John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

October 5, 2018

M E M O R A N D U M

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Taylor F. Barras, Speaker of the House
The Honorable Fred H. Mills, Jr., Chairman, Senate Committee on Health and Welfare
The Honorable Frank A. Hoffmann, Chairman, House Committee on Health and Welfare
The Honorable Eric LaFleur, Chairman, Senate Finance Committee
The Honorable Cameron Henry, Chairman, House Appropriations Committee

FROM: Rebekah E. Gee MD, MPH Cindy Rives
Secretary

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Dental Benefits Prepaid Ambulatory Health Plan - Independent Review Process for Provider Claims.

The Department published a Notice of Intent on this proposed Rule in the August 20, 2018 issue of the *Louisiana Register* (Volume 44, Number 8). A public hearing was held on September 27, 2018 at which a representative of the Louisiana Hospital Association and Louisiana Department of Health staff were present. No oral testimony was given or written comments received regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the November 20, 2018 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification; and
3. the public hearing attendance roster.

REG/CR/RKA

Attachments (3)

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Dental Benefits Prepaid Ambulatory Health Plan
Independent Review Process for Provider Claims
(LAC 50:I.2117)

The Department of Health, Bureau of Health Services Financing proposes to adopt LAC 50:I.2117 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Act 284 of the 2018 Regular Session of the Louisiana Legislature directed the Department of Health, Bureau of Health Services Financing to establish a process for review of dental provider claims submitted to Medicaid dental benefit plan managers (DBPMs) when claim payment determinations are adverse to providers and the DBPM's appeal and reconsideration process has been exhausted. This legislation further directed the department to: 1) establish a panel for the selection of the independent dental claims reviewers; 2) provide for claims review procedures and fees for claims review services; and 3) related matters.

In compliance with the provisions of Act 284, the department proposes to amend the Rule governing the dental benefits prepaid ambulatory health plan in order to adopt

provisions for the independent process for the review of DBPM provider claims payment determinations that are adverse to dental providers.

Title 50
PUBLIC HEALTH - MEDICAL ASSISTANCE
Part 1. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 21. Dental Benefits Prepaid Ambulatory Health Plan

§2117. Independent Review Process for Dental Provider Claims

A. Right of Dentist Providers to Independent Review of Claims

1. Pursuant to Act 284 of the 2018 Regular Session of the Louisiana Legislature, for adverse determinations related to dental claims filed on or after November 20, 2018, a dentist/dental provider shall have a right to an independent review of the adverse action of the DBPM.

2. For purposes of these provisions, adverse determinations shall refer to dental claims submitted by healthcare providers for payment for dental services rendered to Medicaid enrollees and denied by the DBPM, in whole or in part, or more than 60 days have elapsed since the claim was submitted and the dentist has received no remittance advice or other written or electronic notice from the DBPM either partially or totally denying the claim.

B. Request for Reconsideration

1. Prior to submitting a request for independent review, a provider shall submit a written request for reconsideration to the DBPM, as provided for by the DBPM and in accordance with this Section. The request shall identify the claim(s) in dispute, the reasons for the dispute, and any documentation supporting the provider's position or request by the DBPM.

2. The DBPM shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with §2117.B.1, within five calendar days after receipt, and render a final decision by providing a response to the provider within 45 calendar days from the date of receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the dentist/dental provider and the DBPM.

3. If the DBPM reverses the adverse determination pursuant to a request for reconsideration, payment of the claim(s) in dispute shall be made no later than 20 days from the date of the DBPM's decision.

C. Independent Review of Dental Claims Requirements

1. If the DBPM upholds the adverse determination, or does not respond to the reconsideration request within the time frames allowed, the provider may file a written notice with the department requesting the adverse determination be submitted to an independent reviewer. The department must receive the written request from the provider for an independent review within 60

days from the date the provider receives the DBPM's notice of the decision of the reconsideration request, or if the DBPM does not respond to the reconsideration request within the time frames allowed, within 10 days of the last date of the time period allowed for the DBPM to respond.

2. The dentist/dental provider shall include a copy of the written request for reconsideration with the request for an independent review. The appropriate address to be used by the provider for submission of the request shall be Medicaid Dental Benefits Independent Review, P.O. Box 91283, Bin 32, Baton Rouge, LA 70821-9283.

3. Upon receipt of a notice of request for independent review and supporting information and documentation, the department shall refer the adverse determination to the dental claims review panel.

4. Subject to approval by the independent reviewer, a dentist/dental provider may aggregate multiple adverse determinations involving the same DBPM when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law.

5. Within 14 calendar days of receipt of the request for independent review, the independent reviewer shall request to be provided all information and documentation submitted for reconsideration regarding the disputed claim or claims within 30 calendar days.

6. If the independent reviewer determines that guidance on an administrative issue from the department is required to make a decision, the reviewer shall refer this specific issue to the department for review and concise response to the request within 30 calendar days after receipt.

7. The independent reviewer shall examine all materials submitted and render a decision on the dispute within 60 calendar days. The independent reviewer may request in writing an extension of time from the dental claims review panel to resolve the dispute. If an extension of time is granted by the panel, the independent reviewer shall provide notice of the extension to the dental provider and the DBPM.

8. If the independent reviewer renders a decision requiring the DBPM to pay any claims or portion of the claims, within 20 calendar days, the DBPM shall send the provider payment in full along with interest calculated back to the date the claim was originally denied or recouped.

D. Independent Review Costs

1. The DBPM shall pay the fee for an independent review to the Louisiana State University School of Dentistry. The dentist/dental provider shall, within 10 days of the date of the decision of the independent reviewer, reimburse the DBPM for the fee associated with conducting an independent review when the decision of the DBPM is upheld. If the provider fails to submit payment for the independent review within 10 days from

the date of the decision, the DBPM may withhold future payments to the provider in an amount equal to the cost of the independent review, and the department may prohibit that provider from future participation in the independent review process.

2. If the DBPM fails to pay the bill for the independent reviewer's services, the reviewer may request payment directly from the department from any funds held by the state that are payable to the DBPM.

3. The fee for an independent review of a dental claim shall be paid in an amount established in a memorandum of understanding between the department and the Louisiana State University School of Dentistry, not to exceed $2,000 per review.

E. Dental Claims Review Panel

1. The dental claims review panel shall select and identify an appropriate number of independent reviewers to comprise a reviewer pool and continually review the number and outcome of requests for reconsideration and independent reviews on an aggregated basis.

2. The panel shall consist of the secretary or his/her duly designated representative, one representative from each DBPM, a number of dentist representatives equal to the number of representatives from DBPMs and the dean of the Louisiana State University School of Dentistry or his/her designee.

3. The reviewer pool selected by the dental claims review panel shall be comprised of dentists who are on the faculty of the Louisiana State University School of Dentistry and have agreed to applicable terms for compensation, confidentiality, and related provisions established by the department. The reviewer pool shall include:

a. For each of the following specialties, at least one dentist who has completed a residency approved by the Commission on Dental Accreditation in that specialty:

i. periodontics;

ii. endodontics;

iii. prosthodontics; and

iv. oral and maxillofacial surgery.

b. At least two dentists who have completed a residency approved by the Commission on Dental Accreditation in pediatric dentistry.

4. The reviewer pool shall not include any dentist who is currently performing compensated services for the DBPM, whether the compensation is paid directly or through a contract with the Louisiana State University School of Dentistry or other state entity, or has received any such compensation at any time in the prior 12 months.

5. The reviewer pool shall not include any dentist who has received reimbursement for dental services rendered to

Medicaid patients in a private practice setting in the past 60 days.

a. Louisiana State University School of Dentistry clinics, including Louisiana State University School of Dentistry faculty practice, shall not be considered a private practice setting for the purposes of determining eligibility to participate in the reviewer pool.

6. No dentist shall be eligible to submit denied Medicaid claims for independent review while participating in the reviewer pool.

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:

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

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, September 27, 2018 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or

in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION
September 27, 2018
9:30 a.m.

RE: Dental Benefits Prepaid Ambulatory Health Plan
Independent Review Process for Provider Claims
Docket # 09272018-01
Department of Health
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on September 27, 2018 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.

Medicaid Policy and Compliance
Section

09/27/18
Date

Bienville Building • 628 N. Fourth St. • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
Phone: (225) 342-9500 • Fax: (225) 342-5568 • www.ldh.la.gov

LDH/BHSF PUBLIC HEARING

Topic – Dental Benefits Prepaid Ambulatory Health Plan Independent Review Process for Provider Claims

Date – September 27, 2018

PERSONS IN ATTENDANCE

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. Cola Rayford	628 N. 4th Street B.R.LA	225-342-3881	LDH - Policy & Compliance
2. Greg Wadley	9521 Brockline Dr, BR LA 70809	225-333-0210	LHA
3. Ann Burstall			OBH
4. Rebecca Clement	628 N. 4th St BR LA	342-6401	Legal
5.			
6.			

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

October 5, 2018

M E M O R A N D U M

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Taylor F. Barras, Speaker of the House
The Honorable Fred H. Mills, Jr., Chairman, Senate Committee on Health and Welfare
The Honorable Frank A. Hoffmann, Chairman, House Committee on Health and Welfare
The Honorable Eric LaFleur, Chairman, Senate Finance Committee
The Honorable Cameron Henry, Chairman, House Appropriations Committee

FROM: Rebekah E. Gee MD, MPH Cindy Rives
Secretary

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Home Health Program – Durable Medical Equipment – Pharmacy Provider Accreditation.

The Department published a Notice of Intent on this proposed Rule in the August 20, 2018 issue of the *Louisiana Register* (Volume 44, Number 8). A public hearing was held on September 27, 2018 at which only Louisiana Department of Health staff were present. No oral testimony was given or written comments received regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the November 20, 2018 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification; and
3. the public hearing attendance roster.

REG/WJR/YE

Attachments (3)

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Home Health Program
Durable Medical Equipment
Pharmacy Provider Accreditation
(LAC 50:XIII.8501)

The Department of Health, Bureau of Health Services Financing proposes to amend LAC 50:XIII.8501 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing provider participation in the Home Health Program in order to remove the accreditation requirements for pharmacies that provide medical equipment, supplies and appliances, in compliance with federal regulations mandated by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XIII. Home Health Program
Subpart 3. Medical Equipment, Supplies and Appliances

Chapter 85. Provider Participation

§8501. Accreditation Requirements

A. - B. ...

C. Pharmacies. These accreditation requirements do not apply to pharmacies that provide medical equipment, supplies and appliances.

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 36:512 (March 2010), amended LR 37:2159 (July 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

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

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 as it may increase provider participation for pharmacies that provide medical equipment, supplies and appliances which could result in increased recipient access to pharmacies that provide these services.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty as described in R.S. 49:973 as it may increase provider participation locally which will reduce transportation cost and the financial burden on families in need of these pharmacy services.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements and will not impact the direct or indirect cost to the provider to provide the same level of service. However, this proposed Rule removes the accreditation requirement which may enhance the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, September 27, 2018 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge,

LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION
September 27, 2018
9:30 a.m.

RE: Home Health Program
Durable Medical Equipment
Pharmacy Provider Accreditation
Docket # 09272018-02
Department of Health
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on September 27, 2018 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.

Medicaid Policy and Compliance Section

09/27/18
Date

Bienville Building • 628 N. Fourth St. • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
Phone: (225) 342-9500 • Fax: (225) 342-5568 • www.ldh.la.gov

LDH/BHSF PUBLIC HEARING

Topic – Durable Medical Equipment Pharmacy Provider Accreditation

Date – September 27, 2018

PERSONS IN ATTENDANCE

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. Ceola Rayford	628 N. 4th Street B.R. LA	225-342-3881	LDH-Policy & Compliance
2. J. Richter	10761 Perkins RD, Ste D	225-769-8111	LPA
3. Irma Gauthier	628 N 4th St. B.R. LA	225-344-5691	LDH - Benefit & Covered Services
4. Tiffany Pitts	628 N. 4th St BR, LA	225-342-6904	LDH - Benefits & Covered Services
5. Randal Johnson	5673 Spanish Town Road	225-334-9165	johnson@LPAnow.org
6.			

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

October 5, 2018

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Taylor F. Barras, Speaker of the House
The Honorable Fred H. Mills, Jr., Chairman, Senate Committee on Health and Welfare
The Honorable Frank A. Hoffmann, Chairman, House Committee on Health and Welfare
The Honorable Eric LaFleur, Chairman, Senate Finance Committee
The Honorable Cameron Henry, Chairman, House Appropriations Committee

FROM: Rebekah E. Gee MD, MPH Cindy Rowe
Secretary

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Inpatient Hospital Services.

The Department published a Notice of Intent on this proposed Rule in the August 20, 2018 issue of the *Louisiana Register* (Volume 44, Number 8). A public hearing was held on September 27, 2018 at which provider representatives and Louisiana Department of Health staff were present. Oral testimony and written correspondence was received regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the November 20, 2018 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification;
3. the public hearing attendance roster;
4. summary of all oral testimony at the public hearing;
5. summary of all written comments received by the agency;
6. the agency's response to Debbie Tullier;
7. the agency's response to Gary Branum;
8. the agency's responses to Laura Tarantino (2);
9. the agency's response to Michael C. Freeman; and

10. the agency's response to Paul A. Salles.

REG/CR/RKA

Attachments (11)

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services
(LAC 50:V.Subpart 1)

The Department of Health, Bureau of Health Services Financing proposes to repeal and replace LAC 50:V.Subpart 1 and the following uncodified Rules in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act:

Register Date	Title	Register Volume, Number	Page Number
July 20, 1977	Policy change to allow hospital reimbursement when dentists admit patients	Vol. 3, No. 7	309
July 20, 1977	Policy change to permit the use of treatment passes	Vol. 3, No. 7	309
August 20, 1978	Extension of hospitalization beyond yearly maximum	Vol. 4, No. 8	296
March 20, 1980	Inpatient hospital benefits for diagnostic procedures	Vol. 6, No. 3	113
April 20, 1982	MAP exception to Medicare reimbursement	Vol. 8, No. 4	189
December 20, 1982	Prior authorization for elective surgery	Vol. 8, No. 12	650
June 20, 1983	Discontinue use of PSROs	Vol. 9, No.6	413
June 20, 1983	Inpatient Hospital Services	Vol. 9, No.6	414-415
August 20, 1983	Title XIX inpatient hospital reimbursement method	Vol. 9, No.8	562
August 20, 1984	Change in in-patient hospital reimbursement methodology	Vol. 10, No. 8	599
October 20. 1984	Hospital reimbursements	Vol. 10, No. 10	802

June 20, 1985	Hospital Program one-year rate freeze	Vol. 11, No. 6	637
July 20, 1985	Hospital Program one-year freeze	Vol. 11, No. 7	688
October 20, 1985	MAP-Reimbursement for inpatient hospital services: transplant	Vol. 11, No. 10	947
November 20, 1985	Inpatient hospital, eliminate incentive payments	Vol. 11, No. 11	1080
December 20, 1985	MAP-Delete prior authorizations for surgical procedures	Vol. 11, No. 12	1147
April 20, 1986	MAP-Cap "Carve Out" Units	Vol. 12, No. 4	243-244
October 20, 1986	Hospital program rate freeze	Vol. 12, No. 10	678
February 20, 1987	MAP-Hospital interim per diem reduced	Vol. 13, No. 2	92
October 20, 1987	MAP-Psychiatric hospitals standards for payment	Vol. 13, No. 10	578
June 20, 1988	MAP-Hospital program rate freeze	Vol. 14, No. 6	351
December 20, 1988	Inpatient psychiatric service reimbursement	Vol. 14, No. 12	869
November 20, 1989	MAP-Certification of Need for Psychiatric hospitalization	Vol. 15, No. 11	976
April 20, 1992	MAP-vendor payments	Vol. 18, No. 4	391
October 20, 1992	Inpatient Hospital Services Reimbursement (Infants Under One Year)	Vol. 18, No. 10	1132
June 20, 1993	Inpatient Psychiatric Services -Reimbursement	Vol. 19, No. 6	751
July 20, 1993	Hospital Neurological Rehabilitation Program	Vol. 19, No. 7	893-895
June 20, 1994	Hospital Prospective Reimbursement Methodology	Vol. 20, No. 6	668
June 20, 1994	Pre-admission Certification and Length of Stay Criteria for Inpatient Hospital Services	Vol. 20, No. 6	668-669
June 20, 1995	Inpatient Psychiatric Services	Vol. 21, No. 6	575-582
January 20, 1996	Hospital Program-Median	Vol. 22, No. 1	32-33

January 20, 1996	Out-of-State Services	Vol. 22, No. 1	33
January 20, 1996	Reimbursement Inflation	Vol. 22, No. 1	33
February 20, 1996	Acute Inpatient Hospital Services, Outlier	Vol. 22, No. 2	106
July 20, 1996	Transplant Services-Reimbursement	Vol. 22, No. 7	584
February 20, 1997	Hospital Prospective Reimbursement Methodology for Rehabilitation Hospitals	Vol. 23, No. 2	202
February 20, 1997	Hospital Prospective Reimbursement Methodology for Long-Term Acute Hospitals	Vol. 23, No. 2	202
September 20, 1997	Hospital Program-Out-of-State Services	Vol. 23, No. 9	1148
December 20, 1997	Long Term Hospital Reimbursement Methodology	Vol. 23, No. 12	1687
May 20, 1999	Hospital Neurological Rehabilitation Program-Reimbursement Methodology	Vol. 25, No. 5	875
May 20, 1999	Inpatient Hospital Psychiatric Services Reimbursement Methodology	Vol. 25, No. 5	875
June 20, 1999	Private Hospital-Reimbursement Methodology.	Vol. 25, No. 6	1099
March 20, 2000	Hospital Prospective Reimbursement Methodology-Teaching Hospitals	Vol. 26, No. 3	498-500
June 20, 2000	Inpatient Hospital Reimbursement-Medicare Part A Claims	Vol. 26, No. 6	1299
November 20, 2000	Inpatient Psychiatric Services-Medicare Part A Claims	Vol. 26, No. 11	2621
November 20, 2000	Inpatient Hospital Services-Medicare Part A Claims	Vol. 26, No. 11	2621
December 20, 2000	Out-of-State Hospitals-Inpatient Services Reimbursement Reduction	Vol. 26, No. 12	2795
June 20, 2001	Inpatient Hospital Services Extensions an Retrospective Reviews of Length of Stay	Vol. 27, No. 6	856
September 20, 2001	Inpatient Hospital Services-Reimbursement Methodology-Well Baby Care	Vol. 27, No. 6	1522
December 20, 2001	Inpatient Psychiatric Services-Reimbursement Increase	Vol. 27, No. 12	2238

February 20, 2002	Inpatient Hospital Services-Medicare Part A	Vol. 28, No. 2	308
August 20, 2002	Public Hospitals-Reimbursement Methodology-Upper Payment Limits	Vol. 28, No. 8	1794
June 20, 2003	Private Hospitals-Outlier Payments	Vol. 29, No. 6	914
December 20, 2003	Out-of-State Hospitals-Inpatient Services Reimbursement Reduction	Vol. 29, No. 12	2801-2802
December 20, 2003	Public Hospitals-Inpatient Reimbursement Methodology-Target Rate per Discharge	Vol. 29, No. 12	2803-2804
June 20, 2004	Inpatient Hospitals-Private Reimbursement Reduction	Vol. 30, No. 6	1211
June 20, 2004	State Owned or Operated Hospitals-Inpatient Psychiatric Services-Reimbursement Increase	Vol. 30, No. 6	1211
November 20, 2004	Private and Public Non-State Owned and Operated Hospitals-Inpatient Psychiatric Services Reimbursement Increase	Vol. 30, No. 11	2489
March 20, 2005	Hospital Program-Transplant Services	Vol. 31, No. 3	667-668
February 20, 2006	Inpatient Hospital Services-State Hospitals-Reimbursement Methodology	Vol. 32, No. 6	247
February 20, 2007	Inpatient Hospital Services-Private Hospitals-Reimbursement Rate Increase	Vol 33, No. 2	289
February 20, 2007	Inpatient Psychiatric Services-Private Hospitals-Reimbursement Rate Increase	Vol 33, No. 2	289

This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing proposes to repeal and replace the Rules governing inpatient hospital services in order to adopt an all patient refined diagnostic related group (APR-DRG) reimbursement methodology and to revise the remaining provisions for inpatient

hospital services to ensure that these provisions are appropriately promulgated in a codified format for inclusion in the *Louisiana Administrative Code*.

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, Bureau of Health Services Financing, LR 44:

§109. Healthcare-Acquired and Provider Preventable Conditions

A. 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 glycemic control, including:
    a. diabetic ketoacidosis;
    b. nonketotic hyperosmolar coma;
    c. hypoglycemic coma;
    d. secondary diabetes 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;

c. orthopedic procedures, including:

i. spine;

ii. neck;

iii. shoulder; or

iv. elbow; or

d. cardiac implantable electronic device procedures; or

10. deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions; or

11. Iatrogenic pneumothorax with venous catherization.

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, Bureau of Health Services Financing, LR 44:

§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 per discharge 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, Bureau of Health Services Financing, LR 44:

§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. 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 discharge 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:

Chapter 5. State Hospitals

§501. General Provisions

A. Definitions

State Hospital—a hospital that is owned and operated by the state of Louisiana.

Freestanding Psychiatric State Hospital—a hospital that is owned and operated by the state of Louisiana and classified as a psychiatric hospital by Medicare per 42 CFR 412.23(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, Bureau of Health Services Financing, LR 44:

§531. 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. Medicaid rates paid to state-owned acute care hospitals shall be 54 percent of allowable Medicaid costs. Payment shall be made by an interim per diem rate. Final reimbursement is determined from the Medicare/Medicaid cost report.

C. 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.

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:

§533. Inpatient Psychiatric Services

A. Payment for inpatient psychiatric services provided by state hospitals shall be made at a prospective per diem rate of $581.11.

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:

Chapter 7. All Patient Refined Diagnostic Related Group

§701. Definitions

All Patient Refined Diagnostic Related Group (APR-DRG)—a classification system developed to categorize inpatient hospital stays into diagnostic categories.

Base Payment—the payment made to hospitals in the APR-DRG reimbursement system on a per case basis excluding any add on payments. The base payment shall be the hospital base rate multiplied by the relative weight of the DRG and severity of illness (SOI) that the case is classified under.

Base Rate—a fixed value assigned to each hospital for reimbursement in the APR-DRG reimbursement system.

Capital Add On Payment—a payment made to a hospital in addition to the base payment to reimburse for capital costs incurred by the hospital.

Department—the Louisiana Department of Health (LDH), or its successor, in the role of designated state agency for administration of the Medical Assistance Program under Title XIX of the Social Security Act or any successor Act.

Direct Graduate Medical Education Add-On Payment—a payment

made to a hospital in addition to the base payment to reimburse for graduate medical education costs incurred by the hospital.

DRG–Diagnostic Related Group.

1. APR-DRG and DRG are used interchangeably. The DRG values shown are the DRG numbers used in APR-DRG grouper version 35.

a. *Acute Care DRGs*–cases in DRGs 4, 5, 10 through 427, 441 through 724, 791 through 850, 861, and 863 through 952.

b. *Mental Health and Substance Abuse DRGs*–cases in DRGs 740 through 776.

c. *Physical Rehabilitation DRGs*–cases in DRGs 860 and 862.

d. *Transplant DRGs*–cases in DRGs 1, 2, 6, 7, 8 and 440.

Fiscal Model-the model used to assess future payments under the DRG payment methodology.

Grouper-the term used for the software that classifies inpatient cases into APR-DRGs.

High Outlier Hospital-a hospital which, when tested in the fiscal model, would have received more than 33 percent of its total reimbursement under the DRG reimbursement system as outlier payments.

Length of Stay Factor-the value assigned to the number of

days in the length of stay for mental health and substance abuse DRGs. The length of stay factors that are used shall be the same across all mental health and substance abuse DRGs. The department shall utilize the length of stay factors published annually by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for use in its inpatient psychiatric facilities prospective payment system.

Long-Term Hospital-a hospital that is classified by Medicare as a long-term hospital per 42 CFR 412.23(e) and does not meet the criteria for placement in peer groups 1 through 9 provided for in this Chapter.

Medicare/Medicaid Cost Report-Form CMS-2552-10 or any successor version of this report released by CMS. The Medicare/Medicaid cost report captures the costs for hospitals to deliver patient services. The Medicare/Medicaid cost report is used as the source for annual payment updates to the DRG reimbursement methodology as outlined in this Chapter.

Outlier Payment-the payment made when the cost of the case exceeds a threshold amount established for the DRG/SOI.

Post Acute Care Day-a day in which a patient who was admitted to a hospital as an inpatient remains in the hospital facility beyond the period in which the patient meets the medical necessity criteria for acute inpatient level of care.

Payment Year-the year beginning January 1 of each calendar

year. Some pricing components for each hospital are updated at the start of each payment year.

Public State-Owned Hospital-a hospital that is owned and operated by the State of Louisiana.

Relative Weight-a factor assigned to a DRG/SOI that measures the resources required to care for the case compared to the resources required for the average case. The average relative weight in a DRG payment system is 1.0. A relative weight with a value less than 1.0 means that the DRG/SOI requires resources that are less than the average case. A relative weight with a value greater than 1.0 means that the DRG/SOI requires resources that are greater than the average case.

SOI-severity of illness level. In the APR-DRG classification system, each DRG has four subordinate classifications based on the designation of severity of illness. The SOI designations are one through four, with one meaning the lowest severity and four meaning the highest severity.

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:

§703. General Provisions

A. Effective with dates of discharge on or after January

1, 2019, the department shall calculate reimbursement for inpatient stays using a diagnostic related group (DRG)-based methodology. This methodology applies to all hospitals, except long-term hospitals and public state-owned hospitals which shall be exempt from the provisions of this Chapter.

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:

§705. Hospital Peer Group and Medicaid Utilization Criteria

A. The base rate assigned to each hospital paid under the DRG payment system shall be based on two components:

1. the hospital's peer group assignment; and

2. the designation of the hospital of its Medicaid utilization volume.

B. Hospitals paid under the DRG payment system shall be assigned to one of the following nine peer groups.

1. Peer Group 1. Hospitals licensed by the State of Louisiana that are physically located in Louisiana, are recognized by Medicare as teaching hospitals, and that maintain 100 or more full-time equivalent interns and residents positions as reported on the Medicare/Medicaid cost report, Schedule E-4, Line 6, for the fiscal year that ended no less than 12 months prior but no more than 24 month prior to the payment year.

a. For purposes of this Rule, full-time equivalent positions will be calculated as defined in 42 CFR 413.78.

2. Peer Group 2. Hospitals licensed by the State of Louisiana that are physically located in Louisiana, are recognized by Medicare as teaching hospitals, and that maintain at least 10 but no more than 99 full-time equivalent interns and residents as reported on the Medicare/Medicaid cost report, Schedule E-4, Line 6 for the fiscal year that ended no less than 12 months prior but no less than 24 months prior to the payment year.

a. For purposes of this Rule, full-time equivalent positions will be calculated as defined in 42 CFR 413.78.

3. Peer Group 3. Hospitals licensed by the State of Louisiana that are physically located in Louisiana and provide acute care services, but do not meet the criteria for peer group 1, peer group 2, or peer group 4.

4. Peer Group 4. Hospitals licensed by the State of Louisiana that are physically located in Louisiana and meet the definition of a rural hospital as defined by R.S. 40:1189.3.

5. Peer Group 5. Hospitals licensed by the State of Louisiana that are physically located in Louisiana, are classified as a psychiatric hospital by Medicare per 42 CFR

412.23(a), and that restrict their scope of services to the treatment of mental health or substance use disorders.

6. Peer Group 6. Hospitals licensed by the State of Louisiana that are physically located in Louisiana, are classified as a rehabilitation hospital by Medicare per 42 CFR 412.23(b), and that restrict their scope of services to physical rehabilitation care.

7. Peer Group 7. Hospitals outside of the State of Louisiana that have enrolled as an inpatient hospital facility with the department, are located within a 50-mile trade area of the Louisiana state border, and that provided at least 500 inpatient hospital days to Louisiana Medicaid beneficiaries in the fiscal model.

8. Peer Group 8. Hospitals located outside of the State of Louisiana that have enrolled as an inpatient hospital facility with the department, are exempt from the Medicare inpatient prospective payment system, and that restrict their scope of services to pediatric care.

9. Peer Group 9. Hospitals located outside of the State of Louisiana that have enrolled as an inpatient hospital facility with the department and do not meet the criteria of peer group 7 or 8.

C. Certain hospitals shall also be assigned a Medicaid utilization designation as follows:

1. Hospitals in utilization group A are hospitals in peer groups 1, 2, 3, 5 or 6 that have either:

a. forty percent or more of their patient days paid by Medicaid as reported on the most recent filed Medicare/Medicaid cost report, Worksheet S-3, for the fiscal year that ended no less than 12 months prior but no more than 24 months prior to the payment year; or

b. five percent or more of all paid Louisiana Medicaid days among in-state acute care hospitals paid under DRG in the fiscal model.

2. Hospitals in utilization group B are hospitals in peer groups 1, 2, 3, 5 or 6 that have more than 20 percent but less than 40 percent of their patient days paid by Medicaid as reported on the most recent filed Medicare/Medicaid cost report, Worksheet S-3, for the fiscal year that ended no less than 12 months prior but no more than 24 months prior to the payment year.

3. Hospitals in Utilization Group C are:

a. hospitals in peer groups 1, 2, 3, 5 or 6 that have less than 20 percent of their patient days paid by Medicaid as reported on the most recent filed Medicare/Medicaid cost report, Worksheet S-3, for the fiscal year that ended no less than 12 months prior but no more than 24 months prior to the payment year; or

b. hospitals in peer groups 4, 7, 8 and 9.

4. For purposes of assigning hospitals to Medicaid utilization groups A, B or C, the department may round a hospital's percentage up to the nearest integer if the hospital's rounding digit is 5 or greater.

D. Effective with dates of discharge on or after January 1, 2019, the data used to test for eligibility in utilization group A, B or C under the Medicaid payer mix test shall be compiled from each hospital's Medicare/Medicaid cost report filed with the department as of June 30, 2018.

1. The Medicaid utilization formula shall be calculated by the department based upon data from Worksheet S-3 Part I. Medicaid utilization shall be equal to the sum of Medicaid days in column 7 (including managed care and subprovider, but excluding observation) divided by the sum of all patient days in column 8 (including managed care and subprovider, but excluding observation).

2. On an annual basis, the department shall compute the utilization group for each hospital for the next payment year using data from the Medicare/Medicaid cost report for the fiscal year that ended no less than 12 months prior but no more than 24 months prior to the payment year.

E. Effective with dates of discharge on or after January 1, 2019, the data used to test for eligibility in utilization

group A under the percent of statewide Medicaid acute care days test shall be calculated from data compiled for the fiscal model stored in the department's claims data warehouse as of March 31, 2018 of all paid Louisiana Medicaid days among in-state acute care hospitals for the 12-month state fiscal year period that ended June 30, 2017.

1. The percent of statewide acute care days formula for a hospital is the hospital's Louisiana Medicaid acute care days divided by the sum of all hospital acute care days in the data warehouse.

2. On an annual basis, the department shall compute the percent of statewide acute care days for each hospital using data stored in the department's claims data warehouse as of March 31 of the year prior to the payment year. The data used in the calculation shall be from discharges in the state fiscal year that ended 18 months prior to the payment year.

F. If a hospital's proportion of Medicaid days as reported on the Medicare/Medicaid cost report used in the calculation changes upward or downward by more than five percentage points from the prior year value, then the department may use additional data sources to validate the results from the Medicare/Medicaid cost report or ask the hospital to validate the values reported on its Medicare/Medicaid cost report.

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:

§707. Base Rate Calculations and Values

A. With the exception of transplant cases, the cases assigned to acute care DRG/SOIs shall be paid using a peer group case rate. For peer groups 1, 2 and 3, the computation of the peer group base rate shall be as follows.

1. Compute the average inflated cost per case (excluding capital and graduate medical education) for all inlier cases in the relative weight database for the peer group.

2. Sum the relative weight values of all inlier cases in the peer group.

3. Compute a peer group case mix score by dividing the sum of the relative weight values by the number of inlier cases.

4. Compute the average inflated cost per case adjusted for case mix by dividing the average inflated cost per case for the peer group by its peer group case mix score.

5. The peer group base rate equals case mix adjusted average cost per case multiplied by .65.

B. Effective with discharges on or after January 1, 2019, the peer group base rates shall be as follows:

1. peer group 1, $4,682.51;

2. peer group 2, $4,581.37; and

3. peer group 3, $4,337.33.

C. Hospitals assigned to utilization group C receive 100 percent of their peer group base rate. Hospitals assigned to utilization group B receive 110 percent of their peer group base rate. Hospitals assigned to utilization group A receive 120 percent of their peer group base rate.

D. For peer group 4, the computation of the peer group base rate shall be in accordance with the Rural Hospital Preservation Act and calculated as follows.

1. Sum the relative weight values of all inlier cases for each hospital in the peer group.

2. Compute the hospital case mix score by dividing the sum of the relative weight values by the number of inlier cases for each hospital.

3. Compute the average inflated cost per case (excluding capital and graduate medical education) for all inlier cases in the relative weight database for each hospital in the peer group.

4. Compute the average inflated cost per case adjusted for case mix for each hospital by dividing the average inflated cost per case for each hospital by its case mix score.

5. Determine the median value within the peer group among all hospitals' case mix adjusted average cost per case.

6. The peer group base rate equals 110 percent of the median value of the case mix adjusted average cost per case within the peer group.

E. Effective with discharges on or after January 1, 2019, the base rate established for hospitals in peer group 4 shall be $9,145.88.

1. Notwithstanding other changes that may be made for all hospitals in the DRG payment methodology, the base rate established for hospitals in peer group 4 shall be rebased at least once every two years. The new base rate will be effective at the start of the payment year.

2. In the years in which the peer group 4 base rate is not rebased, the peer group 4 base rate will be increased for cost inflation. The new base rate will be effective at the start of the payment year. The inflation factor applied is the inpatient hospital four quarter moving average value for quarter 1 of the start of the payment year as published by CMS on June 30 of the year prior to the effective date.

F. Effective with discharges on or after January 1, 2019, the base rate established for hospitals in peer groups 7 and 8 shall be equal to the base rate set for hospitals in peer group 3.

G. Effective with discharges on or after January 1, 2019, the base rate established for hospitals in peer group 9 shall be

equal to 90 percent of the base rate set for hospitals in peer group 3.

H. A transitional base rate shall be established by the department for hospitals that meet criteria as determined in the fiscal model. The transitional base rate applies to cases in acute care DRGs only.

1. Hospitals in peer groups 1, 2 and 4 are eligible for a transitional base rate.

2. To be eligible for a transitional base rate, the fiscal model developed by the department showed that the hospital would receive payment for less than 70 percent of their costs through the modeled DRG payment system.

3. If the hospital met the criteria for a transitional base rate, then a transitional base rate has been set for the hospital such that the payments in the fiscal model are equivalent to 70 percent of the hospital's costs.

4. The transitional base rate is effective for the hospital with discharges on or after January 1, 2019 and will be in force until such time as the base rates for peer groups 1, 2 and 4 are updated.

I. Effective with discharges on or after January 1, 2019, cases assigned to mental health and substance use disorders DRGs shall be paid using a psychiatric per diem rate for all peer groups. This applies to hospitals in all peer groups and shall

be as follows:

1. The psychiatric per diem rate established for hospitals in peer groups 1, 2, 3, 5, 6, 7 and 8 is $950.

a. Hospitals in peer groups 1, 2, 3, 5 and 6 assigned to utilization group B shall receive 110 percent of their peer group psychiatric per diem rate.

b. Hospitals in peer groups 1, 2, 3, 5 and 6 assigned to utilization group A shall receive 120 percent of their peer group psychiatric per diem rate.

2. The psychiatric per diem rate established for hospitals in peer group 4 is $1,140.

3. The psychiatric per diem rate established for hospitals in peer group 9 is $855.

J. Effective with discharges on or after January 1, 2019, cases assigned to rehabilitation DRGs shall be paid using a rehabilitation per diem rate for all peer groups. This applies to hospitals in all peer groups and shall be as follows.

1. The rehabilitation per diem rate established for hospitals in peer groups 1, 2, 3, 5, 6, 7 and 8 is $500.

a. Hospitals in peer groups 1, 2, 3, 5 and 6 assigned to utilization group B shall receive 110 percent of their peer group rehabilitation per diem rate.

b. Hospitals in peer groups 1, 2, 3, 5 and 6 assigned to utilization group A shall receive 120 percent of

their peer group rehabilitation per diem rate.

2. The rehabilitation per diem rate established for hospitals in peer group 4 is $600.

3. The rehabilitation per diem rate established for hospitals in peer group 9 is $450.

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:

§709. Capital Add-On Values

A. Effective with discharges on or after January 1, 2019, hospitals in peer groups 1, 2, 3, 4, 7, 8 and 9 shall be eligible for a capital add-on payment for all acute care DRG cases. The add-on payment is added to the hospital's base payment and is specific to each hospital.

B. The computation of the hospital capital add-on value for hospitals in peer groups 1, 2, 3 and 4 shall be computed from each hospital's Medicare/Medicaid cost report as follows.

1. Sum the capital costs from Worksheet D part I, column 1, line 200 and Worksheet D part II, column 1, line 200.

2. Obtain total acute discharges from Worksheet S-3, part I, column 15, line 14.

3. The capital cost per discharge is the capital costs divided by the total acute discharges.

4. The hospital capital add on value shall equal the capital cost per discharge multiplied by .65.

C. Hospitals shall be subject to a ceiling or floor value on their hospital capital add-on value within their peer group. The floor and ceiling values shall be computed separately for the hospitals in peer groups 1, 2, 3 and 4 as follows:

1. Compute the straight average capital add-on value within each peer group.

2. Multiply the straight average capital add-on value by .65.

3. Compute the standard deviation value within each peer group based on the values in C.2 above.

4. Identify the hospitals that have values that are two standard deviations above the peer group average value in C.2 above. These hospitals are deemed high outlier hospitals.

5. Remove the high outlier hospitals from the calculation and recompute the straight average capital add-on value within each peer group using the remaining values computed in C.2 above.

6. Compute the floor and ceiling value for each peer group. The floor value is defined as the value that is one standard deviation below the mean computed in C.5 above. The ceiling value is defined as the value that is one standard deviation above the mean computed in C.5 above.

7. Assign the floor value to hospitals that have a computed hospital capital add-on value below the floor for their peer group.

8. Assign the ceiling value to hospitals with a hospital capital add-on value above the ceiling for their peer group.

D. Effective January 1, 2019, hospitals in peer groups 7, 8 and 9 shall receive the same capital add-on value. For hospitals in peer groups 7 and 8, the value shall be equal to the straight average capital add-on value for peer group 3. For hospitals in peer group 9, the value shall be equal to 90 percent of the straight average capital add-on value for peer group 3.

E. Hospital capital add-on values shall be updated on an annual basis. The effective date for updated values shall be with discharges on or after January 1 in each calendar year. The source data used to compute the updated values shall be the most recent filed Medicare/Medicaid cost report, submitted by each hospital in peer groups 1, 2, 3 and 4, for the fiscal year that ended no less than 12 months prior but no more than 24 months prior to the effective date.

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:

§711. Direct Graduate Medical Education Add-On Values

A. Effective with discharges on or after January 1, 2019, hospitals in peer groups 1 and 2 shall be eligible for a direct graduate medical education add-on payment for all acute care DRG cases. The add-on payment is added to the hospital's base payment. The direct graduate medical education add-on payment shall be specific to each hospital. When the payment for an acute care DRG case is made by a prepaid risk-bearing managed care organization (MCO), the direct graduate medical education add-on payment associated with the case will be paid directly by the department.

1. Payments will be made by the department to each hospital in peer groups 1 and 2 on a quarterly basis.

2. The hospital will submit a report to the department by the last day of each calendar quarter.

3. The report will itemize inpatient cases paid by the MCOs to the hospital during the calendar quarter prior to the calendar quarter in which the report is due.

4. The payment to the hospital shall be calculated by multiplying the number of discharges submitted on the quarterly report times the hospital's direct graduate medical education add-on value.

5. Payment amounts shall be verified by the

department using reports of MCO paid inpatient discharges generated from encounter data. Payment adjustments and recoupments shall be made as necessary up to one year after the initial claim payment is made by the department.

B. The direct graduate medical education add-on value shall be computed from each hospital's Medicare/Medicaid cost report as follows:

1. Sum the direct graduate medical education costs from Worksheet B part I, column 21, line 118 and Worksheet B part I, column 22, line 118.

2. Obtain total acute discharges from Worksheet S-3, part I, column 15, line 14.

3. The direct graduate medical education cost per discharge is the direct graduate medical education costs divided by the total acute discharges.

4. The hospital direct graduate medical education add-on value shall equal the direct graduate medical education cost per discharge multiplied by .65.

C. Hospital direct graduate medical education add-on values shall be updated on an annual basis. The effective date for updated values shall be for discharges on or after January 1 in each calendar year. The source data used to compute the updated values shall be the most recent filed Medicare/Medicaid cost report, for the fiscal year that ended no less than 12

months prior but no more than 24 months prior to the effective date.

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:

§713. Calculation of Relative Weight Values

A. Effective with discharges on or after January 1, 2019, the department shall use the designated APR-DRG grouper software to set the relative weight values for DRG/SOIs that are used for payment.

B. Each DRG/SOI level shall be assigned a relative weight value that is multiplied by the hospital's base rate to compute the base payment for the case. However, DRG 955 and 956 shall be assigned a relative weight value of zero.

C. The steps for computing the DRG/SOI relative weight values shall be as follows.

1. All cases with the same DRG/SOI assignment from the APR-DRG are grouped together.

2. The cost values assigned to all cases in the same DRG/SOI are summed and an average cost per case within each DRG/SOI is computed.

3. Trim points are set for cost values on the low and high side around the average cost. The low and high cost

trim values are set within each DRG/SOI at two standard deviations above or below the mean cost within the DRG/SOI.

4. Any claims with a cost value below the low trim point or above the high trim point are removed from the relative weight calculation.

5. A revised average cost per case for the cases inside the trim points within each DRG/SOI is computed.

6. The average cost per case among all cases inside the trim points of every DRG/SOI is computed.

7. The provisional relative weight value for each DRG shall be the average cost per case for the DRG/SOI divided by the average cost per case among all DRG/SOIs.

D. After the provisional relative weight values are computed, two tests shall be conducted by the department to determine the stability of each relative weight.

1. The DRG must have at least ten cases.

2. There must be statistical confidence in the level of variance allowed between the costs of the cases assigned to the DRG/SOI. The formula for this test shall be the number of claims being less than [(1.645/0.25) x (standard deviation/mean cost)](^2).

E. DRG/SOIs that do not meet both of the tests set forth in Paragraph D above shall be deemed to have unstable relative weight values.

1. If a DRG has one or more unstable relative weight values, the cases in the DRG/SOI level with the unstable relative weight shall be merged with the cases of an adjoining DRG/SOI with a stable relative weight.

2. A new average cost per case and new relative weight value shall be computed using the joined data and the new relative weight value shall be assigned to both DRG/SOI levels.

3. The tests for stability are rerun. If the tests for stability pass, then the new relative weight value shall be used.

4. If the new relative weight is not deemed to be stable, the process shall be repeated to merge the cases of three SOI levels or as many as four SOI levels under the DRG/SOI until the relative weight value is determined to be stable.

F. Within a DRG, the relative weight values are intended to increase as the SOI increases. The one exception to this is the relative weight values in DRG 588. If, upon initial computation of the relative weight values do not increase when the SOI level increases, an illogical progression has occurred.

1. When an illogical progression is found, then the cases from the adjoining SOIs inside the DRG shall be merged and a new average cost per case shall be computed for the two combined SOIs.

2. An updated relative weight shall be computed and

assigned to both SOIs. The test for illogical progressions shall be rerun.

G. All relative weights shall be recalibrated so that the average relative weight equals 1.0.

H. For the relative weight values that were developed for use with discharges on or after January 1, 2019, three years of cases shall be utilized in the calculations. Paid Medicaid cases with discharges from July 1, 2014 to June 30, 2017 shall be used as well as uninsured patient claims reported by hospitals with dates of discharge July 1, 2014 to December 31, 2016.

I. The cost value assigned to each case in the relative weight development database shall utilize cost data from each hospital that had cases in the relative weight database. The cost assigned shall be the cost values from each hospital's Medicare/Medicaid cost report that matched to the year in which the discharge occurred. The cost for each case in the relative weight database shall be inflated to December 31, 2018. The inflation factors used to inflate claim costs shall be derived from the CMS' economic index (Inpatient Hospital PPS). A four-quarter moving average percent change value shall be assigned for each month in the 36-month database of claims from July 1, 2014 through June 30, 2017.

J. The department may choose to update the version of the

APR-DRG grouper it uses upon the release of subsequent versions. If the department chooses to update to another APR-DRG grouper version, the department will set relative weight values to any new DRG/SOIs in place in the new grouper version.

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:

§713. Payment Formulas

A. Effective with discharges on or after January 1, 2019, four payment formulas shall be utilized for cases paid under the APR-DRG system. The formula that is applied shall be dependent upon the DRG that the discharge is assigned by the DRG grouper.

B. The payment formula for acute care DRG cases shall be the base payment plus the capital add-on payment plus the direct graduate medical education add-on payment (if the hospital is eligible) plus the outlier payment (if the case meets the criteria).

1. The outlier payment shall be made when the cost of the case is greater than the sum of the base DRG payment plus the capital add-on plus the direct graduate medical education add on plus the fixed threshold value.

a. The cost of the case shall equal the charges billed on the case multiplied by a hospital-specific cost-to-

charge ratio.

b. The hospital-specific cost-to-charge ratio shall be computed for each hospital in peer groups 1, 2, 3 and 4 using the hospital's most recent filed Medicare/Medicaid cost report, for the fiscal year that ended no less than 12 months prior but no more than 24 months prior to the payment year. The cost-to-charge ratio shall be computed as the total costs on Worksheet C, part I, column 5, line 200 divided by the total charges on Worksheet C, part I, column 8, line 200. Each hospital's cost-to-charge ratio shall be updated on an annual basis effective January 1 of each year.

c. The fixed threshold value varies based on hospital or DRG attribution. The fixed threshold value assigned is:

i. $10,000 for all cases for any hospital that meets the definition of a high outlier hospital;

ii. $10,000 for cases for all other hospitals assigned to burn DRGs 841, 842, 843 and 844; or

iii. $30,000 for DRGs for all other hospitals other than burn DRGs.

d. If the cost of the case exceeds the calculated threshold value, then the costs above the threshold value shall be multiplied by an outlier payment percentage. The outlier payment shall equal the costs above the threshold

multiplied by:

i. 1.0 for hospitals deemed a high outlier hospital;

ii. 0.96 for hospitals assigned to utilization group A;

iii. 0.88 for hospitals assigned to utilization group B; or

iv. 0.80 for hospitals assigned to utilization group C.

2. For acute care DRG cases, where the discharge status code on the case equals 02, a transfer payment shall be made that equals the lesser of the cost of the case or the regular DRG payment, respectively calculated as follows:

a. The cost of the case equals the charges billed on the case multiplied by a hospital-specific cost-to-charge ratio.

b. The regular DRG payment equals the base rate multiplied by relative weight plus the capital add-on plus the direct graduate medical education add-on (if hospital is eligible) plus the outlier payment (if the case meets the criteria).

C. The payment formula for mental health and substance use disorder DRG cases shall be the psychiatric per diem rate multiplied by the relative weight then multiplied by the length

of stay factor.

D. The payment formula for physical rehabilitation DRG cases shall be the rehabilitation per diem rate multiplied by the relative weight.

E. The payment formula for transplant DRG cases shall be the per diem payment plus the ancillary payment plus the organ acquisition payment.

1. The per diem payment equals the number of days in the length of stay multiplied by a hospital-specific per diem rate.

2. The ancillary payment equals the charges on the claim excluding room and board and organ acquisition multiplied by a hospital-specific ancillary cost-to-charge ratio.

3. The organ acquisition payment shall be a set payment that is specific to the hospital and to the organ or organs. If the transplant case involves multiple organs, the hospital will be eligible for payment for the acquisition costs of each organ transplanted.

4. The source for the data used in this formula shall be derived from each hospital's Medicare/Medicaid cost report. The values used in the payment formula shall be updated annually with an effective date of January 1. The Medicare/Medicaid cost report used in the calculation shall be the cost reports submitted by hospitals to the department for

the fiscal year that ended no less than 12 months prior but no more than 24 months prior to the effective date.

5. The sources for each payment component shall be as follows.

a. For the per diem rate, the cost value shown on Worksheet D-1, line 43 or 46 for intensive care unit per diem shall be multiplied by .90.

b. For the ancillary cost-to-charge ratio, costs from Worksheet C, part I, column 5, lines 50 through 92 shall be divided by the charges from Worksheet C, part I, column 8, lines 50 through 92.

c. For the organ acquisition cost, the cost from Worksheet D-4 line 61 shall be divided by the total usable organs on line 62.

d. A separate Worksheet D-4 shall be maintained for each organ. In the case of bone marrow, if the hospital did not record the specific acquisition cost of bone marrow on a separate Worksheet D-4, the payment for the acquisition of bone marrow shall be bone marrow acquisition charges multiplied by the ancillary cost-to-charge ratio.

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:

§915. Post Acute Payments

A. Effective with discharges on or after January 1, 2019, a hospital shall not be denied payment for the post-acute days unless the department or MCO can provide the services necessary to ensure the continued safety of the patient in a setting other than the hospital. When the following conditions are met, the hospital shall be paid a post-acute payment in addition to the DRG case payment for each post-acute day that the patient remains in the care of the hospital:

1. The hospital is assigned to peer group 1, 2, 3 or 4;

2. The patient is assigned to an acute care DRG;

3. The hospital has given 36 hours advance notice to the department, or the MCO, that the patient no longer requires inpatient level acute care; and

4. The hospital has provided documentation to the department, or the MCO, showing that inpatient level of care is no longer necessary for the patient.

B. Payment shall be made to the hospital for post-acute days at a rate of $700 per day upon submission of the claim by the hospital if all conditions are met. The department or the MCO may choose to conduct a post-payment review on payments made under this payment formula to determine if, in fact, the patient no longer met medical necessity criteria for acute inpatient

level of care starting with the day that post-acute payment was requested. The department or the MCO may seek recoupment of payment from the hospital on a retrospective basis when the following situations occur:

1. if it has been determined through nationally recognized clinical guidelines that the patient still met medical necessity criteria for acute inpatient level of care for some or all days paid under the post-acute payment policy; or

2. payment was made under the post-acute payment methodology for days within the published average length of stay for the DRG/SOI level that the patient was ultimately classified into using the APR-DRG grouper.

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:

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter A. General Provisions (Reserved)

Subchapter B. Reimbursement Methodology

§951. Acute Care Hospitals

A. Low Income and Needy Care Collaboration. 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. *Non-State Hospital*—a hospital which is owned or operated by a private entity.

b. *Low Income and Needy Care Collaboration Agreement*—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. 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 §951.A.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.

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:

§953. 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.

D. 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 neonatal intensive care unit (NICU) or pediatric intensive care unit (PICU) costs and charge data from the most current cost report.

E. 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.

F. Beginning with SFY 2020, the outlier pool will cover eligible claims through dates of service on or before December 31, 2018 and shall not exceed $5,000,000.

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, Bureau of Health Services Financing, LR 44:

§955. Long-Term Hospitals

A. Qualifying Criteria. Hopsitals licensed by the state of Louisiana that are physically located in Louisiana and are classified by Medicare as a long-term hospital per 42 CFR 412.23(e).

B. Reimbursement. Payment for inpatient services provided in a long-term hospital shall be at a prospective per diem rate of $826.54.

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, Office of the Secretary, Bureau of Health Services Financing, LR 44:

§957. Public Hospitals

A. 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. 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. 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.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:

§959. Children's Specialty Hospitals

A. Effective for dates of service on or after February 1, 2012 through a discharge date on or before December 31, 2018,

medical education payments for inpatient services which are reimbursed by a prepaid risk-bearing 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.

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:

Chapter 11. Rural, Non-State Hospitals

Subchapter A. General Provisions (Reserved)

Subchapter B. Reimbursement Methodology

§1125. Small Rural Hospitals

A. Low Income and Needy Care Collaboration. 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. *Non-State Hospital*—a hospital which is owned or operated by a private entity.

b. *Low Income and Needy Care Collaboration Agreement*—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 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, Bureau of Health Services Financing, LR 44:

Chapter 13. Teaching Hospitals

Subchapter A. General Provisions (Reserved)

Subchapter B. Reimbursement Methodology

§1331. Acute Care Hospitals

A. Effective for dates of service on or after February 1, 2012 through a date of discharge on or before December 31, 2018, medical education payments for inpatient services which are reimbursed by a prepaid risk-bearing 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, Bureau of Health Services Financing, LR 44:

Chapter 17. Public-Private Partnerships

§1701. Baton Rouge Area Hospitals

A. Qualifying Criteria. 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 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, Bureau of Health Services Financing, LR 44:

§1703. Reimbursement Methodology

A. A major teaching hospital that enters into a

cooperative endeavor agreement with the Department of Health 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 reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid 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, Bureau of Health Services Financing, LR 44:

Chapter 19. Medicare Part A Claims

§1901. Inpatient Hospital Services

A. Medicaid reimbursement on Medicare Part A claims for inpatient hospital services is limited to the Medicaid maximum payment by comparing the Medicare payment to the amount that Medicaid would have paid. If the Medicare payment amount exceeds the amount that Medicaid would pay on the claim, the claim is adjudicated as a paid claim with a zero payment. If the amount that Medicaid would have paid exceeds the Medicare payment, the claim is reimbursed at the lesser of the coinsurance and deductible or up to the Medicaid maximum. If the Medicaid

payment is reduced or eliminated as a result of applying the limit of the Medicaid maximum payment, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) is considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

B. Medicare Part A claims for inpatient services in small rural hospitals, and skilled nursing units located in small rural hospitals, are excluded from the Medicaid maximum payment limitation provision. Small rural hospitals are defined in R.S. 40:1189.3.

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:

§1903. Inpatient Psychiatric Services

A. Medicaid reimbursement on Medicare Part A claims for inpatient psychiatric services is limited to the Medicaid maximum payment by comparing the Medicare payment to the amount that Medicaid would have paid. If the Medicare payment amount exceeds the amount that Medicaid would pay on the claim, the claim is adjudicated as a paid claim with a zero payment. If the amount that Medicaid would have paid exceeds the Medicare payment, the claim is reimbursed at the lesser of the

coinsurance and deductible or up to the Medicaid maximum. If the Medicaid payment is reduced or eliminated as a result of applying the limit of the Medicaid maximum payment, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) is considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

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:

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

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed

Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct cost or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, September 27, 2018 at 9:30 a.m. in Room 173, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION
September 27, 2018
9:30 a.m.

RE: Inpatient Hospital Services
Docket # 09272018-03
Department of Health
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on September 27, 2018 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.

Medicaid Policy and Compliance Section

09/27/18
Date

Bienville Building • 628 N. Fourth St. • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
Phone: (225) 342-9500 • Fax: (225) 342-5568 • www.ldh.la.gov

LDH/BHSF PUBLIC HEARING

Topic – Inpatient Hospital Services

Date – September 27, 2018

PERSONS IN ATTENDANCE

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. Ceola Rayford	628 N. 4th Street B.R.La	225-342-3881	LDH Policy & Compliance
2. Christine Sullivan	"	225342 9475	LDH Rate Setting & Audit
3. Amara Blust	628 N. 4th Street BR	225 342 9874	LDH Director's office
4. Michael Freeman	~~628 N. 4th St. BR~~ 5525 United Plaza Blvd	(225) 301-2510	LTCH's
5. Bob Remy	200 STATE ST NOCH	(504) 669-3973	LCMC Health
6. Stanley Bordelon	628 N. 4th St. BRLA	219-3454	LDH

SUMMARY OF PUBLIC HEARING TESTIMONY

Proposed Rule: Inpatient Hospital Services
Public Hearing Date: 09/27/18
Docket No. : 09272018-03
Conducted By: Louisiana Department of Health, Bureau of Health Services Financing Staff

Oral Testimony Given By	Organization Represented	Summary of Comments
Michael Freeman	TFG Consulting	Supports the payment reform and is long overdue. However the 31 long term care hospitals are not included. They meet the same criteria as acute care hospitals and are not nursing homes. With this rule they are paid less. They will propose in writing a recommendation for coverage of LTC hospitals.

SUMMARY OF WRITTEN COMMENTS

Proposed Rule: Inpatient Hospital Services
Public Hearing Date: 09/27/18
Docket No. : 09272018-03
Conducted By: Louisiana Department of Health, Bureau of Health Services Financing Staff

Written Comments Received From	Mode of Receipt	Summary of Comments
Debbie Tullier via Stephen Wright, Lake Pines Hospital	Medicaid Policy Email Account	Expressed concerns relative to the requirements for submission of cost reports and requests that options for interim cost report calculations determined by existing data sets be considered as an alternative.
Gary Branum, Universal Health Services, Inc.	Medicaid Policy Email Account	Proposes: 1. One Base Payment Rate for all cases assigned to mental health and substance use disorders DGR's. 2. Mental health and substance use disorder DRG's payment calculation based on per diem methodology. 3. Post acute payments for mental and substance use DRGs. Requests that §915 be expanded or amended as needed to provide payment to Peer Group 5 hospitals and expanded or amended to provide for the payment of mental health and substance use DRGs.
Laura Tarantino, Ocean's Healthcare	2 Emails to Medicaid Policy Email Account	Requests: 1. That an amendment be considered that permits a newly licensed inpatient psychiatric hospital that has not filed a Medicare/Medicaid Cost Report, the assignment to utilization group A-C based upon projected utilization with corresponding immediate increase in payment and subject to validation by the filed Medicare/Medicaid cost report, Worksheet S-3, for such period. 2. That language be added to §91S.A.1 and 2 to correct a disparity in the proposed reimbursement for post-acute patient days related to an inpatient who has a primary acute diagnosis versus a patient who has a primary psychiatric diagnosis when such patient no longer meets medical necessity criteria and "the department or MCO cannot provide the services necessary to ensure the continued safety of the patient in a setting other than the hospital."
Michael C. Freeman, TFG Consulting, LLC	Medicaid Policy Email Account	Proposes amendments to the Rule concerning the coverage of long term care hospitals in order to: 1. Adequately cover the cost of covered care. 2. Create equity across hospitals. 3. Promote access to Medicaid beneficiaries. 4. Payments reflecting acuity and resource intensity. He recommends that the rule be amended to provide relief to long term care hospitals by increasing the per diem rate described in §955.B to either the greater of an estimate of the case mix adjusted average daily payment of all acute care and rural hospitals under this proposed rule or increasing the

		current 826.54 per diem rate by 38% to $1,140.62. He also requests provisions added to allow long term care hospitals with rehabilitation or psychiatric units to be paid in the same manner as acute care hospitals using either the rehab or psychiatric payment rates.
Paul A. Salles via Greg Waddell, Louisiana Hospital Association	Medicaid Policy Email Account	Requests the Louisiana Department of Health give consideration to the following concerns: 1. APR-DRG information transparency. Believes LDH needs to publish all necessary components on the website and develop a DRG pricing calculator 2. Claims and billing. a. Concerned there is no interim billing especially for patients in high acuity units. He requests LDH develop a policy for inpatient stays that exceed 30 days. b. Requests clarification concerning a situation where a patient stay began prior to 1/1/19 and an interim billing has already occurred. c. Requests clarification of how inpatient encounters are to be properly billed in situation when the patient I moved in-hospital between a med surg unit and a psych or rehab unit. He requests LDH affirm that if both stays meet medical necessity then hospital can submit 2 claims and expect 2 payments. d. Requests guidance on how to bill when patient is only Medicaid eligible for part of the stay. e. Requests that LDH ensure that both the MCO and Molina system are configured to capture all of the procedure and diagnosis codes related to the IP hospital stay. 3. Testing prior to implementation. Requests hospitals to be allowed to test with both the MCO's and Molina and feel this should be offered mid to late October to ensure the appropriate amount of time. 4. Post-acute discharge policy. a. Encourages LDH to increase the proposed $700 day post-acute per diem and requests LDH to develop detailed operational and process guidelines. b. Requests LDH develop a post-acute methodology for excluded peer groups, particularly psychiatric care.

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

October 9, 2018

Debbie Tullier
Lake Pines Hospital
3639 Loyola Avenue
Kenner, LA 70065

Dear Ms. Tullier:

RE: Notice of Intent for Inpatient Hospital Services

This letter is in response to your correspondence regarding the Notice of Intent for Inpatient Hospital Services which was published in the August 20, 2018 edition of the *Louisiana Register.*

The Notice of Intent (NOI) proposes to repeal and replace the Rules governing inpatient hospital services in order to adopt an all patient refined diagnostic related group (APR-DRG) reimbursement methodology, and to revise the remaining provisions for inpatient hospital services to ensure that these provisions are appropriately promulgated in a codified format for inclusion in the *Louisiana Administrative Code.*

The Department has reviewed and given consideration to your comments regarding this proposed Rule. Your correspondence expressed concerns relative to the requirements for submission of cost reports, and requested that options for interim cost report calculations determined by existing data sets be considered as an alternative. We understand your concerns; however, the Department has been intentional in its use of industry standards for cost reporting, specifically a hospital's Medicare/Medicaid cost report filed with the Department as of June 30, 2018, in order to provide for the standard treatment of all hospitals. Alternative data sets are not acceptable for this purpose and as such, the provisions of the NOI relative to this requirement will not be revised.

I would like to thank you for taking the time to provide comments and hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens.

Should you have any questions or comments regarding Medicaid administrative rulemaking activity, you may contact Veronica Dent, Medicaid Program Manager, at 225-342-3238 or by email to Veronica.Dent@la.gov.

Sincerely,

Jen Steele
Medicaid Director

JS/KHB/VYD

c: Darlene Budgewater, Medicaid Deputy Director
Pamela Diez, Deputy Undersecretary
Erin Lee, Medicaid Rate Setting and Audit Section

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

October 9, 2018

Gary Branum
Universal Health Services, Inc.
UHS of Delaware, Inc.
1000 Health Park Drive
Building Three, Suite 400
Brentwood, TN 37027

Dear Mr. Branum:

RE: Notice of Intent for Inpatient Hospital Services

This letter is in response to your correspondence regarding the Notice of Intent for Inpatient Hospital Services which was published in the August 20, 2018 edition of the *Louisiana Register*.

The Notice of Intent (NOI) proposes to repeal and replace the Rules governing inpatient hospital services in order to adopt an all patient refined diagnostic related group (APR-DRG) reimbursement methodology and to revise the remaining provisions for inpatient hospital services to ensure that these provisions are appropriately promulgated in a codified format for inclusion in the *Louisiana Administrative Code*.

The Department has reviewed and given consideration to your comments regarding this NOI. Your correspondence expressed concerns relative to the post-acute payment provisions and requested that they be expanded or amended to provide payment to Peer Group 5 hospitals, and to provide for the payment of mental health and substance use DRGs. While the decision has been made to proceed with these provisions as published in the *Louisiana Register*, the Department remains committed to a multi-year process of modernizing its Medicaid hospital payment methods, and is open to considering the issues you raise in its ongoing collaboration with hospital stakeholders in consideration of future reimbursement policy changes.

I would like to thank you for taking the time to provide comments and hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens.

Should you have any questions or comments regarding Medicaid administrative rulemaking activity, you may contact Veronica Dent, Medicaid Program Manager, at 225-342-3238 or by email to Veronica.Dent@la.gov.

Sincerely,

Jen Steele
Medicaid Director

JS/KHB/VYD

c: Darlene Budgewater, Medicaid Deputy Director
Pamela Diez, Deputy Undersecretary
Erin Lee, Medicaid Rate Setting and Audit Section

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

October 9, 2018

Laura Tarantino
Oceans Healthcare
5850 Granite Parkway, Suite 300
Plano, TX 75024

Dear Ms. Tarantino:

RE: Notice of Intent for Inpatient Hospital Services

This letter is in response to your correspondence regarding the Notice of Intent for Inpatient Hospital Services which was published in the August 20, 2018 edition of the *Louisiana Register.*

The Notice of Intent (NOI) proposes to repeal and replace the Rules governing inpatient hospital services in order to adopt an all patient refined diagnostic related group (APR-DRG) reimbursement methodology and to revise the remaining provisions for inpatient hospital services to ensure that these provisions are appropriately promulgated in a codified format for inclusion in the *Louisiana Administrative Code.*

The Department has reviewed and given consideration to your comments regarding this proposed Rule. Your correspondence expressed concerns relative to inpatient hospital reimbursement for mental illness or substance use disorder treatment and the classification of hospitals based on utilization. Although the decision has been made to proceed with the provisions of this NOI as published in the *Louisiana Register*, the Department remains committed to a multi-year process of modernizing its Medicaid hospital payment methods, and is open to considering the issues you raise in its ongoing collaboration with hospital stakeholders in consideration of future reimbursement policy changes.

I would like to thank you for taking the time to provide comments and hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens.

Should you have any questions or comments regarding Medicaid administrative rulemaking activity, you may contact Veronica Dent, Medicaid Program Manager, at 225-342-3238 or by email to Veronica.Dent@la.gov.

Sincerely,

Jen Steele
Medicaid Director

JS/KHB/VYD

c: Darlene Budgewater, Medicaid Deputy Director
Pamela Diez, Deputy Undersecretary
Erin Lee, Medicaid Rate Setting and Audit

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

October 9, 2018

Laura Tarantino
Oceans Healthcare
5850 Granite Parkway, Suite 300
Plano, TX 75024

Dear Ms. Tarantino:

RE: Notice of Intent for Inpatient Hospital Services

This letter is in response to your correspondence regarding the Notice of Intent for Inpatient Hospital Services which was published in the August 20, 2018 edition of the *Louisiana Register.*

The Notice of Intent (NOI) proposes to repeal and replace the Rules governing inpatient hospital services in order to adopt an all patient refined diagnostic related group (APR-DRG) reimbursement methodology and to revise the remaining provisions for inpatient hospital services to ensure that these provisions are appropriately promulgated in a codified format for inclusion in the *Louisiana Administrative Code.*

The Department has reviewed and given consideration to your comments regarding this proposed Rule. Your correspondence expressed concerns relative to the use of alternative data sources for classifying hospitals based on utilization. We understand your concerns; however, the Department has been intentional in its use of industry standards for cost reporting, specifically a hospital's Medicare/Medicaid cost report filed with the Department as of June 30, 2018, in order to provide for the standard treatment of all hospitals. Alternative data sources are not acceptable for this purpose and as such, the provisions of the NOI relative to this requirement will not be revised.

I would like to thank you for taking the time to provide comments and hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens.

Should you have any questions or comments regarding Medicaid administrative rulemaking activity, you may contact Veronica Dent, Medicaid Program Manager, at 225-342-3238 or by email to Veronica.Dent@la.gov.

Sincerely,

Jen Steele
Medicaid Director

JS/KHB/VYD

c: Darlene Budgewater, Medicaid Deputy Director
Pamela Diez, Deputy Undersecretary
Erin Lee, Medicaid Rate Setting and Audit

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

October 9, 2018

Michael C. Freeman
TFG Consulting, LLC
8550 United Plaza Blvd., Suite 702
Baton Rouge, LA 70809

Dear Mr. Freeman:

RE: Notice of Intent for Inpatient Hospital Services

This letter is in response to your correspondence regarding the Notice of Intent for Inpatient Hospital Services which was published in the August 20, 2018 edition of the *Louisiana Register*.

The Notice of Intent (NOI) proposes to repeal and replace the Rules governing inpatient hospital services in order to adopt an all patient refined diagnostic related group (APR-DRG) reimbursement methodology and to revise the remaining provisions for inpatient hospital services to ensure that these provisions are appropriately promulgated in a codified format for inclusion in the *Louisiana Administrative Code*.

The Department has reviewed and given consideration to your comments regarding this proposed Rule. Your correspondence expressed concerns relative to the inclusion of long-term care hospitals (LTCH) in the payment reform process, recommended options for reimbursement increases, and requested that LTCH's with rehabilitation or psychiatric units be paid in the same manner as acute care hospitals using either the rehabilitation or psychiatric payment rates. While the decision has been made to proceed with these provisions as published in the *Louisiana Register*, the Department remains committed to a multi-year process of modernizing its Medicaid hospital payment methods, and is open to considering the issues you raise in its ongoing collaboration with hospital stakeholders in consideration of future reimbursement policy changes.

I would like to thank you for taking the time to provide comments and hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens.

Should you have any questions or comments regarding Medicaid administrative rulemaking activity, you may contact Veronica Dent, Medicaid Program Manager, at 225-342-3238 or by email to Veronica.Dent@la.gov.

Sincerely,

Jen Steele
Medicaid Director

JS/KHB/VYD

c: Darlene Budgewater, Medicaid Deputy Director
Pamela Diez, Deputy Undersecretary
Erin Lee, Medicaid Rate Setting and Audit

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

October 9, 2018

Paul A. Salles
President and CEO
Louisiana Hospital Association
9521 Brookline Avenue
Baton Rouge, LA 70809-1431

Dear Mr. Salles:

RE: Notice of Intent for Inpatient Hospital Services

This letter is in response to your correspondence regarding the Notice of Intent for Inpatient Hospital Services which was published in the August 20, 2018 edition of the *Louisiana Register*.

The Notice of Intent (NOI) proposes to repeal and replace the Rules governing inpatient hospital services in order to adopt an all patient refined diagnostic related group (APR-DRG) reimbursement methodology and to revise the remaining provisions for inpatient hospital services to ensure that these provisions are appropriately promulgated in a codified format for inclusion in the *Louisiana Administrative Code*.

The Department has reviewed and given consideration to your comments regarding this proposed Rule. Although, the decision has been made to proceed with the provisions of this NOI as published in the *Louisiana Register*, the Department acknowledges the concerns expressed in your correspondence. We are actively working to develop the FAQ and DRG Pricing Calculator you requested. We are also exploring the other areas of concern noted in your letter, as follows:

- **No interim billing, especially for patients in high acuity units and request to develop a policy for inpatient stays that exceed 30 days.**

  The Department will review further and explore options relative to this matter.

- **Allow hospitals to test with both the Managed Care Organizations and Molina in mid to late October to ensure the appropriate amount of time.**

Encounter testing for Molina must take precedence; however, the Department is willing to accommodate this request on a mutually acceptable timeline.

- **Increase the proposed $700 day post-acute per diem and develop detailed operational and process guidelines.**

  The Department is willing to consider this, among other priorities, in ongoing hospital payment modernization effort.

- **Develop a post-acute methodology for excluded peer groups, particularly psychiatric care.**

  Hospital payment modernization is a multi-year effort, and the Department is open to considering this, among other priorities, for future hospital payment reform.

I would like to thank you for taking the time to provide comments on this NOI in particular. More globally, I wish to express my profound appreciation for the Louisiana Hospital Association's ongoing partnership with the Department in a multiyear effort to modernize its Medicaid's hospital payment methods. The Association's leadership has been instrumental to a truly model effort at an inclusive, transparent and data-driven public policy making process that has leveraged stakeholder expertise and laid a foundation of trust for future collaboration.

Should you have any questions or comments regarding Medicaid administrative rulemaking activity, you may contact Veronica Dent, Medicaid Program Manager, at 225-342-3238 or by email to Veronica.Dent@la.gov.

Sincerely,

Jen Steele
Medicaid Director

JS/KHB/VYD

c: Darlene Budgewater, Medicaid Deputy Director
Pamela Diez, Deputy Undersecretary
Erin Lee, Medicaid Rate Setting and Audit

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

October 5, 2018

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Taylor F. Barras, Speaker of the House
The Honorable Fred H. Mills, Jr., Chairman, Senate Committee on Health and Welfare
The Honorable Frank A. Hoffmann, Chairman, House Committee on Health and Welfare
The Honorable Eric LaFleur, Chairman, Senate Finance Committee
The Honorable Cameron Henry, Chairman, House Appropriations Committee

FROM: Rebekah E. Gee MD, MPH Cindy Rees
Secretary

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Medicaid Employee Criminal History Records Checks.

The Department published a Notice of Intent on this proposed Rule in the August 20, 2018 issue of the *Louisiana Register* (Volume 44, Number 8). A public hearing was held on September 27, 2018 at which only Louisiana Department of Health staff were present. No oral testimony was given or written comments received regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the November 20, 2018 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification; and
3. the public hearing attendance roster.

REG/WJR/CEC

Attachments (3)

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Medicaid Employee Criminal History Records Checks
(LAC 50:I.103)

The Department of Health, Bureau of Health Services Financing proposes to adopt LAC 50:I.103 as authorized by R.S. 36:254 and 254.3, and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R. S. 49:950 et seq.

Act 147 of the 2017 Regular Session of the Louisiana Legislature mandated that the Department of Health perform criminal history records checks of current and prospective employees, contractors and subcontractors within the Medicaid eligibility section with access to federal tax information (FTI) in accordance with the procedures provided in R.S. 15:587.5.

In compliance with the requirements of Act 147, the Department of Health, Bureau of Health Services Financing, proposes to amend the provisions governing the administrative procedures for the administration of the Medical Assistance Program in order to adopt provisions which require current or prospective employees, contractors or subcontractors, within the Medicaid eligibility section that have access to FTI or criminal history record information, to submit to criminal history records checks.

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 1. General Provisions

Chapter 1. Administrative Procedures

§103. Employee Criminal History Records Checks

A. Pursuant to Act 147 of the 2017 Regular Session of the Louisiana Legislature, the Department of Health (the "department") shall perform criminal history records checks of current and prospective employees, contractors or subcontractors, within the Medicaid eligibility section, that have access to federal tax information (FTI) and/or criminal history record information.

1. In compliance with the requirements of R.S. 15.587.5, current or prospective employees, contractors or subcontractors within the Medicaid eligibility section shall be required to submit to a criminal history records check to be conducted by the Louisiana Bureau of Criminal Identification and Information.

a. Fingerprints and other identifying information shall be submitted to the Louisiana Bureau of Criminal Identification and Information by the current or prospective employee, contractor or subcontractor.

2. The department shall also request local criminal history records checks for current or prospective employees, contractors or subcontractors within the Medicaid eligibility

section with access to FTI and/or criminal history record information.

a. The local criminal history records checks request shall be sent to any jurisdiction where the current or prospective employee, contractor or subcontractor has lived, worked or attended school within the last five years.

3. Fingerprinting and national, state and local criminal history records checks shall be used by the department to determine the suitability of current or prospective employees, contractors or subcontractors within the Medicaid eligibility section to access federal tax information and records.

a. Prospective employees shall be subject to fingerprinting and national, state and local criminal history records checks only after a conditional offer of employment has been made.

b. Current employees, contractors and subcontractors shall be subject to fingerprinting and national, state and local criminal history records checks at a minimum of every 10 years.

4. The costs of providing the criminal history records check for current employees, contractors or subcontractor within the Medicaid Eligibility Section shall be charged to the department by the Louisiana Bureau of Criminal Identification and Information for furnishing information

contained in its criminal history and identification files, including any additional costs of providing the national and local criminal history records checks, which pertains to the current or prospective employee, contractor or subcontractor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 254.3 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:

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

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, September 27, 2018 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION
September 27, 2018
9:30 a.m.

RE: Medicaid Employee Criminal History Records Checks
Docket # 09272018-04
Department of Health
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on September 27, 2018 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.

Medicaid Policy and Compliance Section

09/27/18
Date

LDH/BHSF PUBLIC HEARING

Topic – Medicaid Employee Criminal History Records Checks

Date – September 27, 2018

PERSONS IN ATTENDANCE

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. Cecila Rayford	628 N. 4th Street B.R. LA	225-342-3881	LDH Policy & Compliance
2. Kim H. Evans.	"	225-342-1325	LDH Policy
3.			
4.			
5.			
6.			

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

October 5, 2018

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Taylor F. Barras, Speaker of the House
The Honorable Fred H. Mills, Jr., Chairman, Senate Committee on Health and Welfare
The Honorable Frank A. Hoffmann, Chairman, House Committee on Health and Welfare
The Honorable Eric LaFleur, Chairman, Senate Finance Committee
The Honorable Cameron Henry, Chairman, House Appropriations Committee

FROM: Rebekah E. Gee MD, MPH Cindy Rivet
Secretary

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Pharmacy Benefits Management Program - Managed Care Supplemental Rebates.

The Department published a Notice of Intent on this proposed Rule in the August 20, 2018 issue of the *Louisiana Register* (Volume 44, Number 8). A public hearing was held on September 27, 2018 at which provider representatives and Louisiana Department of Health staff were present. Oral testimony and written correspondence was received regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the November 20, 2018 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification;
3. the public hearing attendance roster;
4. summary of all oral testimony at the public hearing;
5. summary of all written comments received by the agency;
6. the agency's response to Errol Duplantis;
7. the agency's response to Gary Farmer;
8. the agency's response to Jeanne Abadie;

9. the agency's response to John J. Costanza; and
10. the agency's response to Randal Johnson.

REG/CR/RKA

Attachments (10)

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Pharmacy Benefits Management Program
Managed Care Supplemental Rebates
(LAC 50:XXIX.1103)

The Department of Health, Bureau of Health Services Financing proposes to adopt LAC 50:XXIX.1103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing The Optimal PDL $olution (TOP$) State Supplemental Rebate Agreement Program in order to include pharmacy utilization of managed care organizations (MCOs) that participate in the Healthy Louisiana Program and implement a single state managed preferred drug list to maximize supplemental rebates on MCO utilization.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXIX. Pharmacy

Chapter 11. State Supplemental Rebate Agreement Program

§1103. Managed Care Organization Utilization

A. Effective January 1, 2019, the TOP$ State Supplemental Rebate Agreement Program shall include pharmacy utilization of

managed care organizations (MCOs) that participate in the Healthy Louisiana Program for state supplemental drug rebates.

1. The Healthy Louisiana Program's contracts with the participating MCOs shall:

a. allow inclusion of the pharmacy utilization data for supplemental rebate purposes; and

b. mandate that each participating MCO shall align their respective formulary(ies) and/or preferred drug list (PDL), as applicable, to the fee-for-service (FFS) preferred drug list. MCO prior authorization criteria shall not be more restrictive than FFS.

B. The Department of Health shall implement a single state-managed PDL for all participating MCOs in order to maximize the supplemental and federal rebates on MCO utilization.

1. The MCOs shall not enter into agreements with manufacturers of drugs listed in the single PDL to acquire discounts or rebates.

C. Supplemental rebates on MCO utilization shall be excluded from best price or average manufacturer price (AMP) calculations.

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:

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

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to

the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, September 27, 2018 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E Gee MD, MPH

Secretary

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION
September 27, 2018
9:30 a.m.

RE: Pharmacy Benefits Management Program
Managed Care Supplemental Rebates
Docket # 09272018-05
Department of Health
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on September 27, 2018 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.

Medicaid Policy and Compliance Section

09/27/18
Date

Bienville Building • 628 N. Fourth St. • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
Phone: (225) 342-9500 • Fax: (225) 342-5568 • www.ldh.la.gov

LDH/BHSF PUBLIC HEARING

Topic – Pharmacy Benefits Management Program Managed Care Supplemental Rebates

Date – September 27, 2018

PERSONS IN ATTENDANCE

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. Ceola Rayford	628 N 4th Street B.R. LA	225-342-3881	LDH Policy & Compliance
2. Tim Hambacher	NO, LA 70131 1 Lakewood Estates Dr	5046549283	Otsuka Pharmaceuticals
3. J Rolter	10761 Perkins RD, Ste D	225-766-8111	LJPA
4. Christine Peck	SHW	342-2114	SHW
5. Jill Eldridge	SHW	342-2102	SHW
6. Holly Snow	587 N. St Mary's LN Marietta GA 30064	~~770~~ 404 387 6728	Amgen

LDH/BHSF PUBLIC HEARING

Topic – Pharmacy Benefits Management Program Managed Care Supplemental Rebates

Date – September 27, 2018

PERSONS IN ATTENDANCE

Name	Address	Telephone Number	AGENCY or GROUP you represent
7. Justin Hudman	197 Birch Dr. Kyle, TX 78640	733 414 2365	Amgen
8. Russell Caffery	543 Spanish Town Road, BTR, LA 70806	(225) 308-2030	LIPA
9. Randal Johnson	"	225 334 9165	LIPA
10.			
11.			
12.			

SUMMARY OF PUBLIC HEARING TESTIMONY

Proposed Rule: Pharmacy Benefits Management Program - Managed Care Supplemental Rebates
Public Hearing Date: 09/27/18
Docket No. : 09272018-05
Conducted By: Louisiana Department of Health, Bureau of Health Services Financing Staff

Oral Testimony Given By	Organization Represented	Summary of Comments
Randal Johnson	Louisiana Independent Pharmacists Association	Requests more discussion about this proposed rule which includes stakeholders and will provide additional comments in writing.

SUMMARY OF WRITTEN COMMENTS

Proposed Rule: Pharmacy Benefits Management Program - Managed Care Supplemental Rebates
Public Hearing Date: 09/27/18
Docket No. : 09272018-05
Conducted By: Louisiana Department of Health, Bureau of Health Services Financing Staff

Written Comments Received From	Mode of Receipt	Summary of Comments
Errol Duplantis	Medicaid Policy Email Account	Supports a preferred drug list (PDL) that uses as many generics as possible.
Gary Framer, Reeves Drug Store, Inc	Medicaid Policy Email Account	Concerned about small independent pharmacists. Inventory will increase and will place a strain on cash flow.
Jeanne Abadie, Advocacy Center	Medicaid Policy Email Account	Supports the single PDL except if that if the medications on the single PDL are not meeting the health needs of a Medicaid beneficiary, other medications will be offered even if they are not "preferred".
John J. Costanza, Medi-Thrift Drugs	Medicaid Policy Email Account	Cannot afford to stock products on the PDL and made to fill prescriptions that reimburse below the cost of the medicine. Believes corrupt pay by mails will destroy every small pharmacy in America.
Randal Johnson, Louisiana Independent Pharmacies Association	Medicaid Policy Email Account	Supports the stated motivation for a single PDL, they have concluded that additional expert analysis is needed to determine the financial impact on pharmacy providers, drug wholesalers, and Medicaid enrollees subject to copays. They estimate that transitioning to a single PDL with greater reliance on brand name drugs is in effect a rate cut and will have an adverse financial impact on the ability of more than 400 community pharmacies to continue providing the current level of "person-centered" and convenient access to prescription drugs to hundreds of thousands of our state's most vulnerable residents. They estimate their members' transition and ongoing costs to stock and maintain exponentially costlier brand name—rather than generic—drugs and the associated higher taxes is $20M, assuming an average of $50,000 for each independent pharmacy. The additional inventory and tax costs that will be incurred by independent pharmacies as a result of the single PDL would be even further exacerbated by any downward adjustment to the dispensing fee. We believe that a single PDL must be considered as part of a global Medicaid pharmacy initiative in conjunction with reimbursement for ingredient actual acquisition costs (which have not been reconsidered in over six years) and a dispensing fee that is adequate to cover the current cost of dispensing.
Randal Johnson, Louisiana Independent Pharmacies Association	Email to Governor John Bel Edwards	Requests that LDH does not proceed with the Rule. He believes it will result in increased inventory costs and taxes for community pharmacy providers and have an adverse financial impact on the ability of more than 400 independent community pharmacies in Louisiana to continue providing the same level of "person-centered" and convenient access to prescription drugs. Estimates that transition costs to stock and maintain exponentially costlier brand name—rather than generic—drugs is approximately $20M, assuming an average of $50,000 for

		each independent pharmacy. Will also increase inventories of PDL drugs and generics. Concerned about increased costs and increased co-pays. The known additional inventory costs that will be incurred by independent pharmacies as a result of the single PDL would be even further exacerbated by any downward adjustment to the dispensing fee.

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

October 9, 2018

Jeanne Abadie
Advocacy Center
8325 Oak Street
New Orleans, LA 70118-2043

Dear Ms. Abadie:

RE: Notice of Intent for Pharmacy Benefits Management Program – Managed Care Supplemental Rebates

This letter is in response to your correspondence regarding the Notice of Intent for Pharmacy Benefits Management Program, Managed Care Supplemental Rebates which was published in the August 20, 2018 edition of the *Louisiana Register*.

The Notice of Intent (NOI) proposes to amend the Rule governing the Pharmacy Benefits Management Program to amend the provisions governing the State Supplemental Rebate Program in order to include pharmacy utilization by managed care organizations (MCOs) that participate in the Healthy Louisiana Program, and to implement a single state managed preferred drug list (PDL) to maximize supplemental rebates on MCO utilization.

I would like to thank you for your support of the proposed Rule and the positive feedback regarding the implementation of a single PDL. You can be assured that we will continuously monitor the medications on the single PDL and make changes as needed to ensure the healthcare needs of our recipients are met.

We hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens. Should you have any questions or comments regarding Medicaid administrative rulemaking activity, you may contact Veronica Dent, Medicaid Program Manager, at 225-342-3238 or by email to Veronica.Dent@la.gov.

Sincerely,

Jen Steele
Medicaid Director

JS/DAB

c: Michael Boutte, Medicaid Deputy Director
Stacy Guidry, Section Chief
Melwyn Wendt, Pharmacy Director

Veronica Dent

From: Veronica Dent
Sent: Tuesday, October 09, 2018 3:12 PM
To: 'John Costanza'
Subject: RE: PDL LIST

Good afternoon, Mr. Costanza:

I am responding on behalf of Jen Steele, Medicaid Director, to your comments below regarding the Notice of Intent for Pharmacy Benefits Management Program, Managed Care Supplemental Rebates which was published in the August 20, 2018 edition of the *Louisiana Register*.

The Notice of Intent (NOI) proposes to amend the Rule governing the Pharmacy Benefits Management Program to amend the provisions governing the State Supplemental Rebate Program in order to include pharmacy utilization by managed care organizations (MCOs) that participate in the Healthy Louisiana Program, and to implement a single state managed preferred drug list (PDL) to maximize supplemental rebates on MCO utilization.

I would like to thank you for taking the time to provide comments on this NOI. LDH values the contributions of independent pharmacies to communities throughout our state, and is committed to ongoing collaboration with pharmacy stakeholders to address outstanding concerns as we proceed with the proposed changes to the Pharmacy Benefits Management Program.

We hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens. Should you have any questions or comments regarding Medicaid administrative rulemaking activity, my contact information is included in my signature below.

Veronica Y. Dent
Medicaid Program Manager
Rulemaking Unit
Medicaid Policy and Compliance Section
Phone: 225-342-3238 | Fax: 225-376-4777
veronica.dent@la.gov
Mon-Fri, 7:30 a.m. – 4:00 p.m.

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

From: John Costanza <johnjc8844@yahoo.com>
Sent: Friday, September 28, 2018 12:46 PM
To: Medicaid Policy <MedicaidPolicy@LA.GOV>
Subject: PDL LIST

Dear Mr. Steele

My name is John Costanza and I am one of the owners of Medi-Thrift Drugs, Inc. in Harrisonburg, Louisiana. I just received information about the proposed PDL drug list.

	Drug	Brand	Generic
1	Concerta 18 mg	1067.28	509.60
2	Concerta 27 mg	1094.031	521.36
3	Concerta 36 mg	1128.53	271.62
4	Concerta 54 mg	1128.53	$271.62
5	Focalin XR 5 mg	1172.69	$74.26
6	Focalin XR 10 mg	1190.05	$98.54
7	Focalin XR 15 mg	1223.82	$45.64
8	Focalin XR 20 mg	1223.82	$103.82
9	Focalin XR 25 mg	1285.04	$110.28
10	Focalin XR 30 mg	1178.93	$31.20
11	Focalin XR 35 mg	1349.35	112.94
12	Focalin XR 40 mg	1349.35	296.91

How can the state possible save money on Focalin XR 15mg. I don't care how much rebate you get when you pay $ 1,223.82 for brand when a generic only costs $45.64 there is no way the state can save money. I can't afford to stock these products. The CORRUPT PBM THIEVES stole $14,043.64 from my small pharmacy last month. In addition, every day I have to fill Rxs that reimburse me below the cost of the medicine. Corrupt PBMs will destroy every small pharmacy in America. Please do not proceed with implementing this PDL drug list.

DIR FEES

When you see this icon ⊞ additional information is available. If the icon is not displayed, the payer has not provided details at the claim level.

ACH DATE RANGE 08/01/2018 08/31/2018 Submit

08/01/2018 - 08/31/2018

Look for the icon next to the Payer on the DIR Fees page to see the updated information.

PAYER	TOTAL	ACH DATE	CHECK NUMBER	DIR FEE
AETNA	($590.49)			
Argus/DST	($1,215.00)			
CAREMARK	($11,814.91)			
Envision Rx Options	($12.69)			
OptumRx	($410.55)			

Sincerely yours,

John J. Costanza, R.Ph

Veronica Dent

From: Veronica Dent
Sent: Tuesday, October 09, 2018 3:11 PM
To: 'Errol Duplantis'
Subject: RE: Single PDL

Good afternoon, Mr. Duplantis:

I am responding on behalf of Jen Steele, Medicaid Director, to your comments below regarding the Notice of Intent for Pharmacy Benefits Management Program, Managed Care Supplemental Rebates which was published in the August 20, 2018 edition of the *Louisiana Register*.

The Notice of Intent (NOI) proposes to amend the Rule governing the Pharmacy Benefits Management Program to amend the provisions governing the State Supplemental Rebate Program in order to include pharmacy utilization by managed care organizations (MCOs) that participate in the Healthy Louisiana Program, and to implement a single state managed preferred drug list (PDL) to maximize supplemental rebates on MCO utilization.

I would like to thank you for taking the time to provide comments on this NOI. LDH values the contributions of independent pharmacies to communities throughout our state, and is committed to ongoing collaboration with pharmacy stakeholders to address outstanding concerns as we proceed with the proposed changes to the Pharmacy Benefits Management Program.

We hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens. Should you have any questions or comments regarding Medicaid administrative rulemaking activity, my contact information is included in my signature below.

Veronica Y. Dent
Medicaid Program Manager
Rulemaking Unit
Medicaid Policy and Compliance Section
Phone: 225-342-3238 | Fax: 225-376-4777
veronica.dent@la.gov
Mon-Fri, 7:30 a.m. – 4:00 p.m.

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

-----Original Message-----
From: Errol Duplantis <duplantisent@aol.com>
Sent: Friday, September 28, 2018 11:07 AM
To: Medicaid Policy <MedicaidPolicy@LA.GOV>
Subject: Single PDL

I support a PDL that uses as many generics as possible. DHH and CMS have to stop all the nonsense with our business models.
Thanks
Errol
Sent from my iPhone

Veronica Dent

From: Veronica Dent
Sent: Tuesday, October 09, 2018 3:11 PM
To: 'GARY FARMER'
Subject: RE: Single PDL

Good afternoon, Mr. Farmer:

I am responding on behalf of Jen Steele, Medicaid Director, to your comments below regarding the Notice of Intent for Pharmacy Benefits Management Program, Managed Care Supplemental Rebates which was published in the August 20, 2018 edition of the *Louisiana Register*.

The Notice of Intent (NOI) proposes to amend the Rule governing the Pharmacy Benefits Management Program to amend the provisions governing the State Supplemental Rebate Program in order to include pharmacy utilization by managed care organizations (MCOs) that participate in the Healthy Louisiana Program, and to implement a single state managed preferred drug list (PDL) to maximize supplemental rebates on MCO utilization.

I would like to thank you for taking the time to provide comments on this NOI. LDH values the contributions of independent pharmacies to communities throughout our state, and is committed to ongoing collaboration with pharmacy stakeholders to address outstanding concerns as we proceed with the proposed changes to the Pharmacy Benefits Management Program.

We hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens. Should you have any questions or comments regarding Medicaid administrative rulemaking activity, my contact information is included in my signature below.

Veronica Y. Dent
Medicaid Program Manager
Rulemaking Unit
Medicaid Policy and Compliance Section
Phone: 225-342-3238 | Fax: 225-376-4777
veronica.dent@la.gov
Mon-Fri, 7:30 a.m. – 4:00 p.m.

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

From: GARY FARMER <garyliz@bellsouth.net>
Sent: Friday, September 28, 2018 3:30 PM
To: Medicaid Policy <MedicaidPolicy@LA.GOV>
Subject: Single PDL

Independent pharmacies in Louisiana are already struggling, as you know, with all these negative reimbursements being forced on us by the PBM's. This business was, and our drug store still is, about patient CARE, patient ACCESS and patient CHOICE. We strive to love our patients and care for them every day, but it's getting harder everyday with these non regulated reimbursements and sending our life long friends and patients to other stores. Independent Pharmacy is at a serious crossroads already whether to close, sale out or put our hope in the Louisiana Government to change the way the PBM's operate in our state. With that being said I beg of you to consider a different avenue with this single PDL. Put yourself in a small independent's shoes, Inventory will have to explode with these multiple strength HIGH dollar brands and also keeping the generics on hand. I have already robbed my savings twice in the last 6 months to pay inventory invoices and I definitely can't afford more strain on our cash flow. Thanks for listening and your consideration with this very important matter.

Gary Farmer
Reeves Drug Store, Inc.

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

October 9, 2018

Randal Johnson
Louisiana Independent Pharmacies Association
543 Spanish Town Road
Baton Rouge, LA 70802

Dear Mr. Johnson:

RE: Notice of Intent for Pharmacy Benefits Management Program – Managed Care Supplemental Rebates

This letter is in response to your correspondence regarding the Notice of Intent for Pharmacy Benefits Management Program, Managed Care Supplemental Rebates which was published in the August 20, 2018 edition of the *Louisiana Register*.

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I would like to thank you for taking the time to provide comments on this NOI. LDH values the contributions of independent pharmacies to communities throughout our state, and is committed to ongoing collaboration with LIPA and other pharmacy stakeholders to address outstanding concerns as we proceed with the proposed changes to the Pharmacy Benefits Management Program.

I hope you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens. Should you have any questions or comments regarding Medicaid administrative rulemaking activity, you may contact Veronica Dent, Medicaid Program Manager, at 225-342-3238 or by email to Veronica.Dent@la.gov.

Sincerely,

Jen Steele
Medicaid Director

JS/DAB

c: Michael Boutte, Medicaid Deputy Director
Stacy Guidry, Section Chief
Melwyn Wendt, Pharmacy Director