the evidence presented that the hospital's costs are controllable through good management practices or cost containment measures.

Financial ratio data indicative of the hospital's performance quality in particular areas of hospital operation may require the hospital to provide additional data.

Even if reasonable action to contain costs on a hospital-wide basis has been taken, the hospital may be required to provide audited cost data or other quantitative data, including but not limited to: occupancy statistics, average hourly wages paid, nursing salaries per adjusted patient day, average length of stay, cost per ancillary procedure, average cost per meal served, average cost per pound of laundry, average cost per pharmacy prescription, housekeeping costs per square foot, medical records costs per admission, full-time equivalent employees per occupied bed, age of receivables, bad debt percentage, inventory turnover rate, and information about actions that the hospital has taken to contain costs.

Determination to Award Relief

Additional reimbursement shall be awarded to a hospital that demonstrates to the LDH by clear and convincing evidence that:

1. The hospital demonstrated a qualifying loss;

2. The hospital's current prospective rate jeopardized the hospital's long-term financial viability; and

3. The Medicaid population served by the hospital has no reasonable access to other inpatient hospitals for the services that the hospital provides and that the hospital contends are under-reimbursed.

Notification of Relief Awarded

Notification of decision regarding qualifying loss review shall be provided in writing. Should the decision be to award relief, relief consists of making appropriate adjustments to correctly apply the rate-setting methodology or to correct calculations, data errors, or omissions. A hospital's corrected rate component shall not exceed the lesser of its recalculated cost for that component or 150 percent of the provider's peer group rate for that component.

If subsequent discovery reveals that the provider was not eligible for qualifying loss relief, any relief awarded under this qualifying loss process shall be recouped.

Effect of Decision

Decisions to recognize omitted, additional, or increased costs incurred by any hospital; to adjust the hospital rates; or to otherwise award additional reimbursement to any hospital shall not result in any change in the peer group calculations for any rate component.

Rate adjustments granted under this provision shall be effective from the first day of the rate period to which the hospital's request for qualifying loss review relates, shall continue in effect during subsequent rate periods, and shall be inflated for subsequent years.

However, no retroactive adjustment will be made to the rate or rates that were paid during any SFY prior to the year for which qualifying loss review was requested.

Administrative Appeal

The hospital may appeal an adverse qualifying loss decision to the Division of Administrative Law (DOA)/LDH Section (see Appendix B for contact information). The appeal must be lodged in writing within 30 days of receipt of the written decision, and state the basis for the appeal. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later. The administrative appeal shall be conducted in accordance with the Louisiana

Administrative Procedures Act (L.R.S. 49:951 et seq.). The DOA shall submit a recommended decision to the Secretary of the Department, who will issue the final decision.

Judicial Review

Judicial review of the Secretary's decision shall be in accordance with the Louisiana Administrative Procedures Act (L.R.S. 49:951 et. seq.) and shall be filed in the 19th Judicial District Court.

Reimbursement Methodology for Acute Care Inpatient Hospital Services

Small Rural Hospitals

Small rural hospitals must meet the qualifications and definition as described earlier in this section under Inpatient Reimbursement.

Small rural hospitals shall be reimbursed at a prospective per diem rate. The payment rate for inpatient acute services in small rural hospitals shall be the median cost amount plus 10 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.

State-Owned Hospitals

State-owned acute hospitals are reimbursed costs for inpatient Medicaid services. Payment is made during the year based on an interim per diem rate. Final payment is based on costs determined per the Medicare/Medicaid cost report.

Out-of-State Hospitals

The Louisiana Medicaid program will reimburse claims for emergency medical services provided to Louisiana Medicaid eligible beneficiaries who are temporarily absent from the state when:

1. An emergency is caused by accident or illness;

2. The health of the beneficiary would be endangered if the beneficiary undertook travel to return to Louisiana; and

3. The health of the beneficiary would be endangered if medical care were postponed until the beneficiary returns to Louisiana.

Out-of-state hospital emergency room visits and related inpatient admissions do not require prior authorization. **Any other acute care services to be billed by a hospital require prior authorization for out-of-state services** (both inpatient and outpatient). Reimbursement for out-of-state inpatient services, other than organ transplants, for eligible Louisiana Medicaid beneficiaries shall be made at the Louisiana in-state prospective peer group rate in effect for the corresponding type of non-teaching hospital or specialty carve out service. Transplant services shall be reimbursed at 60 percent of allowable covered charges for beneficiaries under age 21 years of age and 40 percent of allowable covered charges for beneficiaries 21 years of age and over. The out-of-state inpatient hospital per diem fee schedule is published on the lamedicaid.com website under the broad heading of "Inpatient Hospital Per Diems" after opening the "Fee Schedules" link.

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Reimbursement is only made to enrolled Louisiana Medicaid hospital providers. Any hospital may enroll in Louisiana Medicaid and then bill for eligible (and properly authorized) services already provided. However, **the enrollment process must be completed**, and the bill must be submitted **prior to one year after the date of service**.

Out-of-State Inpatient Psychiatric Services

Inpatient stays for psychiatric or substance abuse treatment are only covered in out-of-state hospitals in the event of a medical emergency, for a maximum of two days, to allow time for the beneficiary to be stabilized and transferred to a Louisiana psychiatric hospital when appropriate. Outpatient psychiatric and substance abuse services provided by an out-of-state hospital are not covered.

Inpatient Psychiatric (Free-Standing and Distinct Part Psychiatric Hospitals)

Reimbursement for services provided in these facilities is a prospective per diem rate. This per diem includes all services provided to inpatients, except for physician services, which should be billed separately. All therapies (individual/group counseling or occupational therapy) should be included in the per diem. Federal regulations prohibit Medicaid payment for beneficiaries the ages of 22 and 64 in a free-standing psychiatric hospital**.**

Outpatient Hospitals

There are seven (7) different outpatient hospital fee schedules posted on the Louisiana Medicaid website:

1. Hospital Outpatient Ambulatory Surgery Fee Schedule for Rural Hospitals;
2. Hospital Outpatient Ambulatory Surgery Fee Schedule for State Hospitals;
3. Hospital Outpatient Ambulatory Surgery Fee Schedule for Non-Rural, Non-State Hospitals;
4. Hospital Outpatient Services Fee Schedule (non-ambulatory surgery);
5. Small Rural Hospital Outpatient Services Fee Schedule (non-ambulatory surgery);
6. Sole Community Hospital Outpatient Services Fee Schedule (clinical diagnostic laboratory services); and
7. State Hospital Outpatient Services Fee Schedule (non-ambulatory surgery).

Clinical diagnostic laboratory services are reimbursed at the lower of:

1. Billed charges;
2. The state maximum Medicaid amount for CPT codes in the corresponding Outpatient Hospital Services Fee Schedule which is based on the Medicare fee schedule; or
3. Medicare Fee schedule amount.

Reimbursement for clinical diagnostic laboratory services complies with Upper Payment Limit (UPL) requirements for these services.

NOTE: State-owned hospitals and small rural hospitals shall be reimbursed for outpatient clinical laboratory services at 100 percent of the current Medicare 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 percent of the Medicare Ambulatory Payment Classification (APC) payment rates as published in the 8/9/02 Federal Register).

Small rural hospitals are reimbursed the above rate as an interim payment. Final reimbursement shall be 110 percent of allowable cost as calculated through the cost settlement process.

Outpatient hospital facility surgery 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.

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

Small rural hospitals are reimbursed the above rate as an interim payment. Final reimbursement shall be 100 percent of allowable cost as calculated through the cost settlement process.

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 rate for outpatient rehabilitation services is set using the State maximum rates for rehabilitation services plus an additional 10 percent.

Rates for outpatient rehabilitation services provided to **beneficiaries up to the age of three** are included in the fee schedule.

Small rural hospitals are reimbursed the above rate as an interim payment. Final reimbursement shall be 110 percent of allowable cost as calculated through the cost settlement process.

Other Outpatient Hospital Services

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

In-State Non- Small Rural Private Hospital Outpatient Services

Interim reimbursement is based on a hospital specific cost to charge ratio calculation from the latest filed cost reports. Updated cost to charge ratios are calculated as the cost reports are filed.

Final reimbursement is adjusted as follows:

Dates of Services	Percentage of Costs
Dates before August 1, 2006	83
August 1,2006 to February 19, 2009	86.2
February 20, 2009 to August 3, 2009	83.18
August 4, 2009 to February 2, 2010	78.48
February 3, 2010 to July 31, 2010	74.56
August 1, 2010 to December 31, 2010	71.13
January 1, 2011 to July 31, 2012	69.71
August 1, 2012 to January 31, 2013	67.13
February 1, 2013 to December 31, 2016	66.46
January 1, 2017 to December 31, 2017	71.13
January 1, 2018 and forward	74.56

In-State State-Owned Hospital Outpatient Services

Interim reimbursement shall be 100 percent of each hospital's cost to charge ratio as calculated from the latest filed cost report. Final reimbursement shall be 90 percent of allowable cost as calculated through the cost report settlement process.

In-State Small Rural Hospital Outpatient Services

Interim reimbursement shall be 110 percent of each hospital's cost to charge ratio as calculated from the latest filed cost report. Final reimbursement shall be 110 percent of allowable cost as calculated through the cost report settlement process.

Out of State Hospital Outpatient Services

Approved outpatient hospital services provided in out-of-state hospitals that are subject to a fee schedule in state shall be paid at the same fee schedule amounts that are utilized for in-state non-rural, non-state hospitals. All other covered out-of-state outpatient hospital services shall be paid at annual average cost to charge ratio calculated from the filed Medicaid cost reports for in-state non-rural, non-state hospitals multiplied by the percent of allowable cost that is in effect for the applicable time period for in-state non-rural, non-state hospitals. This ratio shall be applied to the billed charges for covered claims submitted by out-of-state hospitals to determine payment for non-fee schedule services. The Medicaid Program does not cost settle out-of-state hospitals.

Deleted: will be reimbursed at 31.04 percent of billed charges except for those outpatient services reimbursed based on a fee schedule.

Cost Reporting

The LDH is currently contracted with Leblanc, Robertson, Chisholm & Associates, LLC, formerly known as Cypress Audit Team, LLC for audit of Medicaid cost reports. (See Appendix B for contact information). The Louisiana Medicaid Program tracks Medicare requirements for timely filing of cost reports. In accordance with the Medicare filing deadlines, all Louisiana hospitals enrolled in the Title XIX Medical Assistance (Medicaid) Program must submit a copy of their annual cost report to the current contractor.

The following must be included with your hospital cost report submission:

1. Electronic cost report data file (ECR File);
2. PDF copy of the cost report (hard copy if PDF not available);
3. Working Trial Balance (cost center order if available);
4. Completed Centers for Medicare and Medicaid Services (CMS) 339 questionnaire;
5. Copy of Medicaid crosswalks for all units;

6. Hospitals with a DPP Unit, NICU, PICU, Burn Unit, and/or Transplant Unit must complete a separate Worksheet S-3, D Part I, II, III, IV, D-1, and D-4 for each of the units to separately identify program costs, charges, and statistics associated with each specialty unit. The above worksheets for the non-specialty portion of the hospital are to exclude all specialty unit data;

7. A detailed log of Medicaid beneficiaries for carve out specialty units (NICU, PICU, Burn Unit, and/or Transplant Unit) which correlates with the filed cost report and includes the following data elements: beneficiary name, dates of service, number of patient days, number of discharges, room and ancillary charges. Only statistics related to the days that the beneficiary is physically in the specialty unit are includable in the specialty unit carve out. All other days and charges associated with these patients' stays, for instance - nursery, must be included with the non-specialty unit hospital statistics;

8. Completed M Series Worksheets for all hospital based rural health clinics; and

9. Medicare Inpatient Part B Detail from the Medicare Provider Statistical and Reimbursement (PS&R) Report.

Supplemental Payments

Upon approval from the CMS, various types of supplemental payment programs can be implemented given that funding is available. Some examples of these are payments related to hospitals impacted by hurricanes, high Medicaid utilization hospitals, graduate medical education (GME), teaching hospitals, low income and needy care collaboration hospitals, and payments made related to the UPL.

Disproportionate Share

Upon approval from CMS, various categories of Disproportionate Share Hospitals (DSH) payments can be implemented given that funding is available. Examples of these are small rural hospital DSH, high Medicaid utilization DSH, DSH for community hospital uncompensated care, and DSH for public state–operated hospitals.

State Directed Payments

The **State Directed Payment Program Manual** governs directed payments to qualifying hospitals that participate in the Healthy Louisiana program and contract with the Medicaid managed care organizations (MCOs) to provide inpatient and outpatient services to MCO enrollees. The manual may be viewed at:
https://ldh.la.gov/assets/medicaid/Manuals/State_Directed_Payment_Program_Manual.pdf