DECLARATION OF EMERGENCY

Department of Health
Bureau of Health Services Financing

Disproportionate Share Hospital Payments
Louisiana Low-Income Academic Hospitals
(LAC 50:V.2501 and Chapter 31)

The Department of Health, Bureau of Health Services Financing amends LAC 50:V.2501 and adopts LAC 50:V.Chapter 31 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated Emergency Rules which amended the provisions governing disproportionate share hospital (DSH) payments to hospitals participating in public-private partnerships in the south and north Louisiana areas (*Louisiana Register*, Volume 39, Numbers 7 and 10). As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the corresponding State Plan amendments, the department determined that it was necessary to repeal the provisions of the July 6, 2013 and October 1, 2013 Emergency Rules governing DSH payments to the hospitals

participating in the south and north Louisiana area public-private partnerships.

The department promulgated an Emergency Rule which amended the provisions governing DSH payments in order to establish payments to Louisiana low-income academic hospitals (*Louisiana Register,* Volume 40, Number 6). The department subsequently promulgated an Emergency Rule which amended the provisions of the May 24, 2014 Emergency Rule to clarify the provisions governing the payment methodology to Louisiana low-income academic hospitals (*Louisiana Register*, Volume 40, Number 9). The department promulgated an Emergency Rule which amended the provisions of the September 20, 2014 Emergency Rule in order to clarify qualifying criteria for Louisiana low-income academic hospitals and revise the reimbursement and DSH payment methodology (*Louisiana Register*, Volume 42, Number 6).

The department now proposes to amend the provisions governing DSH payments in order to revise the reimbursement schedule for the payments. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services.

Effective October 1, 2016, the Department of Health, Bureau of Health Services Financing amends the provisions of the June 20, 2016 Emergency Rule governing DSH payments to low-income academic hospitals.

TITLE 50

PUBLIC HEALTH–MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 3. Disproportionate Share Hospital Payments

Chapter 25. Disproportionate Share Hospital Payment Methodologies

§2501. General Provisions

A. – C. ...

D. – E. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:657 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:790 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

Chapter 31. Louisiana Low-Income Academic Hospitals

§3101. Qualifying Criteria

A. Hospitals Located Outside of the Baton Rouge and New Orleans Metropolitan Statistical Area

1. Effective for dates of service on or after July 1, 2016, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located outside of the Baton Rouge and New Orleans metropolitan statistical area (MSA)which:

i. entered into a cooperative endeavor agreement with the State of Louisiana to increase its provision of inpatient Medicaid and uninsured services by providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or

ii. is formerly a state owned and operated hospital whose ownership change to non-state privately owned and operated prior to July 1, 2014;

b. has Medicaid inpatient days utilization greater than 18.9 percent. Qualification shall be calculated by dividing the Medicaid inpatient days by the total inpatient days reported on the Medicaid as filed cost report ending during state fiscal year 2015 received by April 30, 2016, and shall include traditional, shared, and managed care Medicaid days per the worksheet S-3 part I, lines 1 through 18. Column 7 shall be used to determine allowable Medicaid days and column 8 shall be used to determine total inpatient days; and

c. has a ratio of intern and resident full time equivalents(FTEs) to total inpatient beds that is greater than .08. Qualification shall be based on the total inpatient beds and intern and resident FTEs reported on the Medicare/Medicaid

cost report ending during state fiscal year 2015. The ratio of interns and resident FTEs shall be calculated by dividing the unweighted intern and resident FTEs reported on the Medicare Cost Report Worksheet E-4, line 6 by the total inpatient beds, excluding nursery and Medicare designated distinct part psychiatric unit beds, reported on worksheet S-3, column 2, lines 1 through 18.

B. Hospitals Located In the New Orleans Metropolitan Statistical Area

1. Effective for dates of service on or after July 1, 2016, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located in the New Orleans MSA which:

i. entered into a cooperative endeavor agreement with the State of Louisiana to increase its provision of inpatient Medicaid and uninsured services by providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or

ii. is formerly a state owned and operated hospital whose ownership changed to non-state privately owned and operated prior to July 1, 2014;

b. has Medicaid inpatient days utilization greater than 45 percent. Qualification shall be calculated by dividing the Medicaid inpatient days by the total inpatient days

reported on the Medicaid as filed cost report ending during state fiscal year 2015 received by April 30, 2016, and shall include traditional, shared, and managed care Medicaid days per the worksheet S-3 part I, lines 1 through 18. Column 7 shall be used to determine allowable Medicaid days and column 8 shall be used to determine total inpatient days; and

c. has a ratio of intern and resident FTEs to total inpatient beds that is greater than 1.25. Qualification shall be based on the total inpatient beds and intern and resident FTEs reported on the Medicare/Medicaid cost report ending during state fiscal year 2015. The ratio of interns and resident FTEs shall be calculated by dividing the unweighted intern and resident FTEs reported on the Medicare Cost Report Worksheet E-4, line 6 by the total inpatient beds, excluding nursery and Medicare designated distinct part psychiatric unit beds, reported on worksheet S-3, column 2, lines 1 through 18.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

§3103. Payment Methodology

A. Each qualifying hospital shall be paid DSH adjustment payments equal to 100 percent of allowable hospital specific uncompensated care costs.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. Costs and lengths of stay shall be reviewed by the department for reasonableness before payments are made.

B. Payment Calculation

1. For the initial year's payment calculation, each qualifying hospital shall submit interim actual cost data calculated utilizing Medicaid allowable cost report principles, along with actual Medicaid and uninsured patient charge data. Annual Medicaid costs shortfalls and unreimbursed uninsured patient costs are determined based on review and analysis of these submissions.

2. For subsequent year's payment calculations, the most recent Medicaid filed cost report along with actual Medicaid and uninsured patient charge data annualized from the most recent calendar year completed quarter is utilized to calculate hospital specific uncompensated care costs.

C. The department shall review cost data, charge data, lengths of stay and Medicaid claims data per the Medicaid Management and Information Systems (MMIS) for reasonableness before payments are made.

D. ~~The first payment of each fiscal year will be made by October 15 and will be 80 percent of the annual calculated~~

~~uncompensated care costs. The remainder of the payment will be made by June 30 of each year.~~Reimbursement Methodology

1. ~~Reconciliation of these payments to actual hospital specific uncompensated care costs will be made when the cost report(s) covering the actual dates of service from the state fiscal year are filed and reviewed~~Payments for Hospitals Outside of the Shreveport Area. The first payment of each fiscal year will be made by October 15 and will be 80 percent of the annual calculated uncompensated care costs. The remainder of the payment will be made by June 30 of each year.

2. ~~Additional payments or recoupments, as needed, shall be made after the finalization of the Centers for Medicare and Medicaid Services (CMS) mandated DSH audit for the state fiscal year~~Payments for Hospitals in the Shreveport Area. The first payment of each fiscal year will be made after October 1 and will be 25 percent of the annual calculated uncompensated care costs. The remainder of the payments due will be made as monthly payments from November through June of each year.

3. Reconciliation of these payments to actual hospital specific uncompensated care costs will be made when the cost report(s) covering the actual dates of service from the state fiscal year are filed and reviewed.

4. Additional payments or recoupments, as needed, shall be made after the finalization of the Centers for Medicare

and Medicaid Services (CMS) mandated DSH audit for the state fiscal year.

E. No payment under this Section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Rebekah E. Gee MD, MPH

Secretary