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

Subpart 1. Inpatient Hospitals Services

Chapter 1. General Provisions

§107. Elective Deliveries

A. Induced deliveries and cesarean sections shall not be reimbursed when performed prior to 39 weeks gestation. This shall not apply to deliveries when there is a documented medical condition that would justify delivery prior to 39 weeks gestation.

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, Bureau of Health Services Financing, LR 40:1530 (August 2014).

§109. Healthcare-Acquired and Provider Preventable Conditions

A. Effective for dates of service on or after July 1, 2012, the Medicaid Program will not provide reimbursement for healthcare-acquired or provider preventable conditions which result in medical procedures performed in error and have a serious, adverse impact to the health of the Medicaid recipient.

B. Reimbursement shall not be provided for the following healthcare-acquired conditions (for any inpatient hospital settings participating in the Medicaid Program) including:

1. foreign object retained after surgery;
2. air embolism;
3. blood incompatibility;
4. stage III and IV pressure ulcers;
5. falls and trauma, including:
   a. fractures;
   b. dislocations;
   c. intracranial injuries;
   d. crushing injuries;
   e. burns; or
   f. electric shock;
6. catheter-associated urinary tract infection (UTI);
7. vascular catheter-associated infection;
8. manifestations of poor clycemic control, including:
   a. iabetic ketoacidosis;
   b. nonketotic hyperosmolar coma;
   c. hypoglycemic coma;
   d. secondary siabetes with ketoacidosis; or
   e. secondary diabetes with hyperosmolarity;
9. surgical site infection following:
   a. coronary artery bypass graft (CABG)-mediastinitis;
   b. bariatric surgery, including:
      i. laparoscopic gastric bypass;
      ii. gastroenterostomy; or
      iii. laparoscopic gastric restrictive surgery; or
   c. orthopedic procedures, including:
      i. spine;
      ii. neck;
      iii. shoulder; or
      iv. elbow; or
10. deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions.

C. Reimbursement shall not be provided for the following provider preventable conditions, (for any inpatient hospital settings participating in the Medicaid Program) including:

1. wrong surgical or other invasive procedure performed on a patient;
2. surgical or other invasive procedure performed on the wrong body part; or
3. surgical or other invasive procedure performed on the wrong patient.

D. For discharges on or after July 1, 2012, all hospitals are required to bill the appropriate present-on-admission (POA) indicator for each diagnosis code billed. All claims with a POA indicator with a health care-acquired condition code will be denied payment.

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, Bureau of Health Services Financing, LR 38:1963 (August 2012).

§113. Coverage of Long-Acting Reversible Contraceptives

A. The Medicaid Program shall provide reimbursement to acute care hospitals for long-acting reversible contraceptives (LARCs) provided to women immediately following childbirth and during the hospital stay.

B. Reimbursement. Hospitals shall be reimbursed for LARCs as an add-on service in addition to their daily per diem rate for the inpatient hospital stay.

1. Physicians/professional practitioners who insert the device will also be reimbursed an insertion fee in accordance with the reimbursement rates established for this service in the Professional Services Program.

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, Bureau of Health Services Financing, LR 40:1104 (June 2014).

§115. Office of Public Health Newborn Screenings

A. The Department of Health, Bureau of Health Services Financing shall provide reimbursement to the Office of Public Health (OPH) through the Medical Assistance Program for newborn screenings performed by OPH on specimens taken from children in acute care hospital settings.

B. Reimbursement

1. Effective for dates of service on or after August 5, 2017, claims submitted by OPH to the Medicaid Program for the provision of legislatively-mandated inpatient hospital newborn screenings shall be reimbursed outside of the acute hospital per diem rate for the inpatient stay.

a. The hospital shall not include any costs related to newborn screening services provided and billed by OPH in its Medicaid cost report(s).

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 44:60 (January 2018).

Chapter 5. State Hospitals

Subchapter B. Reimbursement Methodology

§551. Acute Care Hospitals

A. Inpatient hospital services rendered by state-owned acute care hospitals shall be reimbursed at allowable costs and shall not be subject to per discharge or per diem limits.

B. Effective for dates of service on or after October 16, 2010, a quarterly supplemental payment up to the Medicare upper payment limits will be issued to qualifying state-owned hospitals for inpatient acute care services rendered.

C. Qualifying Criteria for Supplemental Payment. The state-owned acute care hospitals must be located in DHH Administrative Region 8 (Monroe).

D. Effective for dates of service on or after October 16, 2010, Medicaid rates paid to state-owned acute care hospitals that do not meet the qualifying criteria for the supplemental payment shall be adjusted to 60 percent of allowable Medicaid costs.

E. Effective for dates of service on or after February 1, 2012, medical education payments for inpatient services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be paid monthly by Medicaid as interim lump sum payments.

1. Hospitals with qualifying medical education programs shall submit a listing of inpatient claims paid each month by each MCO.

a. *Qualifying Medical Education Programs*—graduate medical education, paramedical education, and nursing schools.

2. Monthly payments shall be calculated by multiplying the number of qualifying inpatient days times the medical education costs included in each state hospital's interim per diem rate as calculated per the latest filed Medicaid cost report.

3. Final payment shall be determined based on the actual MCO covered days and allowable inpatient Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

F. Effective for dates of service on or after August 1, 2012, the inpatient per diem rate paid to state-owned acute care hospitals, excluding Villa Feliciana and inpatient psychiatric services, shall be reduced by 10 percent of the per diem rate on file as of July 31, 2012.

1. The Medicaid payments to state-owned hospitals that qualify for the supplemental payments, excluding Villa Feliciana and inpatient psychiatric services, shall be reimbursed at 90 percent of allowable costs and shall not be subject to per discharge or per diem limits.

2. The Medicaid payments to state-owned hospitals that do not qualify for the supplemental payments shall be reimbursed at 54 percent of allowable costs.

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, Bureau of Health Services Financing, LR 38:1241 (May 2012), amended LR 38:2772 (November 2012), LR 40:312 (February 2014), LR 40:1941 (October 2014).

Chapter 7. Prospective Reimbursement

Subchapter A. Appeals Procedure

§701. Request for Administrative Review

A. Any hospital seeking an adjustment to its rate, shall submit a written request for administrative review to the Medicaid director (hereafter referred to as director) within 30 days after receipt of the letter notifying the hospital of its rates.

1. The receipt of the letter notifying the hospital of its rates shall be deemed to be five days from the date of the letter.

2. The time period for requesting an administrative review may be extended upon written agreement between the department and the hospital.

B. The department will acknowledge receipt of the written request within 30 days after actual receipt. Additional documentation may be requested from the hospital as may be necessary for the director to render a decision. The director shall issue a written decision upon the hospital's request for a rate adjustment within 90 days after receipt of all additional documentation or information requested.

C. Any hospital seeking an adjustment to its rate, must specify all of the following:

1. the nature of the adjustment sought;

2. the amount of the adjustment sought; and

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

D. Any request for an adjustment must include an analysis demonstrating the extent to which the hospital is incurring or expects to incur a qualifying loss in providing covered services to Medicaid and indigent patients.

1. For purposes of these provisions, qualifying loss shall mean that amount by which the hospital's allowable costs (excluding disproportionate share payment adjustments) exceed the Medicaid reimbursement implemented pursuant to these provisions.

2. "Cost" when used in the context of allowable shall mean a hospital's costs incurred in providing covered inpatient services to Medicaid and indigent patients, as calculated in the relevant definitions governing cost reporting.

E. The hospital will not be required to present an analysis of its qualifying loss where the basis for its appeal is limited to a claim that:

1. the rate-setting methodology or criteria for classifying hospitals or hospital claims under the state plan were incorrectly applied;

2. that incorrect or incomplete data or erroneous calculations were used in establishment of the hospital rates; or

3. the hospital had incurred additional costs because of a catastrophe that meets certain conditions.

F. Except in cases where the basis for the hospital's appeal is limited to a claim that rate-setting methodologies or principles of reimbursement established under the reimbursement plan were incorrectly applied, or that the incorrect or incomplete data or erroneous calculations were in the establishment of the hospital's rate, the department will not award additional reimbursement to a hospital, unless the hospital demonstrates that the reimbursement it receives based on its prospective rate is 70 percent or less of the allowable costs it incurs in providing Medicaid patients care and services that conform to the applicable state and federal laws of quality and safety standards.

1. The department will not increase a provider's rate to more than 105 percent of the peer group rate.

G. In cases where the rate appeal relates to an unresolved dispute between the hospital and its Medicare fiscal intermediary as to any cost reported in the hospital's base year cost report, the director will resolve such disputes for purposes of deciding the request for administrative review.

H. The following matters will not be subject to appeal:

1. the use of peer grouped rates;

2. the use of teaching, non-teaching and bed-size as criteria for hospital peer groups;

3. the use of approved graduate medical education and intern and resident full time equivalents as criteria for major teaching status;

4. the use of fiscal year 1991 medical education costs to establish a hospital-specific medical education component of each teaching hospital's prospective rate;

5. the application of inflationary adjustments contingent on funding appropriated by the legislature;

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

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

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

9. the use of hospital specific costs for transplant per diem limits;

10. the criteria used to identify specialty hospital peer groups; and

11. the criteria used to establish the level of burn care.

I. The hospital shall bear the burden of proof in establishing 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.

J. The department may award additional reimbursement to a hospital that demonstrates by clear and convincing evidence that:

1. a qualifying loss has occurred and the hospitals current prospective rate jeopardized the hospital's long-term financial viability; and

2. 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; or

3. alternatively, demonstrates that its uninsured care hospital costs exceeds 5 percent of its total hospital costs, and a minimum of $9,000,000 in uninsured care hospital cost in the preceding 12 month time period and the hospital's uninsured care costs has increased at least 35 percent during a consecutive six month time period during the hospital's latest cost reporting period.

a. For purposes of these provisions, an uninsured patient is defined as a patient that is not eligible for Medicare or Medicaid and does not have insurance.

b. For purposes of these provisions, uninsured care costs are defined as uninsured care charges multiplied by the cost to charge ratios by revenue code per the last filed cost report, net of payments received from uninsured patients.

i. The increase in uninsured care costs must be a direct result of a permanent or long term (no less than six months) documented change in services that occurred at a state owned and operated hospital located less than eight miles from the impacted hospital.

ii. For the purpose of this Rule, if a hospital has multiple locations of service, each location shall measure uninsured care costs separately and qualify each location as an individual hospital. Rate adjustments awarded under this provision will be determined by the secretary of the department and shall not exceed 5 percent of the applicable per diem rate.

K. In determining whether to award additional reimbursement to a hospital that has made the showing required, the director shall consider one or more of the following factors and may take any of these actions.

1. The director shall consider whether the hospital has demonstrated that its 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 to comply with licensing or accrediting standards. Where it appears from the evidence presented that the hospital's costs are controllable through good management practices or cost containment measures or that the hospital has through advertisement to the general public promoted the use of high costs services that could be provided in a more cost effective manner, the director may deny the request for rate adjustment.

2. The director may consider, and may require the hospital to provide financial data, including but not limited to financial ratio data indicative of the hospital's performance quality in particular areas of hospital operation.

3. The director shall consider whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis. In making such a determination, the director may require the hospital to provide audited cost data or other quantitative data including, but not limited to:

a. occupancy statistics;

b. average hourly wages paid;

c. nursing salaries per adjusted patient day;

d. average length of stay;

e. cost per ancillary procedure;

f. average cost per meal served;

g. average cost per pound of laundry;

h. average cost per pharmacy prescription;

i. housekeeping costs per square foot;

j. medical records costs per admission;

k. full-time equivalent employees per occupied bed;

l. age of receivables;

m. bad debt percentage;

n. inventory turnover rate; and

o. information about actions that the hospital has taken to contain costs.

4. The director may also require that an onsite operational review/audit of the hospital be conducted by the department or its designee.

L. In awarding relief under this provision, the director shall:

1. make any necessary adjustments so as to correctly apply the rate-setting methodology, to the hospital submitting the appeal, or to correct calculations, data errors or omissions; or

2. increase one or more of the hospital's rates by an amount that can reasonably be expected to ensure continuing access to sufficient inpatient hospital services of adequate quality for Medicaid patients served by the hospital.

M. The following decisions by the director shall not result in any change in the peer group rates:

1. the decision to:

a. recognize omitted, additional or increased costs incurred by any hospital;

b. adjust the hospital rates; or

c. otherwise award additional reimbursement to any hospital.

N. Hospitals that qualify under this provision must document their continuing eligibility at the beginning of each subsequent state fiscal year. Rate adjustments granted under this provision shall be effective from the first day of the rate period to which the hospital's appeal relates. However, no retroactive adjustments will be made to the rate or rates that were paid during any prior rate period.

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, Bureau of Health Services Financing, LR 37:2159 (July 2011).

§703. Administrative Appeal and Judicial Review

A. If the director's decision is adverse to the hospital, the hospital may appeal the director's decision to the Bureau of Appeals or its successor. The appeal must be lodged within 30 days of receipt of the written decision of the director. The receipt of the decision of the director shall be deemed to be five days from the date of the decision. The administrative appeal shall be conducted in accordance with the Louisiana Administrative Procedure Act (APA). The Bureau of Appeals shall submit a recommended decision to the secretary of the department. The secretary will issue the final decision of the department.

B. Judicial review of the secretary's decision shall be in accordance with the APA and shall be filed in the Nineteenth Judicial District Court.

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, Bureau of Health Services Financing, LR 37:2161 (July 2011).

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter A. General Provisions

§901. Definitions

Non-Rural, Non-State Hospital—a hospital which is either owned and operated by a private entity, a hospital service district or a parish and does not meet the definition of a rural hospital as set forth in R.S. 40:1300.143(3)(a).

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 34:877 (May 2008).

§909. Children's Specialty Hospitals

A. In order to receive Medicaid reimbursement for inpatient services as a children's specialty hospital, the acute care hospital must meet the following criteria:

1. be recognized by Medicare as a prospective payment system (PPS) exempt children's specialty hospital;

2. does not qualify for Medicare disproportionate share hospital payments; and

3. has a Medicaid inpatient days utilization rate greater than the mean plus two standard deviations of the Medicaid utilization rates for all hospitals in the state receiving Medicaid payments.

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, Bureau of Health Services Financing, LR 37:597 (February 2011).

§911. Children's Specialty Hospitals Psychiatric Units

A. A psychiatric sub-provider unit in a Medicare Prospective Payment System (PPS) exempt children's specialty hospital may enroll in the Medicaid Program. The hospital must submit an attestation to the department that the unit meets the PPS exempt criteria outlined in 42 CFR 412.25 [except 412.25(a)(1)(ii)]. Enrollment of the new unit will be effective upon verification of the hospital's attestation by the department.

B. Changes in the number of beds in existing units may only be made at the start of the hospital's cost reporting period. The hospital must notify the department of changes in bed size at least 90 days prior to the end of the hospital's cost reporting period. Qualifying Medicaid services provided in these approved units shall be subjected to the existing pre-admission certification requirements for children and adolescents in distinct part psychiatric/substance abuse units in acute care general hospitals.

C. Reimbursement for services will be the inpatient psychiatric prospective per diem rate.

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 34:876 (May 2008).

§915. Distinct Part Psychiatric Units

A. Changes in the Size of Distinct Part Psychiatric Units. For the purposes of Medicaid reimbursement, the number of beds and square footage of each distinct part psychiatric unit will remain the same throughout the cost reporting period. Any changes in the number of beds or square footage considered to be a part of a distinct part psychiatric unit may be made only at the start of a cost reporting period. Verification of these changes will be completed during the Medicaid agency's on-site survey at least 60 days prior, but no more than 90 days prior, to the end of the hospital's current cost reporting period with other information necessary for determining recognition as a distinct part psychiatric unit.

B. Effective for dates of service on or after February 10, 2012, a Medicaid enrolled non-state acute care hospital that enters into a cooperative endeavor agreement (CEA) with the Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to Medicaid and uninsured patients , and which also assumes the operation and management of a state-owned and formerly state-operated hospital distinct part psychiatric unit,

may make a one-time increase in its number of beds with a one-time opening of a new distinct part psychiatric unit.

1. This expansion or opening of a new unit will not be recognized, for Medicare purposes, until the beginning of the next cost reporting period. At the next cost reporting period, the hospital must meet the Medicare Prospective Payment System (PPS) exemption criteria and enroll as a Medicare PPS excluded distinct part psychiatric unit.

2. At the time of any expansion or opening of a new distinct part psychiatric unit, the provider must provide a written attestation that they meet all Medicare PPS rate exemption criteria.

3. Admissions to this expanded or new distinct part psychiatric unit may not be based on payer source.

C. Changes in the Status of Hospital Units. The status of each hospital unit is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of a unit are made only at the start of a cost reporting period.

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 20:49 (January 1994), amended LR 34:1913 (September 2008), amended by the Department of Health of Health and Hospitals, Bureau of Health Services Financing, LR 39:94 (January 2013).

Subchapter B. Reimbursement Methodology

§953. Acute Care Hospitals

A. For dates of service on or after September 1, 2007, the prospective per diem rate paid to non-rural, non-state acute care hospitals for inpatient services shall be increased by 4.75 percent of the rate on file for August 31, 2007.

B. Effective for dates of services on or after October 1, 2007, a quarterly supplemental payment will be issued to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital.

1. Qualifying Criteria. A hospital is considered to be a "high Medicaid hospital" if it has a Medicaid inpatient utilization percentage greater than 30 percent based on the 12 month cost report period ending in SFY 2006. For the purposes of calculating the Medicaid inpatient utilization percentage, Medicaid days shall include nursery and distinct part psychiatric unit days, but shall not include Medicare crossover days.

2. Each eligible hospital will receive a quarterly supplemental payment which shall be calculated based on the pro rata share of each qualifying hospital's paid Medicaid days (including covered nursery and distinct part psychiatric unit days) for dates of service in SFY 2007 to the total Medicaid days of all eligible hospitals multiplied by $5,000,000 which is the amount appropriated for these supplemental payments.

3. Rehabilitation hospitals, long term acute care hospitals and free-standing psychiatric hospitals are not eligible for this supplemental payment.

C. Effective for dates of service on or after February 20, 2009, the prospective per diem rate paid to acute care hospitals shall be reduced by 3.5 percent of the per diem rate on file as of February 19, 2009.

1. Payments to the following hospitals and/or specialty units for inpatient hospital services shall be exempted from these reductions:

a. small rural hospitals, as defined in R.S. 40:1300.143; and

b. high Medicaid hospitals, level III regional neonatal intensive care units and level I pediatric intensive care units as defined in R.S. 46.979.

2. For the purposes of qualifying for the exemption to the reimbursement reduction as a high Medicaid hospital, the following conditions must be met.

a. The inpatient Medicaid days utilization rate for high Medicaid hospitals shall be calculated based on the cost report filed for the period ending in state fiscal year 2007 and received by the department prior to April 20, 2008.

b. Only Medicaid covered days for inpatient hospital services, which include newborn and distinct part psychiatric unit days, are included in this calculation.

c. Inpatient stays covered by Medicare Part A cannot be included in the determination of the Medicaid inpatient utilization days rate.

D. Effective for dates of service on or after February 20, 2009, the amount appropriated for quarterly supplemental payments to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital shall be reduced to $4,925,000. Each qualifying hospital's quarterly supplemental payment shall be calculated based on the pro rata share of the reduced appropriation.

E. Major Teaching Hospitals. Effective for dates of service on or after October 1, 2009, qualifying major teaching hospitals with current per diem rates that are less than 80 percent of the current peer group rate shall have their per diem rates adjusted to equal 80 percent of the current peer group rate.

F. Minor Teaching Hospitals. Effective for dates of service on or after October 1, 2009, qualifying minor teaching hospitals shall have their per diem rates adjusted to equal 103 percent of the current peer group rate.

G. Non-Teaching Hospitals

1. Effective for dates of service on or after October 1, 2009, qualifying non-teaching hospitals with less than 58 beds shall have their per diem rates adjusted to equal 103 percent of the current peer group rate.

2. Effective for dates of service on or after October 1, 2009, qualifying non-teaching hospitals with 58 through 138

beds shall have their per diem rates adjusted to equal 122 percent of the current peer group rate.

3. Effective for dates of service on or after October 1, 2009, qualifying non-teaching hospitals with more than 138 beds shall have their per diem rates adjusted to equal 103 percent of the current peer group rate.

H. Neonatal Intensive Care Units (NICU)

1. Effective for dates of service on or after October 1, 2009, qualifying NICU level III services with current per diem rates that are less than the NICU level III specialty peer group rate shall have their per diem rates adjusted to equal 100 percent of the specialty group rate.

2. Effective for dates of service on or after October 1, 2009, qualifying NICU level III regional services with current per diem rates that are less than 85 percent of the NICU level III regional specialty group rate shall have their per diem rates adjusted to equal 85 percent of the specialty peer group rate.

3. 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 that varies based on the following five tiers:

a. tier 1—if the qualifying hospital's average percentage exceeds 10 percent, the additional per diem increase shall be $601.98;

b. tier 2—if the qualifying hospital's average percentage is less than or equal to 10 percent, but exceeds 5 percent, the additional per diem increase shall be $624.66;

c. tier 3—if the qualifying hospital's average percentage is less than or equal to 5 percent, but exceeds 1.5 percent, the additional per diem increase shall be $419.83;

d. tier 4—if the qualifying hospital's average percentage is less than or equal to 1.5 percent, but greater than 0 percent, and the hospital received greater than .25 percent of the outlier payments for dates of service in state fiscal year (SFY) 2008 and SFY 2009 and calendar year 2010, the additional per diem increase shall be $263.33; or

e. tier 5—if the qualifying hospital received less than .25 percent, but greater than 0 percent of the outlier payments for dates of service in SFY 2008 and SFY 2009 and calendar year 2010, the additional per diem increase shall be $35.

4. 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.

a. 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.

b. 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.

c. 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.

NOTE: Children's specialty hospitals are not eligible for the per diem adjustments established in §953.H.3.

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

I. Pediatric Intensive Care Unit (PICU)

1. Effective for dates of service on or after October 1, 2009, qualifying PICU level I services with current per diem rates that are less than 77 percent of the PICU level I specialty group rate shall have their per diem rates adjusted to equal 77 percent of the specialty peer group rate.

2. Effective for dates of service on or after October 1, 2009, qualifying PICU Level II services with current per diem rates that are less than the PICU Level II specialty group rate shall have their per diem rates adjusted to equal 100 percent of the specialty peer group rate.

3. 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 that varies based on the following four tiers:

a. tier 1—if the qualifying hospital's average percentage exceeds 20 percent, the additional per diem increase shall be $418.34;

b. tier 2—if the qualifying hospital's average percentage is less than or equal to 20 percent, but exceeds 10 percent, the additional per diem increase shall be $278.63;

c. tier 3—if the qualifying hospital's average percentage is less than or equal to 10 percent, but exceeds 0 percent and the hospital received greater than .25 percent of the outlier payments for dates of service in SFY 2008 and SFY 2009 and calendar year 2010, the additional per diem increase shall be $178.27; or

d. tier 4—if the qualifying hospital received less than .25 percent, but greater than 0 percent of the outlier payments for dates of service in SFY 2008, SFY 2009 and calendar year 2010, the additional per diem increase shall be $35.

4. 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.

a. 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 through 3, a hospital must have received at least .25 percent of outlier payments in SFY 2008, SFY 2009, and calendar year 2010.

b. 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.

c. 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.

NOTE: Children's specialty hospitals are not eligible for the per diem adjustments established in §953.I.3.

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

J. Hospitals Impacted by Hurricane Katrina (Region 1). Effective for dates of service on or after July 1, 2009, a quarterly supplemental payment will be issued to qualifying non-rural, non-state acute care hospitals for services rendered from July 1, 2009 through December 31, 2010. Maximum aggregate payments to all qualifying hospitals in this group (along with those in §963.A and outpatient supplemental payments) will not exceed $170,000,000.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state acute care hospital must be located in LDH administrative region 1 (New Orleans) and identified in the July 17, 2008 United States Government Accountability Office report as a hospital that has demonstrated substantial financial and operational challenges in the aftermath of Hurricane Katrina.

2. Each eligible 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 state fiscal year 2008 service dates. Payments will end on December 31, 2010 or when the hospital specific cap is reached, whichever occurs first.

K. Other Hospitals Impacted by Hurricanes Katrina and Rita. Effective for dates of service on or after July 1, 2009, a quarterly supplemental payment will be issued to qualifying non-rural, non-state acute care hospitals for services rendered from July 1, 2009 through December 31, 2010. Maximum aggregate payments to all qualifying hospitals in this group (along with those in §959.C and §963.B payments) will not exceed $10,000,000.

1. Qualifying Criteria. Non-rural, non-state acute care hospitals that do not qualify for payment under §953.E provisions may receive a supplemental payment if the hospital is located in either the New Orleans or Lake Charles metropolitan statistical area (MSA), had at least 1,000 paid Medicaid days for state fiscal year 2008 service dates and is currently operational.

2. Each eligible hospital shall receive quarterly supplemental payments which in total do not exceed $1,200,000 per hospital for the 18 month period.

a. Payments will be distributed as follows using Medicaid paid days for state fiscal year 2008 service dates.

i. Qualifying hospitals with greater than 7,500 paid Medicaid days for state fiscal year 2008 service dates will be paid $60 per Medicaid paid day.

ii. Qualifying hospitals with greater than 1,000, but less than or equal to 7,500 paid Medicaid days for state fiscal year 2008 service dates will be paid $130 per Medicaid paid day.

b. Payments will end on December 31, 2010 or when the $1,200,000 limit is reached, whichever occurs first.

L. Hospitals Impacted by Hurricanes Gustav and Ike. Effective for dates of service on or after July 1, 2009, a quarterly supplemental payment will be issued to qualifying non-rural, non-state acute care hospitals for services rendered from July 1, 2009 through December 31, 2010. Maximum aggregate payments to all qualifying hospitals in this group (along with §959.D and §963.C payments) will not exceed $7,500,000.

1. Qualifying Criteria. Non-rural, non-state acute care hospitals that do not qualify for payment under §953.E or §953.F may receive a supplemental payment if the hospital is located in either LDH administrative region 2 (Baton Rouge) or 3 (Thibodaux), had at least 1,000 paid Medicaid days for state fiscal year 2008 service dates and is currently operational.

2. Each eligible hospital shall receive quarterly supplemental payments which in total do not exceed $1,200,000 per hospital for the 18 month period.

a. Payments will be distributed as follows using Medicaid paid days for state fiscal year 2008 service dates.

i. Qualifying hospitals with greater than 20,000 paid Medicaid days for state fiscal year 2008 service dates will be paid $60 per Medicaid paid day.

ii. Qualifying hospitals with greater than 2,500, but less than or equal to 20,000 paid Medicaid days for state fiscal year 2008 service dates will be paid $105 per Medicaid paid day.

iii. Qualifying hospitals with greater than 1,000, but less than or equal to 2,500 paid Medicaid days for state fiscal year 2008 service dates will be paid $225 per Medicaid paid day.

b. Payments will end on December 31, 2010 or when the $1,200,000 limit is reached, whichever occurs first.

M. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to acute care hospitals shall be reduced by 6.3 percent of the per diem rate on file as of August 3, 2009.

1. Payments to small rural hospitals as defined in R.S. 40:1300 shall be exempt from this reduction.

N. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2010, quarterly supplemental payments will be issued to qualifying non-rural, non-state acute care hospitals for inpatient services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

a. A *non-state hospital* is defined as a hospital which is owned or operated by a private entity.

b. A *low income and needy care collaboration agreement* is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

3. Effective for dates of service on or after January 1, 2011, all parties that participate in supplemental payments under this Section, either as a qualifying hospital by receipt of supplemental payments or as a state or local governmental entity funding supplemental payments, must meet the following conditions during the period of their participation.

a. Each participant must comply with the prospective conditions of participation in the Louisiana Private Hospital Upper Payment Limit Supplemental Reimbursement Program.

b. A participating hospital may not make a cash or in-kind transfer to their affiliated governmental entity that has a direct or indirect relationship to Medicaid payments and would violate federal law.

c. A participating governmental entity may not condition the amount it funds the Medicaid Program on a specified or required minimum amount of low income and needy care.

d. A participating governmental entity may not assign any of its contractual or statutory obligations to an affiliated hospital.

e. A participating governmental entity may not recoup funds from an affiliated hospital that has not adequately performed under the low income and needy care collaboration agreement.

f. A participating hospital may not return any of the supplemental payments it receives under this Section to the governmental entity that provides the non-federal share of the supplemental payments.

g. A participating governmental entity may not receive any portion of the supplemental payments made to a participating hospital under this Section.

4. Each participant must certify that it complies with the requirements of §953.N.3 by executing the appropriate certification form designated by the department for this purpose. The completed form must be submitted to the Department of Health, Bureau of Health Services Financing.

5. Each qualifying hospital must submit a copy of its low income and needy care collaboration agreement to the department.

6. The supplemental payments authorized in this Section shall not be considered as interim Medicaid inpatient payments in the determination of cost settlement amounts for inpatient hospital services rendered by children's specialty hospitals.

O. Effective for dates of service on or after February 3, 2010, the inpatient per diem rate paid to acute care hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1300 shall be exempt from this reduction.

P. Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to acute care hospitals

shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1300 shall be exempt from this reduction.

Q. Effective for dates of service on or after January 1 2011, the inpatient per diem rate paid to acute care hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1300 shall be exempt from this reduction.

R. Effective for dates of service on or after August 1, 2012, the inpatient per diem rate paid to acute care hospitals shall be reduced by 3.7 percent of the per diem rate on file as of July 31, 2012.

S. Effective for dates of service on or after February 1, 2013, the inpatient per diem rate paid to acute care hospitals shall be reduced by 1 percent of the per diem rate on file as of January 31, 2013.

T. Effective for dates of service on or after March 1, 2017, supplemental payments to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital shall be annual. The amount appropriated for annual supplemental payments shall be reduced to $1,000. Each qualifying hospital's annual supplemental payment shall be calculated based on the pro rata share of the reduced appropriation.

U. Effective for dates of service on or after January 1, 2017, the inpatient per diem rate paid to acute care hospitals shall be increased by 7.03 percent of the per diem rate on file as of December 31, 2016.

1. Small rural hospitals as defined in R.S. 40:1300 and public-private partnership hospitals as defined in LAC 50:V.1701-1703 shall be exempt from this rate increase.

V. Effective for dates of service on or after January 1, 2018, the inpatient per diem rate paid to acute care hospitals shall be increased by indexing to 56 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

1. Acute care hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 56 percent the January 1, 2017 small rural hospital rate shall not be increased.

2. Carve-out specialty units, nursery boarder, and well-baby services are excluded from these rate increases.

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 34:876 (May 2008), amended LR 34:877 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895, 1896 (September 2009), repromulgated LR 35:2182 (October 2009), amended LR 36:1552 (July 2010), LR 36:2561 (November 2010), LR 37:2161 (July 2011), LR 39:3095 (November 2013), LR 39:3297 (December 2013), LR 40:312 (February 2014), repromulgated LR 40:1939, 1940 (October 2014), LR 41:133 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:963 (May 2017), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1389 (July 2017), repromulgated LR 43:1757 (September 2017), amended LR 43:2533 (December 2017).

§954. Outlier Payments

A. Pursuant to §1902(s)(1) of title XIX of the Social Security Act, additional payments called outlier payments shall be made to hospitals for catastrophic costs associated with inpatient services provided to:

1. children less than six years of age who receive services in a disproportionate share hospital setting; and

2. infants less than one year of age who receive services in any acute care hospital setting.

B. The marginal cost factor for outlier payments is considered to be 100 percent of costs after the costs for the case exceed the sum of the hospital's prospective payment and any other payment made on behalf of the patient for that stay by any other payee.

C. To qualify as a payable outlier claim, a deadline of not later than six months subsequent to the date that the final claim is paid shall be established for receipt of the written request for outlier payments.

1. Effective March 1, 2011, in addition to the 6 month timely filing deadline, 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.

D. 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 cases for:

a. children less than six years of age who received inpatient services in a disproportionate share hospital setting; or

b. 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.

a. 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.

E. The initial outlier pool will cover eligible claims with admission dates from the period beginning March 1, 2011-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 costs 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.

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 the pool.

F. Beginning with SFY 2012, the outlier pool will cover eligible claims with admission dates during the state fiscal year (July 1-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.

G. The claim must be submitted no later than six months subsequent to the date that the final claim is paid and no later than September 15 of each year.

H. Qualifying cases for which payments are not finalized by September 1 shall be eligible for inclusion for payment in the subsequent state fiscal year outlier pool.

I. Outliers are not payable for:

1. transplant procedures; or

2. services provided to patients with Medicaid coverage that is secondary to other payer sources.

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, Bureau of Health Services Financing, LR 36:519 (March 2010), amended LR 39:3096 (November 2013).

§955. Long-Term Hospitals

A. For dates of service on or after September 1, 2007, the prospective per diem rate paid to long term hospitals for inpatient services shall be increased by 4.75 percent of the rate on file for August 31, 2007.

B. For dates of service on or after February 20, 2009, the prospective per diem rate paid to long term hospitals for inpatient services shall be reduced by 3.5 percent of the rate on file as of February 19, 2009.

1. Payments for inpatient hospital services to high Medicaid hospitals classified as long term hospitals shall be exempted from these reductions.

2. For the purposes of qualifying for the exemption to the reimbursement reduction as a high Medicaid hospital, the following conditions must be met.

a. The inpatient Medicaid days utilization rate for high Medicaid hospitals shall be calculated based on the cost report filed for the period ending in state fiscal year 2007 and received by the department prior to April 20, 2008.

b. Only Medicaid covered days for inpatient hospital services, which include newborn and distinct part psychiatric unit days, are included in this calculation.

c. Inpatient stays covered by Medicare Part A cannot be included in the determination of the Medicaid inpatient utilization days rate.

C. Effective for dates of service on or after October 1, 2009, the prospective peer group per diem rate paid to qualifying long term acute care hospitals for inpatient services other than psychiatric treatment shall be increased by 3 percent of the rate on file.

D. Hurricane Impacted Hospitals. Effective for dates of service on or after July 1, 2009, a quarterly supplemental payment will be issued to qualifying long term hospitals for services rendered from July 1, 2009 through December 31, 2010. Maximum aggregate payments to all qualifying hospitals in this group (along with §961.A payments) will not exceed $500,000.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the long-term hospital must have had at least 100 paid Medicaid days for state fiscal year 2008 service dates and must be located in one of the following LDH administrative regions:

a. Region 1 (New Orleans);

b. Region 2 (Baton Rouge);

c. Region 3 (Thibodaux);

d. Region 5 (Lake Charles); or

e. Region 9 (Mandeville).

2. Each eligible hospital shall receive quarterly supplemental payments at the rate of $40 per Medicaid paid day for state fiscal year 2008 service dates. Payments will end on December 31, 2010 or when the $500,000 maximum payment limit for this group is reached, whichever occurs first.

E. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to long term hospitals for inpatient services shall be reduced by 6.3 percent of the per diem rate on file as of August 3, 2009.

F. Effective for dates of service on or after February 3, 2010, the inpatient per diem rate paid to long term hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

G. Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to long term hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

H. Effective for dates of service on or after January 1, 2011, the inpatient per diem rate paid to long term hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

I. Effective for dates of service on or after August 1, 2012, the inpatient per diem rate paid to long term hospitals

shall be reduced by 3.7 percent of the per diem rate on file as of July 31, 2012.

J. Effective for dates of service on or after February 1, 2013, the inpatient per diem rate paid to long term hospitals shall be reduced by 1 percent of the per diem rate on file as of January 31, 2013.

K. Effective for dates of service on or after January 1, 2017, the inpatient per diem rate paid to long-term hospitals shall be increased by 7.03 percent of the per diem rate on file as of December 31, 2016.

L. Effective for dates of service on or after January 1, 2017, the inpatient per diem rate paid to long-term hospitals shall be increased by indexing to 42 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017. Long-term hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 42 percent of the January 1, 2017 small rural hospital rate shall not be increased.

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: 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1554 (July 2010), LR 36:2562 (November 2010), LR 37:2162 (July 2011), LR 40:312 (February 2014), repromulgated LR 40:1940 (October 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 43:2533 (December 2017).

§957. Hospital Intensive Neurological Rehabilitation Units

A. For dates of service on or after September 1, 2007, the prospective per diem rate paid to hospital intensive neurological rehabilitation care units shall be increased by 4.75 percent of the rate on file for August 31, 2007.

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 34:876 (May 2008).

§959. Inpatient Psychiatric Hospital Services

A. For dates of service on or after September 1, 2007, the prospective per diem rate paid to private free-standing psychiatric hospitals and distinct part psychiatric units shall be increased by 4.75 percent of the rate on file for August 31, 2007.

B. Effective for dates of service on or after February 20, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units shall be reduced by 3.5 percent of the rate on file as of February 19, 2009.

1. Distinct part psychiatric units that operate within an acute care hospital that qualifies as a high Medicaid hospital, as defined in §953.C.2, are exempt from the rate reduction.

C. Effective for dates of service on or after October 1, 2009, the prospective per diem rate paid to private free-standing psychiatric hospitals and distinct part psychiatric units shall be increased by 3 percent of the rate on file.

D. Free-Standing Psychiatric Hospitals Impacted by Hurricanes Katrina and Rita. Effective for dates of service on or after July 1, 2009, a quarterly supplemental payment will be issued to qualifying free-standing psychiatric hospitals for services rendered from July 1, 2009 through December 31, 2010. Maximum aggregate payments to all qualifying hospitals in this group (along with §953.F and §961.A payments) will not exceed $10,000,000.

1. Qualifying Criteria. Non-rural, non-state free-standing psychiatric hospitals that do not qualify for payment under §953.F provisions may receive a supplemental payment if the hospital is located in either the New Orleans or Lake Charles metropolitan statistical area (MSA), had at least 1,000 paid Medicaid days for state fiscal year 2008 service dates and is currently operational.

2. Each eligible hospital shall receive quarterly supplemental payments which in total do not exceed $1,200,000 per hospital for the 18 month period.

a. Payments will be distributed as follows using Medicaid paid days for state fiscal year 2008 service dates.

i. Qualifying hospitals with greater than 7,500 paid Medicaid days for state fiscal year 2008 service dates will be paid $60 per Medicaid paid day.

ii. Qualifying hospitals with greater than 1,000, but less than or equal to 7,500 paid Medicaid days for state fiscal year 2008 service dates will be paid $130 per Medicaid paid day.

b. Payments will end on December 31, 2010 or when the $1,200,000 limit is reached, whichever occurs first.

E. Free-Standing Psychiatric Hospitals Impacted by Hurricanes Gustav and Ike. Effective for dates of service on or after July 1, 2009, a quarterly supplemental payment will be issued to qualifying free-standing psychiatric hospitals for services rendered from July 1, 2009 through December 31, 2010. Maximum aggregate payments to all qualifying hospitals in this group (along with §953.G and §961.C payments) will not exceed $7,500,000.

1. Qualifying Criteria. Non-rural, non-state free-standing psychiatric hospitals that do not qualify for payment under §953.E or §953.F may receive a supplemental payment if the hospital is located in either LDH administrative region 2 (Baton Rouge) or 3 (Thibodaux), had at least 1,000 paid Medicaid days for state fiscal year 2008 service dates and is currently operational.

2. Each eligible hospital shall receive quarterly supplemental payments which in total do not exceed $1,200,000 per hospital for the 18 month period.

a. Payments will be distributed as follows using Medicaid paid days for state fiscal year 2008 service dates.

i. Qualifying hospitals with greater than 20,000 paid Medicaid days for state fiscal year 2008 service dates will be paid $60 per Medicaid paid day.

ii. Qualifying hospitals with greater than 2,500, but less than or equal to 20,000 paid Medicaid days for state fiscal year 2008 service dates will be paid $105 per Medicaid paid day.

iii. Qualifying hospitals with greater than 1,000, but less than or equal to 2,500 paid Medicaid days for state fiscal year 2008 service dates will be paid $225 per Medicaid paid day.

b. Payments will end on December 31, 2010 or when the $1,200,000 limit is reached, whichever occurs first.

F. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be reduced by 5.8 percent of the rate on file as of August 3, 2009.

G. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to non-rural, non-state distinct part psychiatric units shall be reduced by 6.3 percent of the rate on file as of August 3, 2009.

H. Effective for dates of service on or after February 3, 2010, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

I. Effective for dates of service on or after August 1, 2010, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

J. Effective for dates of service on or after January 1, 2011, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

K. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2012, quarterly supplemental payments shall be issued to qualifying non-rural, non-state free-standing psychiatric hospitals for inpatient services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state free-standing psychiatric hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

a. A *non-state free-standing psychiatric hospital* is defined as a free-standing psychiatric hospital which is owned or operated by a private entity.

b. A *low income and needy care collaboration agreement* is defined as an agreement between a hospital and a state or local governmental entity to collaborate for the purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient psychiatric services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

L. Effective for dates of service on or after February 10, 2012, a Medicaid-enrolled non-state acute care hospital that enters into a cooperative endeavor agreement (CEA) with the Department of Health, Office of Behavioral Health to provide inpatient psychiatric hospital services to Medicaid and uninsured patients, and which also assumes the operation and management of formerly state-owned and operated psychiatric hospitals/visits, shall be paid a per diem rate of $581.11 per day.

M. Effective for dates of service on or after January 1, 2017, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by 2 percent of the per diem rate on file as of December 31, 2016.

1. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.L of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

N. Effective for dates of service on or after January 1, 2018, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by indexing to 31 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

1. Psychiatric hospitals and units whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 31 percent of the January 1, 2017 small rural hospital rate shall not be increased.

2. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.L of

this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

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 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1554 (July 2010), LR 36:2562 (November 2010), LR 37:2162 (July 2011), LR 39:94 (January 2013), LR 39:323 (February 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 43:2533 (December 2017).

§961. Inpatient Rehabilitation Hospital Services

A. Definitions

Free-Standing Rehabilitation Hospital—a non-rural, non-state hospital that is designated as a rehabilitation specialty hospital by Medicare.

B. Reimbursement Methodology

1. Effective for dates of service on or after January 1, 2018, the prospective per diem rate paid to non-rural, non-state free-standing rehabilitation hospitals shall be indexed to 36 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

2. Rehabilitation hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 36 percent of the January 1, 2017 small rural hospital rate shall not be increased.

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 43:2533 (December 2017).

§963. Public Hospitals

A. Effective for dates of service on or after May 15, 2011, non-rural, non-state public hospitals shall be reimbursed up to the Medicare inpatient upper payment limits as determined in accordance with 42 CFR §447.272.

B. Effective for dates of service on or after August 1, 2012, quarterly supplemental payments will be issued to qualifying non-rural, non-state public hospitals for inpatient services rendered during the quarter. Payment amounts shall be reimbursed up to the Medicare inpatient upper payment limits as determined in accordance with 42 CFR §447.272.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must:

a. be designated as a major teaching hospital by the department as of July 1, 2015 and have at least 300 licensed acute hospital beds; or

b. effective for dates of service on or after August 1, 2012, be located in a city with a population of over 300,000 as of the 2010 U.S. Census.

C. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payments shall be the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department.

D. With respect to qualifying hospitals that are enrolled in Medicaid after December 1, 2013, projected Medicaid utilization and claims data submitted by the hospital and confirmed by the department as reasonable will be used as the basis for making quarterly supplemental payments during the hospital's start-up period.

1. For purposes of these provisions, the start-up period shall be defined as the first three years of operation.

2. During the start-up period, the department shall verify that supplemental payments do not exceed the inpatient charge differential based on each state fiscal year's claims data and shall recoup amounts determined to have been overpaid.

E. In the event that there is allowable non-state public upper payment limit that is not utilized, additional non-state public hospitals as defined by the department may be qualified for this payment.

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

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§965. Hemophilia Blood Products

A. Effective for dates of service on or after July 1, 2015, the Department of Health and Hospitals shall provide additional reimbursements to certain non-rural, non-state acute care hospitals for the extraordinary costs incurred in purchasing blood products for certain Medicaid recipients diagnosed with, and receiving inpatient treatment for hemophilia.

B. Hospital Qualifications. To qualify for the additional reimbursement, the hospital must:

1. be classified as a major teaching hospital and contractually affiliated with a university located in Louisiana that is recognized by the Centers for Disease Control and Prevention and the Health Resource and Services Administration, Maternal and Child Health Bureau as maintaining a comprehensive hemophilia care center;

2. have provided clotting factors to a Medicaid recipient who:

a. has been diagnosed with hemophilia or other rare bleeding disorders for which the use of one or more clotting

factors is Food and Drug Administration (FDA) approved; and

b. has been hospitalized at the qualifying hospital for a period exceeding six days; and

3. have actual cost exceeding $50,000 for acquiring the blood products used in the provision of clotting factors during the hospitalization;

a. actual cost is the hospital's cost of acquiring blood products for the approved inpatient hospital dates of service as contained on the hospital's original invoices, less all discount and rebate programs applicable to the invoiced products.

C. Reimbursement. Hospitals who meet the qualifications in §965.B may receive reimbursement for their actual costs that exceed $50,000 if the hospital submits a request for reimbursement to the Medicaid Program within 180 days of the patient's discharge from the hospital.

1. The request for reimbursement shall be submitted in a format specified by the department.

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 34:2176 (October 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:674 (April 2009), LR 42:406 (March 2016).

§967. Children's Specialty Hospitals

A. Routine Pediatric Inpatient Services. For dates of service on or after October 4, 2014, payment shall be made per a prospective per diem rate that is 81.1 percent of the routine pediatric inpatient cost per day as calculated per the "as filed" fiscal year end cost report ending during SFY 2014. The "as filed" cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

B. Inpatient Psychiatric Services. For dates of service on or after October 4, 2014, payment shall be a prospective per diem rate that is 100 percent of the distinct part psychiatric cost per day as calculated per the as filed fiscal year end cost report ending during SFY 2014. The as filed cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

1. Costs and per discharge/per diem limitation comparisons shall be calculated and applied separately for acute, psychiatric and each specialty service.

C. Carve-Out Specialty Services. These services are rendered by neonatal intensive care units, pediatric intensive care units, burn units and include transplants.

1. Transplants. Payment shall be the lesser of costs or the per diem limitation for each type of transplant. The base period per diem limitation amounts shall be calculated using the allowable inpatient cost per day for each type of transplant per the cost reporting period which ended in SFY 2009. The target rate shall be inflated using the update factors published by the Centers for Medicare and Medicaid (CMS) beginning with the cost reporting periods starting on or after January 1, 2010.

a. For dates of service on or after September 1, 2009, payment shall be the lesser of the allowable inpatient costs as determined by the cost report or the Medicaid days for the period for each type of transplant multiplied times the per diem limitation for the period.

2. Neonatal Intensive Care Units, Pediatric Intensive Care Units, and Burn Units. For dates of service on or after October 4, 2014, payment for neonatal intensive care units, pediatric intensive care units, and burn units shall be made per prospective per diem rates that are 84.5 percent of the cost per day for each service as calculated per the "as filed" fiscal year end cost report ending during SFY 2014. The "as filed" cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

D. Children's specialty hospitals shall be eligible for outlier payments for dates of service on or after October 4, 2014.

E. These provisions shall not preclude children's specialty hospitals from participation in the Medicaid Program under the high Medicaid or graduate medical education supplemental payment provisions.

F. Effective for dates of service on or after February 3, 2010, the per diem rates as calculated per §967.C.1 above shall be reduced by 5 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 95 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

G. Effective for dates of service on or after August 1, 2010, the per diem rates as calculated per §967.C.1 above shall be reduced by 4.6 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 90.63 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

H. Effective for dates of service on or after January 1, 2011, the per diem rates as calculated per §967.C.1 above shall be reduced by 2 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 88.82 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

I. Effective for dates of service on or after February 1, 2012, medical education payments for inpatient services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be paid by Medicaid monthly as interim lump sum payments.

1. Hospitals with qualifying medical education programs shall submit a listing of inpatient claims paid each month by each MCO.

a. *Qualifying Medical Education Programs*—graduate medical education, paramedical education, and nursing schools.

2. Monthly payments shall be calculated by multiplying the number of qualifying inpatient days times the medical education costs included in each children's specialty hospital's interim per diem rate as calculated per the latest filed Medicaid cost report.

3. Final payment shall be determined based on the actual MCO covered days and medical education costs for the cost reporting period per the Medicaid cost report. Reimbursement shall be at the same percentage that is reimbursed for fee-for-service covered Medicaid costs after application of reimbursement caps as specified in §967.A-C and reductions specified in §967.F-H.

J. Effective for dates of service on or after August 1, 2012, the per diem rates as calculated per §967.C.1 above shall be reduced by 3.7 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 85.53 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

K. Effective for dates of service on or after February 1, 2013, the per diem rates as calculated per §967.C.1 above shall be reduced by 1 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 84.67 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

L. Effective for dates of service on or after January 1, 2017, the inpatient per diem rates paid to children's specialty hospitals for acute, neonatal intensive care units, pediatric intensive care units and burn units' services shall be increased by 7.03 percent of the per diem rate on file as of December 31, 2016.

M. Effective for dates of service on or after January 1, 2017, the prospective per diem rate paid to distinct part psychiatric units within children's specialty hospitals shall be increased by 2 percent of the per diem rate on file as of December 31, 2016.

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, Bureau of Health Services Financing, LR 36:2562 (November 2010), amended LR 37:2162, 2162 (July 2011), LR 38:2773 (November 2012), LR 39:3097 (November 2013), LR 40:312 (February 2014), repromulgated LR 40:1940 (October 2014), amended LR 40:1941 (October 2014), LR 42:275 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017).

Chapter 11. Rural, Non-State Hospitals

Subchapter A. General Provisions (Reserved)

Subchapter B. Reimbursement Methodology

§1125. Small Rural Hospitals

A. Effective for dates of service on or after July 1, 2008, the prospective per diem rate paid to small rural hospitals for inpatient acute care services shall be the median cost amount plus 10 percent.

1. The per diem rate calculation shall be based on each hospital's year-end cost report period ending in calendar year 2006. If the cost reporting period is not a full period (12 months), the latest filed full period cost report shall be used.

B. The Medicaid cost per inpatient day for each small rural hospital shall be inflated from their applicable cost reporting period to the midpoint of the implementation year (December 31, 2008) by the Medicare market basket inflation factor for PPS hospitals, then arrayed from high to low to determine the median inpatient acute cost per day for all small rural hospitals.

C. 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.

D. Effective for dates of service on or after August 1, 2010, the reimbursement for inpatient acute care services rendered by small rural hospitals shall be up to the Medicare upper payment limits for inpatient hospital services.

E. Low Income and Needy Care Collaboration. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments shall be issued to qualifying non-state acute care hospitals for inpatient services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.

b. A *low income and needy care collaboration agreement* is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered

during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

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, Bureau of Health Services Financing, LR 35:955 (May 2009), amended LR 38:1240 (May 2012), LR 40:541 (March 2014).

§1127. Inpatient Psychiatric Hospital Services

A. Effective for dates of service on or after July 1, 2008, the prospective per diem rate paid to small rural hospitals for psychiatric services rendered in distinct part psychiatric units shall be the median cost amount per inpatient day plus 10 percent.

1. The per diem rate calculation shall be based on each hospital's year-end cost report period ending in calendar year 2006. If the cost reporting period is not a full period (12 months), the latest filed full period cost report shall be used.

B. The Medicaid cost per inpatient psychiatric day for each small rural hospital shall be inflated from their applicable cost reporting period to the midpoint of the implementation year (December 31, 2008) by the Medicare market basket inflation factor for PPS hospitals, then arrayed from high to low to determine the median inpatient acute cost per day for all small rural hospitals.

C. 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.

D. Effective for dates of service on or after August 1, 2010, the reimbursement paid for psychiatric services rendered by distinct part psychiatric units in small rural hospitals shall be up to the Medicare inpatient upper payment limits.

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, Bureau of Health Services Financing, LR 35:955 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1240 (May 2012).

Chapter 13. Teaching Hospitals

Subchapter A. General Provisions

§1301. Major Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a major teaching hospital is limited to facilities having a documented affiliation agreement with a Louisiana medical school accredited by the Liaison Committee on Medical Education (LCME). A major teaching hospital shall meet one of the following criteria:

1. be a major participant in at least four approved medical residency programs and maintain at least 15 intern and resident un-weighted full-time equivalent positions. For purposes of this Rule, full-time equivalent positions will be calculated as defined in 42 CFR 413.78. At least two of the programs must be in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, emergency medicine or psychiatry; or

2. maintain at least 20 intern and resident un-weighted full-time equivalent positions, with an approved medical residency program in family practice located more than 150 miles from the medical school accredited by the LCME. For purposes of this Rule, full-time equivalent positions will be calculated as defined in 42 CFR 413.78.

B. For the purposes of recognition as a major teaching hospital, a facility shall be considered a "major participant" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience;

2. require explicit approval by the appropriate residency review committee (RRC) of the medical school with which the facility is affiliated prior to utilization of the facility; or

3. provide residency rotations of more than one sixth of the program length or more than a total of six months at the facility and are listed as part of an accredited program in the graduate medical education directory of the Accreditation Council for Graduate Medical Education (ACGME).

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, Bureau of Health Services Financing, LR 39:324 (February 2013), amended LR 40:1697 (September 2014).

§1303. Minor Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a minor teaching hospital is limited to facilities having a documented affiliation agreement with a Louisiana medical school accredited by the LCME. A minor teaching hospital shall meet the following criteria:

1. must participate significantly in at least one approved medical residency program in either medicine,

surgery, obstetrics/gynecology, pediatrics, family practice, emergency medicine or psychiatry; and

2. maintain at least six intern and resident unweighted full-time equivalent positions. For purposes of this Rule, full-time equivalent positions will be calculated as defined in 42 CFR 413.78.

B. For the purposes of recognition as a minor teaching hospital, a facility is considered to "participate significantly" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience;

2. require explicit approval by the appropriate residency review committee of the medical school with which the facility is affiliated prior to utilization of the facility; or

3. provide residency rotations of more than one sixth of the program length or more than a total of six months at the facility and are listed as part of an accredited program in the graduate medical education directory of the Accreditation Council for Graduate Medical Education.

a. If not listed, the sponsoring institution must have notified the ACGME, in writing, that the residents rotate through the facility and spend more than one sixth of the program length or more than a total of six months at the facility.

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, Bureau of Health Services Financing, LR 39:324 (February 2013), amended LR 40:1698 (September 2014).

§1305. Approved Medical Residency Program

A. An approved medical residency program is one that meets one of the following criteria:

1. is approved by one of the national organizations listed in 42 CFR 415.152;

2. may count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

a. *The Directory of Graduate Medical Education Programs* published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications; or

b. *The Annual Report and Reference Handbook* published by the American Board of Medical Specialties, and available from American Board of Medical Specialties;

3. is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine; or

4. is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

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, Bureau of Health Services Financing, LR 39:324 (February 2013), amended LR 40:1698 (September 2014).

§1309. Requirements for Reimbursement

A. Qualification for teaching hospital status shall be re-established at the beginning of each fiscal year.

B. To be reimbursed as a teaching hospital, a facility shall submit a signed “certification for teaching hospital recognition” form to the Bureau of Health Services, Rate Setting and Audit Section at least 30 days prior to the beginning of each state fiscal year or at least 30 days prior to the effective date of the conversion of a state owned and operated teaching hospital to private ownership in accordance with a public/private partnership cooperative endeavor agreement that was instituted to preserve graduate medical education training and access to healthcare services for indigent patients.

C. Each hospital which is reimbursed as a teaching hospital shall submit the following documentation with their Medicaid cost report filing:

1. a copy of the intern and resident information system report that is submitted annually to the Medicare intermediary; and

2. a copy of any notice given to the ACGME that residents rotate through a facility for more than one sixth of the program length or more than a total of six months.

D. Copies of all affiliation agreements, contracts, payroll records and time allocations related to graduate medical education must be maintained by the hospital and available for review by the state and federal agencies or their agents upon request.

E. If it is subsequently discovered that a hospital has been reimbursed as a major or minor teaching hospital and did not qualify for that peer group for any reimbursement period, retroactive adjustment shall be made to reflect the correct peer group to which the facility should have been assigned. The resulting overpayment will be recovered through either immediate repayment by the hospital or recoupment from any funds due to the hospital from the department.

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, Bureau of Health Services Financing, LR 39:325 (February 2013), amended LR 40:1698 (September 2014).

Subchapter B. Reimbursement Methodology

§1331. Acute Care Hospitals

A. Effective for dates of service on or after February 1, 2012, medical education payments for inpatient services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be paid monthly by Medicaid as interim lump sum payments.

1. Hospitals with qualifying medical education programs shall submit a listing of inpatient claims paid each month by each MCO.

a. Qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.

2. Qualifying hospitals must have a direct medical education add-on component included in their prospective Medicaid per diem rates as of January 31, 2012 which was carved-out of the per diem rate reported to the MCOs.

3. Monthly payments shall be calculated by multiplying the number of qualifying inpatient days submitted by the medical education costs component included in each hospital's fee-for-service prospective per diem rate. Monthly payment amounts shall be verified by the department semi-annually using reports of MCO covered days generated from encounter data. Payment adjustments or recoupments shall be made as necessary based on the MCO encounter data reported to the department.

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 34:877 (May 2008), amended LR 38:2773 (November 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1388 (July 2017).

Chapter 17. Public-Private Partnerships

§1701. Baton Rouge Area Hospitals

A. Qualifying Criteria. Effective for dates of service on or after April 15, 2013, the department shall provide supplemental Medicaid payments for inpatient hospital services rendered by non-state privately owned hospitals in the Baton Rouge Area that meet the following conditions.

1. The hospital must be a non-state privately owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

B. Reimbursement Methodology

1. Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year.

2. Payments shall not exceed the allowable Medicaid charge differential. The Medicaid inpatient charge differential is the Medicaid inpatient charges less the Medicaid inpatient payments (which includes both the base payments and supplemental payments).

a. The payments will be made in four equal quarterly payments based on 100 percent of the estimated charge differential for the state fiscal year.

3. The qualifying hospital will provide quarterly reports to the department that will demonstrate that, upon implementation, the annual Medicaid inpatient payments do not exceed the annual Medicaid inpatient charges per 42 CFR 447.271. The department will verify the Medicaid claims data of these interim reports using the state's MMIS system. When the department receives the annual cost report as filed, the supplemental calculations will be reconciled to the cost report.

4. If there is additional cap room, an adjustment payment will be made to assure that supplemental payments are the actual charge differential. The supplemental payments will also be reconciled to the final cost report.

5. The annual supplemental payments will not exceed the allowable Medicaid inpatient charge differential per 42 CFR 447.271, and the maximum inpatient Medicaid payments shall not exceed the upper limit per 42 CFR 447.272.

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, Bureau of Health Services Financing, LR 42:407 (March 2016).

§1703. Reimbursement Methodology

A. Reserved.

B. Effective for dates of service on or after April 15, 2013, a major teaching hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to provide acute care hospital services to Medicaid and uninsured patients and which assumes providing services that were previously delivered and terminated or reduced by a state-owned and operated facility shall be reimbursed as follows.

1. The inpatient reimbursement shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid costs.

C. - E.3. Reserved.

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, Bureau of Health Services Financing, LR 42:573 (April 2016).