RULE

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services
High Medicaid Utilization Academic Hospitals
(LAC 50:V.Chapter 22)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:V.Chapter 22 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of publication.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospital Services

Chapter 22. High Medicaid Utilization Academic Hospitals

§2201. Qualifying Criteria

A. In order to qualify as a high Medicaid utilization academic hospital effective for dates of service on or after July 1, 2024 the hospital shall meet the following criteria per the Medicare/Medicaid as filed cost report for their fiscal year ended in SFY 2023:

1. have a Medicaid inpatient utilization percent of at least 39 percent; and

2. have an approved graduate medical education program with at least 400 intern and resident full-time equivalents (FTEs). The intern and resident FTE count must be included on the Medicare/Medicaid cost report on worksheet E-4, line 6 plus worksheet E-3, Part II, line 6.

NOTE: Payments will not be processed and claims will not be recycled until the Rule is final.

B. Qualifying hospitals shall not add additional locations under their license, without prior written approval of the department.

1. The addition of any off-site campus, beyond an outpatient primary care clinic, to the license of this hospital will invalidate the provisions of this reimbursement methodology.

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 50:

§2203. Reimbursement Methodology

A. Reimbursement for inpatient hospital services to qualifying high Medicaid academic hospitals who meet all of the criteria in §2201 shall be reimbursed a prospective per diem rate of $3,880.73 for acute inpatient hospital services including special care units. This rate is based on the

allowable Medicaid cost determined from the latest filed Medicare/Medicaid cost report as of March 31, 2024. The prospective graduate medical education component included in this rate is $271.12.

B. Reimbursement for inpatient hospital service for psychiatric services to qualifying high Medicaid academic hospitals who meet all of the criteria in §2201 shall be reimbursed a prospective per diem rate of $1,705.76. This rate is based on the allowable Medicaid cost determined from the latest filed Medicare/Medicaid cost report as of March 31, 2024.

C. These rates are conditional on the hospital continuing to meet all qualifying criteria included in §2201. If the hospital no longer qualifies, payments will revert back to appropriate non-rural, non-state hospital assigned rates effective on the date that the qualification(s) in §2201 are no longer met.

D. The department may review all above provisions every three years, at a minimum to evaluate continuation of these enhanced reimbursements.

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 50:

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.

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Outpatient Hospital Services
High Medicaid Utilization Academic Hospitals
(LAC 50:V.Chapter 77)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:V.Chapter 77 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 5. Outpatient Hospital Services

Chapter 77. High Medicaid Utilization Academic Hospitals

§7701. Qualifying Criteria

A. In order to qualify as a high Medicaid utilization academic hospital effective for dates of service on or after July 1, 2024 the hospital shall meet the following criteria per the Medicare/Medicaid as filed cost report for their fiscal year ended in SFY 2023:

1. have a Medicaid inpatient utilization percent of at least 39 percent; and

2. have an approved graduate medical education program with at least 400 intern and resident full time

equivalents (FTEs). The intern and resident FTE count must be included on the Medicare/Medicaid cost report on worksheet E-4, line 6 plus worksheet E-3, Part II, line 6.

NOTE: Payments will not be processed and claims will not be recycled until the Rule is final.

B. Qualifying hospitals shall not add additional locations under their license, without prior written approval of the department.

1. The addition of any off-site campus, beyond an outpatient primary care clinic, to the license of this hospital will invalidate the provisions of this reimbursement methodology.

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 50:

§7703. Reimbursement Methodology

A. Reimbursement for outpatient hospital services to qualifying high Medicaid academic hospitals who meet all of the criteria in §7701 shall be made 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 amount of 95 percent of

allowable Medicaid cost as calculated through the cost report settlement process.

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 amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

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. Rehabilitation Services. The reimbursement amount for outpatient rehabilitation services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

5. Other Outpatient Hospital Services. The reimbursement amount for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

B. These rates are conditional on the hospital continuing to meet all qualifying criteria included in §7701. If the

hospital no longer qualifies, payments will revert back to appropriate non-rural, non-state hospital assigned rates effective on the date that the qualification(s) in §7701 are no longer met.

C. The department may review all above provisions every three years, at a minimum to evaluate continuation of these enhanced reimbursements.

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 50:

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.

Michael Harrington, MBA, MA

Secretary