§965. Hemophilia Blood Products

A. Effective for dates of service on or after May 20, 2008, the Department of Health and Hospitals shall provide additional reimbursements to certain non-rural, non-state acute care hospitals for the extraordinary costs incurred in purchasing blood products for certain Medicaid recipients diagnosed with, and receiving inpatient treatment for hemophilia.

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

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

2. have provided clotting factors to a Medicaid recipient who has been diagnosed with hemophilia or other rare bleeding disorders for which the use of one or more clotting factors is FDA approved and has been hospitalized at the qualifying hospital for a period exceeding six days; and

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2176 (October 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:674 (April 2009).

§967. Children’s Specialty Hospitals

A. Routine Pediatric Inpatient Services. These services shall be paid at the lesser of cost or the target rate per discharge ceiling. The base period target rate per discharge ceiling amount shall be calculated using the allowable inpatient cost per discharge per the cost reporting period ended in state fiscal year (SFY) 2009. The target rate shall be inflated using the update factors published by the Centers for Medicare and Medicaid Services (CMS) beginning with cost reporting periods starting on or after January 1, 2010.

1. For dates of service on or after September 1, 2009, payment shall be the lesser of the allowable inpatient costs as determined by the cost report or the Medicaid discharges for the period multiplied times the target rate per discharge for the period.

B. Inpatient Psychiatric Services. These services shall be paid at the lesser of cost or the target rate per discharge ceiling. The base period target rate per discharge ceiling amount shall be calculated using the allowable inpatient cost per discharge per the cost reporting period ended in state fiscal year (SFY) 2009. The target rate shall be inflated using the update factors published by CMS beginning with cost reporting periods starting on or after January 1, 2010.

1. For dates of service on or after September 1, 2009, payment shall be the lesser of the allowable inpatient costs as determined by the cost report or the Medicaid discharges for the period multiplied times the target rate per discharge for the period.

C. Carve-Out Specialty Services. These services are rendered by neonatal intensive care units, pediatric intensive care units, burn units and include transplants. Payment shall be the lesser of costs or the per diem limitation for each specialty service or type of transplant. The base period per diem limitation amounts shall be calculated using the allowable inpatient cost per day for each specialty or type of transplant per the cost reporting period ended in SFY 2009. The target rate shall be inflated using the update factors published by the Centers for Medicare and Medicaid Services (CMS) beginning with cost reporting periods starting on or after January 1, 2010.

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

D. Children’s specialty hospitals shall not be eligible for outlier payments after September 1, 2009.

1. Outlier payments made in SFY 2010 in excess of $12,798,000 shall be considered as an interim payment in the determination of the cost settlement.

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

1. Medicaid supplemental payments related to high cost Medicaid and graduate medical education supplemental payments shall be included as an interim Medicaid inpatient payment in the determination of cost settlement amounts on the filed cost report.

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

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

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

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

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

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

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2562 (November 2010), amended LR 37:2162, 2162 (July 2011), LR 38:2773 (November 2012), LR 39:3097 (November 2013), LR 40:312 (February 2014), repromulgated LR 40:1940 (October 2014), amended LR 40:1941 (October 2014).