Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State Plan.

☒ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State Plan.

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☐ Additional Other Provider-Preventable Conditions identified below:
NOT APPLICABLE

Effective July 1, 2012, reimbursement for services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Provider-Preventable Conditions are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

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Payments for Hospital Acquired Conditions (HACs) shall be adjusted in the following manner. For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the International Classification of Diseases (ICD) vendor used by the Louisiana Medicaid Program. For example, an inpatient claim with 45 covered days identified with an HAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

No payment shall be made for inpatient services other than Other Provider Preventable Conditions (OPPCs). OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for provider preventable condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

i. The identified provider-preventable conditions would otherwise result in an increase in payment.

ii. The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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CITATION
42 CFR 413.30
and 413.40

Inpatient hospital services (other than those provided in an institution for Tuberculosis or mental disease) are reimbursed as follows:

I. Reimbursement Methodology

Medicaid uses the Medicare (Title XVIII) principles of reimbursement in accordance with HIM 15 requirements as a guide to determine Medicaid (Title XIX) reimbursement.

A. Methods of Payment for State-operated hospitals.

1. For all hospitals participating as a Title XVIII/XIX provider, the State agency shall apply:

   a. Medicare standards for reporting.

   b. Medicare cost reporting periods for the ceiling on the rate of increase in operating costs under 42 CFR 413.40 The base year cost reporting period to be used in determining the target rate shall be the hospital's fiscal year ending on or after September 30, 1982.

2. Inpatient hospital services provided by state acute hospitals shall be reimbursed at allowable costs and shall not be subject to per discharge or per diem limits.

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

   Qualifying Criteria: State-owned acute care hospitals located in DHH Administrative Region 8 will receive a quarterly supplemental payment.

4. Effective for dates of service on or after October 16, 2010, the Medicaid payments to state hospitals that do not qualify for the supplemental payment in #3 above as paid through interim per diem rates and final cost settlements shall be 60 percent of allowable Medicaid costs.
5. Effective for dates of service **on or after February 1, 2012**, medical education payments for inpatient services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be paid monthly by Medicaid as interim lump sum payments.
   a. Hospitals with qualifying medical education programs shall submit a listing of inpatient claims paid each month by each MCO. Qualifying medical education programs are defined as graduate medical education, paramedical

education, and nursing schools.

b. 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.

c. 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.

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

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PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES
METHODS AND STANDARDS FOR ESTABLISHING RATES - IN-PATIENT HOSPITAL CARE

B. Effective for dates of service on or after July 1, 1994, Medicaid reimbursement for inpatient hospital services in a non-state operated hospital will be made according to prospective per diem rates for various peer groups of hospitals/units.

Exception: Reimbursement for the following specialty units differs from the methodology in Item B., and each is calculated using a unique methodology as described in the specified letter location under Section I. Costs for these units are carved out of the costs for the general or specialty hospitals, and used to calculate rates specific to these units.

Hospital/Unit Type	Item Letter
Distinct Part Psychiatric Units	F
Transplant Units	G
Head Injury Neurological Rehab Care Units	H

1. Peer Groups

a. The five general hospital peer groups are:
(1) Major teaching hospitals
(2) Minor teaching hospitals
(3) Non-teaching hospitals with less than 58 beds
(4) Non-teaching hospitals with 58 through 138 beds
(5) Non-teaching hospitals with more than 138 beds

b. Separate peer group payment rates are established for each group of these specialty hospitals:
(1) Long-term (ventilator) hospitals (for services other than psychiatric treatment, which are reimbursed at the prospective per diem rate described in the following items in Attachment 4.19-A: Item 14a, Item 16, and Item 1.F. beginning on page 10l)
(2) Children's hospitals

c. Separate peer group payment rates are established for each group of resource-intensive inpatient services listed below. Costs for these units are carved out of the costs for the general or specialty hospitals listed above, and used to calculate rates specific to these units.

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(1) Neonatal Intensive Care (NICU) Unit (3 levels)
(2) Pediatric Intensive Care (PICU) Unit (2 levels)
(3) Burn Care Unit

2. General Information About Calculation of Rates

Costs are proportionately allocated in cost reports filed by the provider to ensure that there is no duplication of costs to the hospital and its specialty unit(s).

Allowable costs are those unaudited reported costs which conform to the Medicare principles of reimbursement.

Swing bed days and costs are excluded from reported costs.

3. Base Cost

Cost for each component for each hospital that was enrolled as a Medicaid provider in 1991 is derived from that provider's allowable cost per day for that component from its filed cost report for the hospital's reporting period ending in calendar year 1991.

For hospitals that completed six months or more of operation and filed a cost report by June 30, 1994, component cost will be derived from the first cost report filed.

Hospitals not having completed six months or more of operations and not having filed a cost report by June 30, 1994 will receive the applicable peer group rates for SFY 1994/95 and subsequent years.

Hospitals beginning operations subsequent to FY 1991 (the base year) will be placed into the appropriate peer group. Change of ownership or acquisition of a different provider number by an operating, participating hospital does not result in a hospital becoming a new hospital. A hospital that existed but was not enrolled in the base year is considered a new hospital.

Base costs for hospitals or specialty units that change peer groups are derived from 1991 allowable cost per day for that component from its filed cost report for the hospital's reporting period ending in calendar year 1991.

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4. Inflation Factor

The Data Resources Incorporated (DRI) Hospital Market Basket Index for non-PPS hospitals, Table 2 was used to inflate components prior to rates applicable July 1, 1995.

Derivation of first year payment components. For hospitals enrolled as Medicaid providers in 1991, cost for each component (fixed capital costs, medical education costs, movable equipment costs, and operating costs) for each hospital is calculated based on each provider's allowable cost per day for that component from its filed cost report for the hospital's reporting period ending in calendar year 1991 inflated from the hospital's fiscal year midpoint of the base year (1991) to the midpoint of the implementation year (December 31, 1994) using the index from the fourth quarter percent movable average.

Hospitals that have completed six months or more of operation and have filed a cost report by June 30, 1994 have components trended forward from the midpoint of the hospital's first cost report year to the midpoint for the state fiscal year beginning July 1, 1994 (which is December 31, 1994) using the index from the fourth quarter percent movable average.

Calculation of subsequent year components. Medical education costs, movable equipment costs, and operating costs are inflated by applying the lowest of the most recently published Data Resources Incorporated (DRI) Hospital Market Basket Index for non-PPS hospitals, Table 2; Consumer Price Index-All Urban Consumers; or Medicare PPS Market Basket Index before the start of the next fiscal year (between April 1 and June 30) to the most recent component cost for each hospital effective with rates effective July 1, 1995.

Recalculated rates resulting from application of inflation factors are effective for services provided on or after July 1 of each year except that rates for Hospital Intensive Neurological Rehabilitation Units, Psychiatric Hospitals, and Distinct Part Psychiatric Units are effective for services provided on or after January 1.

5. Cost Components Used in Calculating Rates

a. Fixed capital cost.

Step 1 - Peer grouping.
A single fixed capital rate cap was established for all hospitals in the five general peer groups by combining all hospitals in the five general peer groups into one array. Separate fixed capital rate caps were established for each specialty hospital peer group and each specialty unit peer group.
Step 2 - Cap calculation.
Fixed capital cost for each hospital was inflated from the midpoint of the base year to the midpoint of the implementation year (December 31,

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

1994) then arrayed by peer group from high to low in order to determine the median cost for the peer group. Fixed capital cost for each hospital/unit above the median was capped at the median. Exception: Long term hospitals are capped at the 30th percentile facility as reported on the as-filed cost report for the hospital cost report year ending between July 1, 1995 through June 30, 1996.

Step 3 - Calculation of blended component.
A blended component for each hospital was calculated comprised of 70% of the peer group median and 30% of the hospital specific component (capped at the median).

Step 4 - Calculation of capped weighted average.
A capped weighted average for each pee-r group was calculated by multiplying the per diem cost for each hospital (capped at the median) by the number of Medicaid days provided by the hospital in 1991, adding the products then dividing the resulting sum by the total number of Medicaid days in 1991 for all hospitals in the group.

Step 5 - Determination of hospital specific component.
Each hospital's fixed capital cost component was set at the lower of the hospital's blended rate or the capped weighted average for the peer group.

The inflation factor is not applied annually.

b. Medical education cost.

A facility-specific cost component is allowed for any hospital that maintains a program or "Approved Educational Activities" as defined in the Medicare Provider Reimbursement Manual§ 402.1 and listed in § 404. The audit intermediary determines whether the hospital program qualifies to have medical education costs included in each hospital's rate. In addition to the above, hospitals qualifying for graduate medical education reimbursement must meet the criteria specified in either II.D. or E, and II F.

Hospitals which begin new qualifying programs are eligible to have this component included in the calculation of the hospital's rate at the beginning of the state fiscal year subsequent to the hospital's valid request for medical education costs to be included, trended forward from the most recent filed cost report year to the current state fiscal year.

The component cost for each hospital that had qualifying program(s) in the hospital's base year cost report was inflated from the midpoint of the base year to the midpoint of the implementation year (December 31, 1994). Costs are inflated for each subsequent non-rebasing year when the state legislature allocates funds for this purpose.

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c. **Movable equipment cost.**

Items considered to be movable equipment are those included in the Medicare Provider Reimbursement Manual § 104.4 definition of "Major Movable Equipment".

Step 1- Peer grouping.
Separate movable equipment cost component caps were established for each general hospital peer group, specialty hospital peer group and specialty unit peer group. In the case of a group with only one hospital, the hospital specific cost is used.

Step 2 - Cap calculation.
Movable equipment cost for each hospital was inflated from the midpoint of the base year to the midpoint of the implementation year (December 31, 1994), then arrayed by peer group from high to low to determine the median cost for the peer group. Movable equipment cost for each hospital/unit above the median was capped at the median. Exception: Long term hospitals are capped at the 30th percentile facility as reported on the as-filed cost report for the hospital cost report year ending between July 1, 1995 through June 30, 1996.

Step 3 - Calculation of blended component.
A blended component for each hospital was calculated comprised of 70% of the peer group median and 30% of the hospital-specific component (capped at the median).

Step 4 - Calculation of capped weighted average.
A capped weighted average for each peer group was calculated by multiplying the per diem cost for each hospital (capped at the median) by the number of Medicaid days provided by the hospital in 1991, adding the products, then dividing the resulting sum by the total number of Medicaid days in 1991 for all hospitals/units in the group.

Step 5- Determination of hospital-specific component.
Each hospital's movable equipment cost component was set at the lower of the hospital's blended rate or the capped weighted average for the peer group.

Costs are inflated for each subsequent non-rebasing year when the state legislature allocates funds for this purpose.

d. **Operating cost.**

Step 1 - Peer grouping.
Separate operating cost component caps were established for each general hospital peer group specialty hospital peer group and specialty unit peer group. In the case of a group with only on hospital, the hospital specific cost is used.

Step 2 - Supplementation.
Operating cost for each hospital was inflated from the midpoint of the base year to the midpoint of the implementation year (December 31, 1994), then arrayed by peer group from high to low to determine the weighted median cost for the peer group. In peer groupings with less than three facilities, the median is used. In the case of a group with only one facility, the facility-specific cost is used. For those hospitals below the weighted median, the operating cost was supplemented by 25% of the difference between the hospital-specific cost per day and the median cost per day for the peer group.

Step 3 - Cap calculation.
Operating cost for each hospital as determined in Step 2 was arrayed by peer group from high to low to determine the weighted median cost for the peer group. Operating cost for each hospital/unit above the weighted median was capped at the weighted median. Exception: Long term hospitals are capped at the 30th percentile facility as reported on the as-filed cost report for the hospital cost report year ending between July 1, 1995 through June 30, 1996.

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Step 4 - Calculation of blended component.
A blended component for each hospital was calculated comprised of 70% of the peer group weighted median and 30% of the hospital-specific component (as supplemented in Step 2 and capped in Step 3).

Step 5 - Calculation of capped weighted average.
A capped weighted average for each peer group was calculated by multiplying the per diem cost for each hospital (as supplemented in Step 2 and capped in Step 3) by the number of Medicaid days provided by the hospital in 1991, adding the products, then dividing the resulting sum by the total number of Medicaid days in 1991 for all hospitals/units in the group.

Step 6 - Determination of hospital-specific component.
Each hospital's operating cost component was set at the lower of the hospital's blended rate or the capped weighted average for the peer group.
Costs are inflated for each subsequent non-rebasing year when the state legislature allocates funds for this purpose.

6. **Calculation of Payment Rates**
Individual facility rates are calculated annually by adding together the four components listed above for each facility.

Effective for dates of service on or after October 1, 2003 inpatient services rendered in

private (non-state) acute hospitals, including long term hospitals, with a Medicaid utilization rate of less than 25 percent shall be reimbursed as follows: in state fiscal year 2003-2004 only, the reimbursement shall be 98.75 percent (a 1.25 percent reduction) of the per diem rates in effect on September 30, 2003, and for subsequent years, the reimbursement shall be 99.2 percent (a .8 percent reduction) of the per diem rates in effect on September 30, 2003 for private hospitals.

The Medicaid inpatient days utilization rate shall be calculated based on the filed cost report for the period ending in state fiscal year 2002 and received by the Department prior to April 30, 2003. Only Medicaid covered days for inpatient hospital services, which include newborn days and distinct part psychiatric units, are included in this calculation. Inpatient stays covered by Medicare Part A can not be included in the determination of the Medicaid inpatient days utilization rate. Small rural hospitals as defined by the Rural Hospital Preservation Act (R.S. 40:1300.143) shall be excluded from this reimbursement reduction. Also, inpatient services provided to fragile newborns or critically ill children in either a Level III Regional Neonatal Intensive Care Unit or a Level I Pediatric Intensive Care Unit, which units have been recognized by the Department on or before January 1, 2003, shall be excluded from this reimbursement reduction.

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Effective for dates of services on or after August 1, 2006, the inpatient prospective per diem rates paid to private acute hospitals, including long term hospitals, shall be increased by 3.85% of the rates in effect on July 31, 2006.

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

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Effective for dates of service on or after February 20, 2009, the prospective per diem rate paid to acute care hospitals shall be reduced by 3.5 percent of the per diem rate on file as of February 19, 2009. Payments to the following hospitals and/or specialty units for inpatient hospital services shall be exempted from these reductions:

1. Small rural hospitals, as defined in D.3.b.; and
2. Level III Regional Neonatal Intensive Care Units and level I Pediatric Intensive Care Units as defined in Louisiana R.S. 46.979.
3. High Medicaid hospitals as defined in Louisiana R.S. 46.979. For the purposes of qualifying for the exemption to the reimbursement reduction as a High Medicaid hospital, the following conditions must be met.
   a. The inpatient Medicaid days utilization rate for high Medicaid hospitals shall be calculated based on the cost report filed for the period ending in state fiscal year 2007 and received by the Department prior to April 20, 2008.

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

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

Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to acute care hospitals, including long term care hospitals, shall be reduced by 6.3 percent of the per diem rate on file as of August 3, 2009. Payments to small rural hospitals as defined in Louisiana R.S. 40:1300.143 shall be exempt from this reduction.

Effective for dates of service on or after October 1, 2009, current per diem rates shall be adjusted as follows:

A. Acute Care General Hospitals:

1. Qualifying major teaching hospitals with current per diem rates that are less than 80 percent of the current peer group rate shall have their per diem rates adjusted to equal 80 percent of the current peer group rate.
2. Qualifying minor teaching hospitals shall have their per diem rates adjusted to equal 103 percent of the current peer group rate.
3. Qualifying non-teaching hospitals with less than 58 beds shall have their per diem rates adjusted to equal 103 percent of the current peer group rate.
4. Qualifying non-teaching hospitals with 58 through 138 beds shall have their per diem rates adjusted to equal 122 percent of the current peer group rate.
5. Qualifying non-teaching hospitals with more than 138 beds shall have their per diem rates adjusted to equal 103 percent of the current peer group rate.

B. Specialty Hospitals:

1. Qualifying long-term acute care hospitals shall have their prospective per diem rates for inpatient services other than psychiatric treatment increased by 3 percent of the rate on file.

C. Specialty Intensive Inpatient Services:

1. Qualifying NICU Level III services with current per diem rates that are less than the NICU Level III specialty peer group rate shall have their per diem rates adjusted to equal 100 percent of the specialty group rate.

2. Qualifying NICU Level III regional services with current per diem rates that are less than 85 percent of the NICU Level III regional specialty group rate shall have their per diem rates adjusted to equal 85 percent of the specialty group rate.

3. Qualifying PICU Level I services with current per diem rates that are less than 77 percent of the PICU Level I specialty peer group rate shall have their per diem rates adjusted to equal 77 percent of the specialty peer group rate.

4. Qualifying PICU Level II services with current per diem rates that are less than the PICU Level II specialty peer group rate shall have their per diem rates adjusted to equal 100 percent of the specialty group rate.

Effective for dates of service on or after February 3, 2010, the inpatient per diem rate paid to private (non-rural, non-state) acute care hospitals, including long term hospitals, shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

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Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to private (non-rural, non-state) acute care hospitals, including long term hospitals, shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

Effective for dates of service on or after January 1, 2011, the inpatient per diem rate paid to private (non-rural, non-state) acute care hospitals, including long term hospitals, shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

Effective for dates of service on or after August 1, 2012, the inpatient per diem rate paid to private (non-rural, non-state) acute care hospitals, including long term hospitals, shall be reduced by 3.7 percent of the per diem rate on file as of July 31, 2012.

Effective for dates of service on or after February 1, 2013, the inpatient per diem rate paid to private (non-rural, non-state) acute care hospitals, including long term hospitals, shall be reduced by 1 percent of the per diem on file as of January 31, 2013.

NICU Rate Adjustment

Effective for dates of service on or after March 1, 2011, the per diem rates for Medicaid inpatient services rendered by NICU Level III and NICU Level III regional units, recognized by the Department as such on December 31, 2010, shall be adjusted to include an increase that varies based on the following five tiers:

Tier 1. The qualifying hospital's average percentage exceeds 10 percent, the additional per diem increase shall be $601.98;

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

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

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

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

Tier Placement Criteria

Placement into a tier will be determined by the average of a hospital's percentage of paid NICU Medicaid days for SFY 2010 dates of service to the total of all qualifying hospitals' paid NICU days for the same time period, and its percentage of NICU patient outlier payments made as of December 31, 2010 for dates of service in SFY 2008 and SFY 2009 and calendar year 2010 to the total NICU outlier payments made to all qualifying hospitals for these same time periods.

1. This average shall be weighted to provide that each hospital's percentage of paid NICU days will comprise 25 percent of this average, while the percentage of outlier payments will comprise 75 percent.

2. In order to qualify for Tiers 1 through 4, a hospital must have received at least .25 percent of outlier payments in SFY 2008, SFY 2009, and calendar year 2010.

3. SFY 2010 is used as the base period to determine the allocation of NICU and PICU outlier payments for hospitals having both NICU and PICU units.

4. If the daily paid outlier amount per paid NICU day for any hospital is greater than the mean plus one standard deviation of the same calculation for all NICU Level III and NICU Level III regional hospitals, then the basis for calculating the hospital's percentage of NICU patient outlier payments shall be to substitute a payment amount equal to the highest daily paid outlier amount of any hospital not exceeding this limit, multiplied by the exceeding hospital's paid NICU days for SFY 2010, to take the place of the hospital's actual paid outlier amount.

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

PICU Rate Adjustment

Effective for dates of service on or after March 1, 2011, the per diem rates for Medicaid inpatient services rendered by PICU Level I and PICU Level II units, recognized by the Department as such on December 31, 2010, shall be adjusted to include an increase that varies based on the following four tiers:

Tier 1. The qualifying hospital's average percentage exceeds 20 percent, the additional per diem increase shall be $418.34;
Tier 2. If the qualifying hospital's average percentage is less than or equal to 20 percent, but exceeds 10 percent, the additional per diem increase shall be $278.63;

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

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

Tier Placement Criteria

Placement into a tier will be determined by the average of its percentage of paid PICU Medicaid days for SFY 2010 dates of service to the total of all qualifying hospitals' paid PICU days for the same time period, and its percentage of NICU patient outlier payments made as of December 31, 2010 for dates of service in SFY 2008 and SFY 2009 and calendar year 2010 to the total PICU outlier payments made to all qualifying hospitals for these same time periods.

1. This average shall be weighted to provide that each hospital's percentage of paid PICU days will comprise 25 percent of this average, while the percentage of outlier payments will comprise 75 percent.

2. In order to qualify for Tiers 1 through 3, a hospital must have received at least .25 percent of outlier payments in SFY 2008, SFY 2009, and calendar year 2010.

3. SFY 2010 is used as the base period to determine the allocation of NICU and PICU outlier payments for hospitals having both NICU and PICU units.

4. If the daily paid outlier amount per paid PICU day for any hospital is greater than the mean plus one standard deviation of the same calculation for all PICU Level I and PICU Level II hospitals, then the basis for calculating the hospital's percentage of PICU patient outlier payments shall be to substitute a payment amount equal to the highest daily paid outlier amount of any hospital not exceeding this limit,

multiplied by the exceeding hospital's paid PICU days for SFY 2010, to take the place of the hospital's actual paid outlier amount.

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

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Qualification for teaching hospital status shall be reestablished at the beginning of each fiscal year.

To be reimbursed as a teaching hospital a facility shall submit a signed "Certification For Teaching Hospital Recognition" form to the Bureau of Health Services, Supplemental Payments Section at least thirty days prior to the beginning of each state fiscal year, or at least 30 days prior to the effective date of converting a state owned and operated teaching hospital to private operation and management.

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

1. a copy of the Intern and Resident Information System report that is submitted annually to the Medicare intermediary; and
2. a copy of any notice given to the ACGME that residents rotate through a facility for more than one sixth of the program length or more than a total of six months.

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

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

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

1. Hospitals with qualifying medical education programs shall submit a listing of inpatient claims paid each month by each MCO. 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 recoupment shall be made as necessary based on the MCO encounter data reported to the Department.

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The following payments shall be made in addition to the prospective rate described above:

a. Infant Care

(1) Nursery Boarder Infants Payment

On some occasions a newborn remains in a hospital nursery after the mother has been discharged. Reimbursement is established at the weighted median for all hospitals providing maternity care, based on 1991 cost inflated to the implementation year as described in "Inflation Factor" above, and annually thereafter.

(2) Well Baby Care

A separate prospective per diem rate is established for well baby care rendered to infants who are discharged at the same time that the mother is discharged. The separate per diem rate for well baby care shall be available to private hospitals that perform more than 1500 Medicaid deliveries per year. The per diem rate for well baby care shall be the lesser of actual costs as documented on the last finalized cost report or the rate for a nursery boarder.

b. Outlier Payments

In compliance with the requirement of §1902(s)(1) of the Social Security Act, additional payment shall be made for catastrophic costs associated with services provided to 1) children under age six who received inpatient services in a disproportionate share hospital setting, and 2) infants who have not attained the age of one year who received inpatient services in any acute care setting.

Cost is defined as the hospital-specific cost to charge ratio based on the hospital's cost report period ending in state fiscal year (SFY) 2000 (July 1, 1999 through June 30, 2000).

For new hospitals and hospitals that did not provide Medicaid Neonatal Intensive Care Unit (NICU) services in SFY 2010, the hospital-specific cost to charge ratio will be calculated based on the first full year cost reporting period that the hospital was open or that Medicaid NICU services were provided.

The hospital specific cost to charge ratio will be reviewed bi-annually to determine the need for adjustment to the outlier payment.

A deadline of six months subsequent to the date that the final claim is paid shall be established for receipt of the written request filing for outlier payments. In addition, effective March 1, 2011, outlier claims for dates of service on or before February 28, 2011 must be received by the Department on or before May 31, 2011 in order to qualify for payment. Claims for this time period received by the Department after May 31, 2011 shall not qualify for payment.

Outlier payments are not payable for transplant procedures, and services provided to patients with Medicaid coverage that is secondary to other payer sources.

Effective for dates of service on or after March 1, 2011, a catastrophic outlier pool shall be established with annual payments limited to $10,000,000. In order to qualify for payments from this pool, the following conditions must be met:

1. The claims must be for children less than six years of age who received inpatient services in a disproportionate share hospital setting; or 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. The hospital specific cost to charge ratio utilized to calculate the claim costs shall be calculated using the Medicaid NICU or PICU costs and charge data from the most current cost report.

The initial outlier pool will cover eligible claims with admission dates from the period beginning March 1, 2011 through June 30, 2011.

1. Payment for the initial partial year pool will be $3,333,333 and shall be the costs of each hospital's qualifying claims net of claim payments divided by the sum of all qualifying claims cost in excess of payments, multiplied by $3,333,333.

2. Cases with admission dates on or before February 28, 2011 that continue beyond the March 1, 2011 effective date, and that exceed the $150,000 cost threshold, shall be eligible for payment in the initial catastrophic outlier pool.

3. Only the costs of the cases applicable to dates of service on or after March 1, 2011, shall be allowable for determination of payment from this pool.

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

8. Reimbursement for Small Rural Hospitals

a. Effective for dates of service on or after July 1, 2008, small rural hospitals as defined in D.3.b. shall be reimbursed at a prospective per diem rate. The per diem rate shall be the median cost plus ten percent which shall be calculated based on each hospital's year-end cost report period ending in calendar year 2006. If the cost reporting period is not a full period (twelve months), the latest filed full period cost report shall be used. The Medicaid cost per inpatient day for each small rural hospital shall be inflated from their applicable cost reporting period to the midpoint of the implementation year (December 31, 2008) by the Medicare market basket inflation factor for PPS hospitals, then arrayed from high to low to determine the median inpatient acute cost per day for all small rural hospitals. The payment rate for inpatient acute services in small rural hospitals shall be the median cost amount plus ten percent. The median cost and rates shall be rebased at least every other year using the latest filed full period cost reports as filed in accordance with Medicare timely filing guidelines.

b. Effective for dates of service on or after August 1, 2010, quarterly supplemental payments will be issued to qualifying small rural hospitals for inpatient services rendered during the quarter.

1. Qualifying criteria

a). Public (non-state) small rural hospital – a small rural hospital as defined in D.3.b.(1) which is owned by a local government and as of August 1,2010 and has a certified neonatal intensive care unit.

b). Private small rural hospital- a small rural hospital as defined in D.3.b.(1)(i).

2. Reimbursement methodology - 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. In the event that the above supplemental payments exceed state appropriated amounts, payment amounts to qualifying hospitals shall be reduced on a pro rata basis to equal the state appropriated level of funding.

c. Supplemental Payments for Low Income and Needy Care Collaboration (Small Rural Hospitals)

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

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement.

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

   b) A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

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

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

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

9. Supplemental Payment for Non-Rural, Non-State Government Hospitals & Private Hospitals

A non-rural, non-state hospital is a hospital which is owned and operated by either a private entity, a hospital service district or a parish and does not meet the definition of a rural hospital as set forth in Louisiana R.S. 40:1300.143.

a. Acute Care Hospitals

i. Definition of Qualifying Hospitals

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

ii. Reimbursement Methodology

An annual supplemental payment will be issued to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital.

Payments shall be based on the annual upper payment limit calculation per state fiscal year. The annual supplemental payments will not exceed the allowable Medicaid inpatient charge differential per 42CFR 447.271. Maximum inpatient Medicaid payments shall not exceed the upper payment limit per 42CFR 447.272. Each eligible hospital will receive an annual supplemental payment which shall be calculated based on the pro rata share of each qualifying hospital's paid Medicaid days (including covered nursery and distinct part psychiatric unit days).

Effective for dates of service on or after November 20, 2013, the amount appropriated for annual supplemental payments to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital shall be reduced to $1,000,000. Each qualifying hospital's annual supplemental payment shall be calculated based on the pro rata share of the reduced appropriation.

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b. Non-Rural Non-State Hospital Supplemental Payments

Effective for dates of service on or after July 1, 2009, Medicaid Supplemental payments will be made to qualifying non-rural non-state public and private hospitals for dates of service from July 1, 2009 through December 31, 2010 as follows.

1) Hospitals impacted by Hurricane Katrina

Maximum aggregate payments to all qualifying hospitals in this group (which includes outpatient supplemental payments described in Attachment 4.19-B, Item 2.a.) will not exceed $170,000,000.

a) Qualifying criteria – Non-rural non-state public or private hospital which is located in DHH Administrative Region 1 and identified in the July 17, 2008 United States Governmental Accountability Office report as a hospital that has demonstrated substantial financial and operational challenges in the aftermath of Hurricane Katrina.

b) Payment Methodology – Each eligible qualifying hospital shall receive quarterly supplemental payments which in total do not exceed a specified individualized hospital limit. Each hospital's limit shall be calculated by multiplying their Medicaid paid days for SFY 2008 dates of service weighted by 1.5 (to cover the 18 month payment period) and then multiplied by 90% by the following rates:

East Jefferson	$1,083.57
Ochsner Baptist Medical Center	$4,607.06
Ochsner Foundation Hospital	$850.75
Ochsner Medical Center Kenner	$1,486.24
Touro Infirmary	$927.06
Tulane University Hospital and Clinic	$1,267.40
West Jefferson Medical Center	$406.67

If a hospital's number of licensed beds at the end of SFY 2008 were less than 50% of the number of licensed beds at the end of SFY 2009, Medicaid paid days for SFY 2009 dates of service shall be multiplied by the above rates to determine the limit. If two qualifying hospitals merged under a single Medicaid provider number subsequent to the end of SFY 2008, the paid days of the two hospitals will be combined under the surviving hospital provider number.

Effective for dates of service on or after July 1, 2009, supplemental payments will be made quarterly for the inpatient services provided during that quarter. Quarterly payment distribution shall be calculated using the Medicaid paid days for SFY 2008 (or SFY 2009 as applicable) serving as a proxy for SFYs 2010 and 2011 service days and multiplying by the above hospital specific rate. Payments are applicable to Medicaid service dates provided during each quarter and will end when the hospital specific cap is reached or December 31, 2010 whichever occurs first.

2) Other Hospitals impacted by Hurricanes Katrina and Rita.

Maximum aggregate payments to all qualifying hospitals in this group (which includes inpatient psychiatric hospital supplemental payments described in Attachment 4.19-A, Item 14a and Item 16) will not exceed $10 million.

a) Qualifying criteria – Non- rural non-state public or private general acute care or freestanding inpatient psychiatric hospital which did not qualify for inclusion in Group 1) above, which is located in either the New Orleans or Lake Charles metropolitan statistical area (MSA), and had at least 1,000 paid Medicaid days for SFY 2008 dates of service and is currently operational.

b) Payment Methodology – Effective for dates of service on or after July 1, 2009, each eligible qualifying hospital shall receive quarterly supplemental payments which in total do not exceed $1,200,000 per hospital for the 18 month period. Payments are applicable to Medicaid service dates provided during each quarter and will end on December 31, 2010 or when the $1,200,000 limit is reached, whichever occurs first. Payments distributed in the qualifying quarters will be calculated as follows using Medicaid paid days for state fiscal year 2008 service dates serving as a proxy for state fiscal years 2010 and 2011 service dates.

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

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

3) Hospitals Impacted by Hurricanes Gustav and Ike.

Maximum aggregate payments to all qualifying hospitals in this group (which includes inpatient psychiatric hospital supplemental payments described in Attachment 4.19-A, Item 14a and Item 16) will not exceed $7,500,000.

a) Qualifying Criteria – Non- rural non-state public or private general acute care or freestanding inpatient psychiatric hospital which did not qualify for inclusion in either Group 1) or Group 2) above may receive a supplemental payment if the hospital is located in either DHH Administrative Region 2 (Baton Rouge) or 3 (Thibodaux), had at least 1,000 paid Medicaid days for state fiscal year 2008 service dates and is currently operational.

b) Payment Methodology – Effective for dates of service on or after July 1, 2009, each eligible hospital shall receive quarterly supplemental payments which in total do not exceed $1,200,000 per hospital for the 18 month period. Payments are applicable to Medicaid service dates provided during each quarter and will end on December 31, 2010 or when the $1,200,000 limit is reached, whichever

occurs first. Payments distributed in the qualifying quarters will be calculated as follows using Medicaid paid days for state fiscal year 2008 service dates serving as a proxy for state fiscal years 2010 and 2011 service dates.

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

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

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

4) Hurricane Impacted Freestanding Rehabilitation and Long Term Acute Care Hospitals

Maximum aggregate payments to all qualifying hospitals in this group will not exceed $500,000.

a) Qualifying Criteria – Medicare designated freestanding rehabilitation hospital or long term acute hospital that is located in DHH Administrative Region 1 (New Orleans), 2 (Baton Rouge), 3 (Thibodaux), 5 (Lake Charles), or 9 (Mandeville), and had at least 100 paid Medicaid days for SFY 2008 dates of service.

b) Payment Methodology – Effective for dates of service on or after July 1, 2009, each eligible hospital shall receive quarterly supplemental payments. Payments distributed in the qualifying quarters will be calculated using Medicaid paid days for state fiscal year 2008 service dates serving as a proxy for state fiscal years 2010 and 2011 service dates multiplied by $40 per Medicaid paid day. Payments are applicable to Medicaid service dates provided during each quarter and will end on December 31, 2010 or when the $500,000 maximum payment limit for this group is reached, whichever occurs first.

c. Teaching Hospitals

i. Definition of Qualifying Hospitals

In order to qualify for the supplemental payment, an acute care hospital must meet the following criteria. The hospital must:

1. be a non-rural, non-state hospital;
2. have a documented affiliation agreement with a Louisiana medical school accredited by the liaison Committee on Medical Education (LCME);

3. have greater than 5 additional intern and resident full time equivalencies (FTEs) in SFY 2007 and the first six months of 2008 as compared to the Pre-hurricane Katrina period of SFY 2005. These additional intern and residency FTEs must directly result from the graduate medical education (GME) programs that were formerly taught at the Medical Center of Louisiana at New Orleans (MCLNO) and the suspension of training at MCLNO due to the impact of Hurricane Katrina; and

4. reimburse the medical school for the direct GME costs. Direct GME costs are defined as the costs of the resident's salaries and the faculty and administrative costs from the medical school.

ii. Reimbursement Methodology

Effective for dates of services on or after October 1, 2007, a quarterly supplemental payment will be issued to non-rural, non-state acute care hospitals that furnish additional graduate medical education (GME) services.

Each eligible hospital shall be paid a quarterly supplemental payment which shall be calculated based on the pro rata share of each qualifying hospital's weighted paid Medicaid days to the total Medicaid days of all eligible hospitals multiplied by $5,000,000 which is the amount appropriated for these supplemental payments.

Paid Medicaid days (including newborn days included with the mother's stay) for dates of service in SFY 2007 shall be weighted using the following factor(s) as applicable:

1. 1.0 – if the qualifying hospital has average additional resident FTEs of greater than 5, but less than or equal to 10, or
2. 1.5 – if the qualifying hospital has average additional resident FTEs of equal to or greater than 10, but less than or equal to 20, or
3. 2.0 – if the qualifying hospital has an average additional resident FTEs of equal to or greater than 20, and
4. 1.5 – if the qualifying hospital's cost is at least 20 percent more than the current Medicaid per diem rate.

Payment of one third of $5,000,000 will be made at the beginning of the three remaining calendar quarters in SFY 2008 beginning with October 2007. The $5,000,000 pool amount will be paid to qualifying hospitals in four equal quarterly payments beginning with SFY 2009.

d. Major Teaching Hospitals Supplemental Payments

i. Qualifying Criteria

In order to qualify for the supplemental payment, a non-rural, non-state acute care hospital must:

1. be designated as a major teaching hospital by the department in state fiscal year 2009;
2. have provided at least 25,000 Medicaid acute care paid days for state fiscal year 2008 dates of service; and
3. have provided at least 4,000 Medicaid distinct part psychiatric unit paid days for the state fiscal year 2008 dates of service.

ii. Reimbursement Methodology

Effective for the dates of service on or after October 1, 2009, a quarterly supplemental payment shall be issued to qualifying non-rural, non-state acute care hospitals for inpatient services rendered during the quarter. These payments shall be used to facilitate the development of public-private partnerships to preserve access to medically necessary services for Medicaid enrollees. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable caps of $17,451,935 for SFY 2010 and $56,475,474 for SFY 2011.

Payments shall be distributed quarterly and shall be calculated using the Medicaid acute and distinct part psychiatric unit paid days for service dates in state fiscal year 2009 serving as a proxy for SFYs 2010 and 2011 service dates. The annual days from 2009 shall be divided by 4 to obtain the quarterly days.

Payments shall be calculated as followed:

- For dates of service 10/1/09 – 12/31/10 – the Medicaid acute and distinct part psychiatric unit paid days for service dates in state fiscal year 2009 shall be multiplied by the rate of $712.65.
- For dates of service 1/1/11 – 6/30/11 – the Medicaid acute and distinct part psychiatric unit paid days for service dates in state fiscal year 2009 shall be multiplied by the rate of $2,746.59.

Payments are applicable to Medicaid service dates provided during each quarter and shall be discontinued for the remainder of the state fiscal year in the event that the maximum payment cap is reached or by June 30, 2011, whichever occurs first.

iii. Effective for the dates of service July 1, 2011, through September 30, 2011, a supplemental payment will be issued subject to upper payment limits to qualifying non-rural, non-state acute care hospitals for inpatient services rendered during this quarter. These payments shall be used to facilitate the development of public-private partnerships to preserve access to medically necessary services for Medicaid enrollees. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable cap of $4,403,403 for the quarter.

Payments shall be distributed quarterly and shall be calculated using the Medicaid acute and distinct part psychiatric paid days for service dates in state fiscal year 2010 serving as a proxy for SFYs 2012. The annual days from 2010 shall be divided by four to obtain the quarterly days.

Payments shall be calculated as follows:

- For dates of service 7/1/11 – 9/30/11 – the Medicaid acute and distinct part psychiatric unit paid days for service dates in state fiscal year 2010 shall be multiplied by the rate of $559.45.

Payments are applicable to Medicaid service dates provided during the quarter noted above only and shall be discontinued for the remainder of the state fiscal year after the maximum payment cap is reached.

e. **Non-Rural Non-State Government Hospitals**
Effective for dates of service on or after May 15, 2011, quarterly supplemental payments will be issued to qualifying non-rural, non-state government hospitals for inpatient services rendered during the quarter. Payment amounts shall be up to the Medicare inpatient upper payment limit (UPL) as determined in accordance with 42 CFR §447.272.

1. **Qualifying Criteria**
In order to qualify for the supplemental payment, a non-rural, non-state government acute care hospital must meet one of the following:

a. Effective for dates of service on or after October 1, 2012 through June 30, 2013, be:
   i. located in a Medicare Metropolitan Statistical Area (MSA) per 42 CFR 413.231(b)(1), and be located within 15 miles of a state-owned hospital scheduled to closed in SFY 2013; or

b. Effective for dates of service on or after July 1, 2013, be designated as a non-teaching hospital and:
   i. located in a Medicare Metropolitan Statistical Area (MSA) per 42 CFR 413.231(b)(1), and
   ii. provide inpatient obstetrical and Neonatal Intensive Care Unit services, and
   iii. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report; or

c. Effective for dates of service on or after January 1, 2014, be located in a city with a population of over 300,000 as of the 2010 U.S. Census; or

d. Effective for dates of service on or after July 1, 2015, be designated as a major teaching hospital by the Department and have at least 300 licensed acute hospital beds. This provision qualifies East Jefferson General Hospital.

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2. **Reimbursement Methodology**

a. 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.

b. Qualifying hospitals that are enrolled in Medicaid **after January 1, 2014**, will use actual Medicaid utilization and claims data for the hospital for the preceding quarter per the Department's paid claims data as the basis for making quarterly supplemental payments during the hospital's start-up period:

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

   ii. During the start-up period, each quarterly supplemental payment shall be made no later than the 60th day of the subsequent quarter to allow the Department sufficient time to compile actual inpatient Medicaid claims data for the new hospitals to calculate the actual quarterly inpatient charge differential. These retroactive quarterly payments shall be applicable to service dates in the preceding quarter.

c. Payments in the aggregate will not exceed the UPL for all hospitals included in the non-state government owned group.

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f. Supplemental Payments for Private Hospitals

1. Baton Rouge Area

Qualifying Criteria

Effective for dates of service on or after April 15, 2013, a quarterly supplemental payment shall be made to Our Lady of the Lake Hospital, Inc.

Reimbursement Methodology

Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. 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). The payments will be made in four equal quarterly payments based on 100 percent of the estimated charge differential for the state fiscal year. The qualifying hospital will provide quarterly reports to DHH that will demonstrate that, upon implementation, the annual Medicaid inpatient payments do not exceed the annual Medicaid inpatient charges per 42CFR 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. 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. The annual supplemental payments will not exceed the allowable Medicaid inpatient charge differential per 42CFR 447.271. Maximum inpatient Medicaid payments shall not exceed the upper payment limit per 42CFR 447.272.

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DATE APPV'D JUL 23 2013
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10. Additional Payments for Non-Rural, Non-State Hospitals

Hemophilia Blood Products

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

A. Hospital Qualifications

To qualify for the additional reimbursement, the hospital must:

1. be classified as a major teaching hospital and contractually affiliated with a university located in Louisiana that is recognized by the Centers for Disease Control and Prevention and the Health Resource and Services Administration, Maternal and Child Health Bureau as maintaining a comprehensive hemophilia care center;
2. have provided clotting factors to a Medicaid recipient who:
   a. has been diagnosed with hemophilia or other rare bleeding disorders for which the use of one or more clotting factors is Food and Drug Administration (FDA) approved; and
   b. has been hospitalized at the qualifying hospital for a period exceeding six days; and
3. have actual cost exceeding $50,000 for acquiring the blood products used in the provision of clotting factors during the hospitalization.
   a. Actual cost is the hospital's cost of acquiring blood products for the approved inpatient hospital dates of service as contained on the hospital's original invoices, less all discount and rebate programs applicable to the invoiced products.

B. Reimbursement

Hospitals who meet the above 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.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

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11. Reimbursement for In-State Children's Specialty Hospitals

a. Qualifications

In order to qualify to receive Medicaid reimbursement as an in-state children's specialty hospital, a non-rural, non-state acute care hospital must meet the following criteria. The hospital must:

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

(2) not qualify for Medicare disproportionate share hospital payments; and

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

b. Reimbursement Methodology

Effective for dates of service on or after October 4, 2014, hospitals that meet the above qualifications shall be eligible for outlier payments.

Qualifying and receiving reimbursement as a children's specialty hospital shall not preclude these hospitals from participation in the Medicaid Program under the high Medicaid or graduate medical education supplemental payments provisions.

Reimbursement shall be made in accordance with the following children's specialty hospitals services:

(1) Routine Pediatric Inpatient Services

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

(2) Carve-Out Specialty Services

Carve-out specialty services are rendered by neonatal intensive care units, pediatric intensive care units, burn units and include transplants.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Neonatal Intensive Care Units, Pediatric Intensive Care Units, and Burn Units

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

Transplants

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

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

Effective for dates of service on or after February 3, 2010, the rates to children's specialty hospitals shall be reduced by 5 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified for the period, multiplied by 95 percent of the target rate per diem limitation as specified for the period.

Effective for dates of service on or after August 1, 2010, the rates paid to children's specialty hospitals shall be reduced by 4.6 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified for the period, multiplied by 90.63 percent of the target rate per diem limitation as specified for the period.

Effective for dates of service on or after January 1, 2011, the rates paid to children's specialty hospitals shall be reduced by 2 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified for the period multiplied by 88.82 percent of the target rate per diem limitation as specified for the period

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Effective for dates of service on or after August 1, 2012, the per diem rates paid to children's specialty hospitals shall be reduced by 3.7 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified for the period, multiplied by 85.53 percent of the target rate per diem limitation as specified for the period.

Effective for dates of service on or after February 1, 2013, the per diem rates paid to children's specialty hospitals shall be reduced by 1 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified for the period, multiplied by 84.67 percent of the target rate per diem limitation as specified for the period.

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12. Reimbursement for Our Lady of the Lake Hospital, Inc.

Effective for dates of service on or after April 15, 2013, Our Lady of the Lake Hospital, Inc. will qualify for reimbursement at 95 percent of allowable Medicaid costs.

Reimbursement methodology

The inpatient reimbursement shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement will be paid based on a per diem rate and will be cost settled to 95% of allowable costs based on the as filed cost reports. The final reimbursement will be cost settled using the final audited cost report CMS-2552-10 to 95 percent of allowable Medicaid costs.

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13. Qualifying Loss Review Process

Any hospital seeking an adjustment to the operations, movable, fixed capital, or education component of its rate shall submit a written request for administrative review within 30 days after receipt of the letter notifying the hospital of its rate. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later.

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

The Department will acknowledge receipt of the written request within 30 days after actual receipt. Additional documentation may be requested from the hospital as may be necessary to render a decision. A written decision will be rendered within 90 days after receipt of all additional documentation or information requested.

a. Definitions

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"Qualifying loss" in this context refers to that amount by which the hospital's operating costs, movable equipment costs, fixed capital costs, or education costs (excluding disproportionate share payment adjustments) exceeds the Medicaid reimbursement for each component.

"Costs" when used in the context of operating costs, movable equipment costs, fixed capital costs, and education costs, means a hospital's costs incurred in providing covered inpatient services to Medicaid and indigent clients as allowed by the *Medicare Provider Reimbursement Manual*.

"Uninsured Patient" in this context is defined as a patient that is not eligible for Medicare and Medicaid and does not have insurance.

"Uninsured Care Costs" in this context means uninsured care charges multiplied by the cost to charge ratios by revenue code per the last filed cost report, net of payments received from uninsured patients.

b. Permissible Basis

Consideration for qualifying loss review is available only if one of the following conditions exists:

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1) rate-setting methodologies or principles of reimbursement are incorrectly applied; or

2) incorrect or incomplete data or erroneous calculations were used in the establishment of the hospital's rate; or

3) the amount allowed for a component in the hospital's prospective rate is 70 percent or less of the component cost it incurs in providing services that conform to the applicable state and federal laws of quality and safety standards.

For administrative review request in cases that relate to an unresolved dispute between the hospital and its Medicare fiscal intermediary as to any cost reported in the hospital's base year cost report, the Department will resolve such disputes for purposes of deciding the request for administrative review.

c. **Basis Not Allowable**

The following matters are not subject to a qualifying loss review:

1) the use of peer grouped rates;

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

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

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

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

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

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

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

9) the criteria used to identify specialty hospital peer groups;

10) the criteria used to establish the level of burn care; and

11) the use of hospital specific costs for transplant per diem limits.

d. Burden of Proof

The hospital shall bear the burden of proof in establishing the facts and circumstances necessary to support a rate adjustment. Any costs that the provider cites as a basis for relief under this provision must be calculable and auditable.

e. Information to be Provided

All requests for qualifying loss review shall specify the following:

1) the nature of the adjustment sought;

2) the amount of the adjustment sought;

3) the reasons or factors that the hospital believes justify an adjustment; and

4) an analysis demonstrating the extent to which the hospital is incurring or expects to incur a qualifying loss in providing covered services to Medicaid and indigent patients. However, such analysis is not required if the request is limited to a claim that:

a) the rate-setting methodology or criteria for classifying hospitals or hospital claims were incorrectly applied;

b) incorrect or incomplete data or erroneous calculations were used in establishment of the hospital rates; or

c) the hospital has incurred additional costs because of a catastrophe.

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f. Factors Considered

In determining whether to award additional reimbursement to a hospital that has made the showing required, the following factors shall be considered:

1) whether unreimbursed costs are generated by factors generally not shared by other hospitals in the hospital's peer group. Such factors may include, but are not limited to, extraordinary circumstances beyond the control of the hospital, and improvements required to comply with licensing or accrediting standards. Where it appears from the evidence presented that the hospital's costs are controllable through good management practices or cost containment measures, or the hospital through advertisement to the general public promoted the use of high costs services that could be provided in a more cost effective manner, the request for rate adjustment may be denied.

2) financial ratio data indicative of the hospital's performance quality in particular areas of hospital operation. The hospital may be required to provide additional data.

3) whether every reasonable action to contain costs on a hospital-wide basis has been taken. The hospital may be required to provide audited cost data or other quantitative data (including but not limited to) occupancy statistics, average hourly wages paid, nursing salaries per adjusted patient day, average length of stay, cost per ancillary procedure, average cost per meal served, average cost per pound of laundry, average cost per pharmacy prescription, housekeeping costs per square foot, medical records costs per admission, full-time equivalent employees per occupied bed, age of receivables, bad debt percentage, inventory turnover rate, and information about actions that the hospital has taken to contain costs.

4) An onsite operational review/audit of the hospital by the Department may be required.

g. Determination to Award Relief

Additional reimbursement shall be awarded to a hospital that demonstrates to the Department by clear and convincing evidence that:

1) the hospital demonstrated a qualifying loss; and

2) the hospital's current prospective rate jeopardized the hospital's long-term financial viability; and

3) the Medicaid population served by the hospital has no reasonable access to other inpatient hospitals for the services that the hospital provides and that the hospital contends are under-reimbursed; or

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

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

   2. Hospitals with multiple locations of service shall measure uninsured costs separately and qualify each location as an individual hospital and rate adjustments shall not exceed 5 percent of the applicable per diem rate.

h. Relief Awarded

Notification of decision regarding qualifying loss review shall be provided in writing. Should the decision be to award relief, relief consists of making appropriate adjustments so as to correctly apply the rate-setting methodology, or to correct calculations, data errors, or omissions, or increase one or more of the hospital's rates by an amount that can reasonably be expected to ensure continuing access to sufficient inpatient hospital services of adequate quality for Medicaid patients served by the hospital. A hospital's corrected rate component shall not exceed the lesser of its recalculated cost for that component or 105% of the provider's peer group rate for that component.

If subsequent discovery reveals that the provider was not eligible for qualifying loss relief, any relief awarded under this qualifying loss process shall be recouped.

i. Effect of Decision

Decisions to recognize omitted, additional, or increased costs incurred by any hospital; to adjust the hospital rates; or to otherwise award additional reimbursement to any hospital shall not result in any change in the peer group calculations for any rate component.

Rate adjustments granted under this provision shall be effective from the first day of the rate period to which the hospital's request for qualifying loss review relates. Hospitals must document their continuing eligibility at the beginning of each subsequent state fiscal year.

However, no retroactive adjustment will be made to the rate or rates that were paid during any state fiscal year prior to the year for which qualifying loss review was requested.

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j. Administrative Appeal

The hospital may appeal an adverse qualifying loss decision to the Office of the Secretary, Bureau of Appeals for the Department of Health and Hospitals, P.O. Box 4183, Baton Rouge, LA 70821-4183. The appeal must be lodged in writing with the Bureau of Appeals within thirty days of receipt of the written decision, and state the basis for the appeal. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later. The administrative appeal shall be conducted in accordance with the Louisiana Administrative Procedures Act (L.R.S. 49:951 et seq). The Bureau of Appeals shall submit a recommended decision to the Secretary of the Department, who will issue the final decision.

k. Judicial Review

Judicial review of the Secretary's decision shall be in accordance with the Louisiana Administrative Procedures Act) L.R.S. 49:951 et seq) and shall be filed in the Nineteenth Judicial District Court.

CITATION 42CFR
447.253, OBRA 90
P.L. 101-508,
Sections 4702-4703

Medical and Remedial
Care and Services
Item 1 (Cont.)

C. Out-of-State Facilities-

Effective for dates of service on or after April 1, 2003, out-of-state facilities are reimbursed for inpatient hospital services at the lower of 40% of billed charges or the Medicaid per diem rate of the state wherein the services are provided for recipients age 21 and older and the lower of 60% of billed charges or the Medicaid per diem rate of the state wherein the services are provided for recipients under the age of 21. Hospitals designated as children's hospitals that are located in states that border Louisiana shall be reimbursed at the lower of the Medicaid per diem rate of the state wherein the services are provided or the Louisiana children's hospital Medicaid peer group rate. Neonatal intensive care unit services, pediatric intensive care unit services, and burn unit services provided in these children's hospitals shall be paid the Louisiana peer group rate for the qualifying level of service documented by the hospital. The hospital stay and the level of service shall be authorized by the Bureau.

D. Disproportionate Share Hospitals

Effective for inpatient hospital services provided on or after July 1, 2003, a payment adjustment for hospitals serving a disproportionate share of low income patients (DSH) shall be implemented in the following manner:

State: Louisiana
Date Received: August 22, 2014
Date Approved: OCT - 6 2014
Date Effective: July 1, 2014
Transmittal Number: 14-29

CITATION	Medical and Remedial Care and Services Item 1 (Contd.)
42 CFR 447.253 OBRA-90 P.L. 101-508 Sections 4702-4703	

1. Qualifying criteria for a Disproportionate Share Hospital:

a. Hospital has at least two obstetricians who have staff privileges and who have agreed to provide obstetric services to individuals who are Medicaid eligible. In the case of a hospital located in a rural area (i.e., an area outside of a metropolitan statistical area), the term obstetrician includes any physician who has staff privileges at the hospital to perform nonemergency obstetric procedures; or

b. Hospital treats inpatients who are predominantly individuals under 18 years of age; or

c. Hospital which did not offer nonemergency obstetric services to the general population as of December 22, 1987; and

d. Hospital has a utilization rate in excess of one or more of the following specified minimum utilization rates:

(i) Medicaid Utilization Rate is a fraction (expressed as a percentage). The numerator is the hospital's number of Medicaid (Title XIX) inpatient days. The denominator is the total number of the hospital's inpatient days for a cost reporting period. Inpatient days include newborn and psychiatric days and exclude swing bed and skilled nursing days. Hospitals shall be deemed disproportionate share providers if their Medicaid utilization rates are in excess of the mean, plus one standard deviation of the Medicaid utilization rates for all hospitals in the state receiving payments; or

(ii) Hospitals shall be deemed disproportionate share providers if their low-income utilization rates are in excess of 25 percent. Low-Income Utilization Rate is the sum of:

(a) the fraction (expressed as a percentage), the numerator of which is the sum (for the period)

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CITATION	Medical and Remedial Care and Services Item 1 (Contd.)
42 CFR 447.253 OBRA-90 P.L. 101-508 Sections 4702-4703	

of the total Medicaid patient revenues plus the amount of the cash subsidies for patient services received directly from state and local governments. The denominator is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the cost reporting period from the financial statements; and

(b) the fraction (expressed as a percentage), the numerator of which is the total amount of the hospital's charges for inpatient services which are attributable to charity (free) care in a period, less the portion of any cash subsidy as described in (ii) (a) above in the period which are reasonably attributable to inpatient hospital services; and the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the period. For public providers furnishing inpatient services free of charge or at a nominal charge, this percentage shall not be less than zero (0). The above numerator shall not include contractual allowances and discounts (other than for indigent patients ineligible for Medicaid), i.e., reductions in charges given to other third party payors, such as HMOs, Medicare, or Blue Cross; nor charges attributable to Hill-Burton obligations.

A hospital providing "free care" must submit its criteria and procedures for identifying patients who qualify for free care to BHSF for approval. The policy for free care must be posted prominently and all patients must be advised of the availability of free care and procedures for applying. Hospitals not in compliance with free care criteria will be subject to recoupment of DSH and Medicaid payments; or

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

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e. Meet the definition of a public non-rural community hospital as defined in I.D.3.e. below; **or**

f. Effective September 15, 2006, be a private non-rural community hospital as defined in I.D.3.f. below; **or**

g. Effective November 3, 1997, be a small rural hospital as defined in I.D.3.b.; **or**

h. Effective for dates of service on or after January 1, 2008, be a Medicaid enrolled non-state acute care hospital that expands their existing distinct part psychiatric unit or that enrolls a new distinct part psychiatric unit, and signs an addendum to the Provider Enrollment form (PE-50) by April 3, 2008 with the Department of Health and Hospitals, Office of Mental Health; **or**

i. Effective for dates of service on or after January 21, 2010, be a hospital participating in the Low Income and Needy Care Collaboration; **or**

j. Effective for dates of service on or after May 24, 2014, meet the definition of a Louisiana Low-Income Academic Hospital; **and**

k. In addition to the qualification criteria outlined in I.D.1.a.-j. above, effective July 1, 1994, the qualifying disproportionate share hospital must also have a Medicaid inpatient utilization rate of at least one percent (1%).

2. General Provisions for Disproportionate Share Payments

a. Total cumulative disproportionate share payments under any and all DSH payment methodologies shall not exceed the federal disproportionate share state allotment for Louisiana for each federal fiscal year. The Department shall make necessary downward adjustments to hospitals' disproportionate share payments to remain within the federal disproportionate share allotment.

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b. Appropriate action including, but not limited to, deductions from DSH, Medicaid payments and cost report settlements shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify.

c. DSH payments to a hospital determined under any of the methodologies below shall not exceed the disproportionate share limits as defined in Section 1923(g)(1)(A) of the Social Security Act for the state fiscal year to which the payment is applicable. Any Medicaid profit will be used to offset the cost of treating the uninsured in determining the hospital specific DSH limits.

d. Qualification is based on the hospital's latest filed cost report and related uncompensated cost data as required by the Department. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization. Qualification for small rural hospitals is based on the latest filed cost report. Hospitals must file cost reports in accordance with Medicare deadlines, including extensions. Hospitals that fail to timely file Medicare cost reports and related uncompensated cost data shall be assumed to be ineligible for disproportionate share payments.

Hospitals are notified by letter at least 60 days in advance of calculation of the DSH payment to submit documentation required to establish DSH qualification. Required documents are: 1) obstetrical qualification criteria form; 2) low income utilization revenue calculation; 3) Medicaid cost report; 4) uncompensated cost calculation. Only hospitals that timely return disproportionate share qualification documentation will be considered for disproportionate share payments.

After the final payment during the state fiscal year has been issued, no adjustment will be given on DSH payments, with the exception of public state-operated and public non-rural community hospitals, even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital.

e. Hospitals and/or units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments for the remainder of the current DSH pool payment cycle and thereafter.

f. Effective for dates of service on after March 21, 2010, the uncompensated care costs associated with outpatient high-tech imaging that do not meet the established criteria for radiology utilization management are not allowable for disproportionate share payments.

g. Effective for dates of service on after July 1, 2010, the Medicaid shortfall resulting from Medicaid days that did not meet the established criteria for pre-admission certification and length of stay assignment is not allowable for the uncompensated care costs for the disproportional share payment calculation. The exclusion of these costs and associated days (if applicable) does not affect the hospital specific uncompensated care limit or eligibility for disproportionate share payments.

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3. Reimbursement Methodologies

Qualifying hospitals shall be reimbursed in accordance with only one of the following reimbursement methodology categories.

a) Inpatient Distinct Part Psychiatric Units

1. Effective for dates of service on or after February 10, 2012, a Medicaid enrolled non-state acute care hospital that enters into a Cooperative Endeavor Agreement (CEA) with the Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to Medicaid and uninsured patients, and which also assumes operation and management of a state owned and formerly state operated hospital distinct part psychiatric unit, shall be paid a per diem rate of $581.11 per day for each uninsured inpatient.

2. Qualifying hospitals must submit costs and patient specific data in a format specified by the Department. Cost and lengths of stay will be reviewed for reasonableness before payments are made.

3. Payments shall be made on a quarterly basis.

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b. Small Rural Hospitals

1) A Small Rural Hospital is defined as a hospital (other than a long-term care hospital, rehabilitation hospital, or free-standing psychiatric hospital but including distinct part psychiatric units) that meets the criteria below.

A qualifying hospital:

a) has no more than sixty beds as of July 1, 1994; and: 1) is located in a parish with a population of less than fifty thousand; or 2) is located in a municipality with a population of less than twenty thousand.

OR

b) meets the qualifications of a sole community hospital under 42 CFR §412.92(a); or met the qualifications of a sole community hospital as of June 30, 2005 and subsequently converts to critical access hospital status;

OR

c) effective October 1, 1999, has no more than sixty hospital beds as of July 1, 1999, and is located in a parish with a population of less than 17,000 as measured by the 1990 census.

OR

d) effective October 1, 1999 has no more than sixty hospital beds as of July 1, 1997 and is a publicly owned and operated hospital; and: 1) is located in a parish with a population of less than fifty thousand; or 2) is located in a municipality with a population of less than twenty thousand;

OR

e) effective August 8, 2001, has no more than sixty hospital beds as of June 30, 2000 and is located in a municipality with a population of less than 20,000 as measured by the 1990 census.

OR

f) effective August 8, 2001, has no more than sixty hospital beds as of July 1, 1997 and is located in a parish with a population of less than fifty thousand as measured by the 1990 and 2000 census;

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g) effective August 8, 2001, was a facility licensed by the Department that had no more than sixty hospital beds as of July 1, 1994, which hospital facility has been in continuous operation since July 1, 1994, is currently operating under a license issued by the Department, and is located in a parish with a population of less than fifty thousand as measured by the 1990 census;

OR

h) has no more than 60 hospital beds or has notified the Department as of March 7, 2002 of its intent to reduce its number of hospital beds to no more than 60, and is located in a municipality with a population of less than 13,000 and in a parish with a population of less than 32,000 as measured by the 2000 census.

OR

i) has no more than 60 hospital beds or has notified DHH as of December 31, 2003, of its intent to reduce its number of hospital beds to no more than 60; and is located in a municipality with a population of less than 7,000, as measured by the 2000 census; and is located in a parish with a population of less than 53,000, as measured by the 2000 census; and is located within 10 miles of a United States military base;

OR

j) has no more than 60 hospital beds as of September 26, 2002; and is located in a municipality with a population of less than 10,000, as measured by the 2000 census; and is located in a parish with a population of less than 33,000, as measured by the 2000 census;

OR

k) has no more than 60 beds as of January 1, 2003; and is located in a municipality with a population of less than 11,000, as measured by the 2000 census; and is located in parish with a population of less than 90,000, as measured in the 2000 census.

OR

l) has no more than 40 hospital beds as of January 1, 2005, and is located in a municipality with a population of less

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than 3,100; and is located in a parish with a population of less than 15,800 as measured by the 2000 census;

OR

has no more than 60 hospital beds as of November 1, 2013, and is located in a municipality with a population of less than 33,000 as measured by the 2000 census; and is located in a parish with a population of less than 68,000, as measured in the 2000 census; and is located within 3 miles of Jackson Barracks.

2) Payment is based on uncompensated cost for qualifying small rural hospitals in one of the following pools:

   a) Public (non-state) Small Rural Hospitals are small rural hospitals as defined above which are owned by a local government; OR

   b) Private Small Rural Hospitals are small rural hospitals as defined above that are privately owned; OR

   c) Small Rural Hospitals as defined above in sections 1)i) through 1)k).

   d) Small Rural Hospitals as defined above in section 1) l).

3) DSH payments to small rural hospitals are prospective and paid once per year for the federal fiscal year. Payment to hospitals included in 2)a) through 2)d) above is equal to each qualifying hospital's pro rata share of net uncompensated costs from the hospital's latest filed cost report for all hospitals meeting these criteria multiplied by $49,775,657which is the state appropriation for disproportionate share payments allocated for this pool of hospitals for SFY 2010-2011. Net Uncompensated Cost is the cost of furnishing inpatient and outpatient hospital services, net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, and all other inpatient and outpatient payments received from patients. If the cost reporting period is not a full period (twelve months), actual uncompensated cost data for the previous cost reporting period may be used on a pro rata basis to equate to a full year.

4) A pro rata decrease necessitated by conditions specified in I.D.2.a. above for hospitals described in this section will be calculated based on the ratio determined by dividing the hospital's uncompensated costs by the uncompensated costs for all qualifying hospitals in this section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment. Additional payments shall only be made after finalization of the CMS mandated DSH audit for the state fiscal year.

Payments shall be limited to the aggregate amount recouped from small rural hospitals based on these reported audit results. If the small rural hospitals' aggregate amount of underpayments reported per the audit results exceeds the aggregate amount overpaid, the payment redistribution to underpaid shall be paid on a pro rata basis calculated using each hospital's amount underpaid divided by the sum of underpayments for all small rural hospitals.

5) Qualifying hospitals must meet the definition for a small rural hospital contained in I.D.3.b.1). Qualifying hospitals must maintain a log documenting the provision of uninsured care as directed by the Department.

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c. Federally Mandated Statutory Hospitals

1) Hospitals that meet the federal DSH statutory utilization requirements in D.1.d.(i) and (ii).

2) DSH payments to individual federally mandated statutory hospitals shall be based on actual paid Medicaid days for a six-month period ending on the last day of the last month of that period, but reported at least 30 days preceding the date of payment. Annualization of days for the purposes of the Medicaid days pool is not permitted. The amount will be obtained by the Department from a report of paid Medicaid days by service date.

3) Disproportionate share payments for individual hospitals in this group shall be calculated based on the product of the ratio determined by:

   (i) dividing each qualifying hospital's actual paid Medicaid inpatient days for a six month period ending on the last day of the month preceding the date of payment (which will be obtained by the Department from a report of paid Medicaid days by service date) by the total Medicaid inpatient days obtained from the same report of all qualified hospitals included in this group. Total Medicaid inpatient days include Medicaid nursery days but do not include skilled nursing facility or swing bed days; and

   (ii) for the SFY 2014-2015, multiplying by $1,000,000 which is the state appropriation share payments allocated for this pool of hospitals. Thereafter, multiplying by $1,000,000, the state appropriation for disproportionate share payments allocated for this pool of hospitals.

4) A pro rata decrease necessitated by conditions specified in I.D.2. above for hospitals in this group will be calculated based on the ratio determined by dividing the hospitals' Medicaid days by the Medicaid days for all qualifying hospitals in this group; then multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate share allotment or state disproportionate share appropriated amount as indicated in paragraph c.3) (ii) above.

   Payments from this DSH category to hospitals qualifying for another DSH category will be made subsequent to the other DSH payments. Aggregate DSH payments for hospitals that received payment from this and any other DSH category shall not exceed the hospital's specific DSH limit as defined in section D.2.c. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be adjusted downward not to exceed the limit.

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d. Public State-Operated Hospitals

1) Public State Operated Hospital is a hospital that is owned or operated by the State of Louisiana.

2) DSH payments to individual public state-owned or operated hospitals shall be up to 100 percent of the hospital's net uncompensated costs. Final payment will be made in accordance with final uncompensated care costs as calculated per the CMS mandated audit for the state fiscal year. DSH payments calculated under this payment methodology shall be subject to the adjustment provision below in § 3).

3) In the event that it is necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment, the department shall calculate a pro rata decrease for each public state-owned or operated hospital based on the ratio determined by:

   (i) dividing that hospitals' uncompensated cost by the total uncompensated cost for all qualifying public state-owned or operated hospitals during the state fiscal year; and then

   (ii) multiplying the amount of disproportionate share payments calculated in excess of the federal disproportionate allotment.

4) It is mandatory that hospitals seek all third party payments including Medicare, Medicaid and other third party carriers and payments from patients. Hospitals must certify that excluded from net uncompensated cost are any costs for the care of persons eligible for Medicaid at the time of registration. Acute hospitals must maintain a log documenting the provision of uninsured care as directed by the Department. Hospitals must adjust uninsured charges to reflect retroactive Medicaid eligibility determination. Patient specific data is required after July 1, 2003. Hospitals shall annually submit:

   (i) annual attestation that patients whose care is included in the hospitals' net uncompensated cost are not Medicaid eligible at the time of registration; and

(ii) supporting patient specific demographic data that does not identify individuals, but is sufficient for audit of the hospitals' compliance with the Medicaid ineligibility requirement as required by the Department, including:

(a) patient age;
(b) family size;
(c) number of dependent children; and
(d) household income.

e. Non-state (public), Non-Rural Community Hospitals Disproportionate Share Hospital (DSH)

1) A public, non-rural community hospital is defined as any non-state, non-rural hospital (including hospitals with distinct part psychiatric units, long term care hospitals, rehabilitation, and free standing psychiatric hospitals) that is owned by a parish, city, or other local government agency or instrumentality; and meets the qualifying criteria for disproportionate share hospital in I.D.1.

2) Uncompensated care costs are defined as the hospital's costs of furnishing inpatient and outpatient hospital services, net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, private payer payments, and all other inpatient and outpatient payments received from patients. Uncompensated care costs payments for the period(s) covering the state fiscal year to which the payment is applicable shall be calculated as follows:

(i) Initial Payment – Based on data per the most recently filed Medicare cost report.

(ii) Interim Reconciliation Payment – Based on as filed cost report(s) for applicable state fiscal year.

(iii) Final Payment – Based on the final uncompensated care costs as calculated per the CMS mandated audit for the state fiscal year.

DSH payments to individual public non-rural community hospitals shall be equal to 100 percent of the hospital's uncompensated costs. DSH payments under this payment methodology shall be subject to the adjustment provision below in §3. Payments will be made annually.

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3) In the event it is necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment for this group, the Department shall calculate a pro rata decrease for each public non-rural community hospital based on the ratio determined by dividing that hospital's uncompensated cost by the total uncompensated cost for all qualifying public non-rural community hospitals during the state fiscal year; and then multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate allotment.

4) It is mandatory that hospitals seek all third party payments including Medicare, Medicaid and other third party carriers and payments from patients. Hospitals must certify that excluded from net uncompensated cost are any costs for the care of persons eligible for Medicaid at the time of registration. Hospitals must maintain a log documenting the provision of uninsured care as directed by the Department. Hospitals must adjust uninsured charges to reflect retroactive Medicaid eligibility determination.

5) A hospital receiving DSH payments shall furnish emergency and nonemergency services to uninsured persons with family incomes less than or equal to 100 percent of the federal poverty level on an equal basis to insured patients.

6) Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit. The remaining payments shall be redistributed to the other hospitals in accordance with these provisions.

f. THIS SECTION RESERVED

STATE Louisiana
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DSH REIMBURSEMENT METHODOLOGIES (continued)

f. Louisiana Low-Income Academic Hospitals

Qualifying Criteria

A. Hospitals Located Outside of the Lake Charles Metropolitan Statistical Area

Effective for dates of service on or after May 24, 2014, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located outside of the Lake Charles Metropolitan Statistical Area (MSA);
b. having uninsured patient utilization, as measured by allowable uninsured inpatient and outpatient charges, greater than 20 percent. Qualification shall be based on uninsured utilization data per the prior state fiscal year date of service time period; and
c. maintaining at least 15 unweighted intern and resident full-time equivalent positions, as reported on the Medicare Cost Report Worksheet E-4, Line 6.

B. Hospitals Located In the Lake Charles Metropolitan Statistical Area

Effective for dates of service on or after May 24, 2014, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located in the Lake Charles MSA;
b. having uninsured patient utilization, as measured by allowable uninsured inpatient and outpatient charges, greater than 10 percent. To determine qualification in state fiscal year 2014, the first six month dates of service time period (July 1, 2013 through December 31, 2013) shall be used. In subsequent state fiscal years, qualification shall be based on uninsured utilization data per the prior state fiscal year date of service time period; and
c. maintaining at least 20 unweighted intern and resident full-time equivalent positions, as reported on the Medicare Cost Report Worksheet E-4, Line 6.

Payment Methodology

a) Each qualifying hospital shall be paid DSH adjustment payments equal to 100 percent of allowable hospital specific uncompensated care costs subject to the Appropriations Act. DSH payments to qualifying hospitals shall not exceed the disproportionate share limits as defined in Section 1923(g)(1)(A) of the Social Security Act for the state fiscal year to which the payment is applicable.
b) For the initial year's payment calculation, each qualifying hospital shall submit interim actual cost data calculated utilizing Medicaid allowable cost report principles, along with actual Medicaid and uninsured patient charge data. Annual Medicaid costs shortfalls and

unreimbursed uninsured patient costs are determined based on review and analysis of these submissions. For subsequent year's payment calculations, the most recent Medicaid filed cost report along with actual Medicaid and uninsured patient charge data annualized from the most recent calendar year completed quarter is utilized to calculate hospital specific uncompensated care costs.

c) The Department shall review cost data, charge data, lengths of stay and Medicaid claims data per the MMIS system for reasonableness before payments are made.

d) The first payment of each fiscal year will be made by October 15 and will be 80 percent of the annual calculated uncompensated care costs. The remainder of the payment will be made by June 30 of each year. Reconciliation of these payments to actual hospital specific uncompensated care costs will be made when the cost report(s) covering the actual dates of service from the state fiscal year are filed and reviewed. Additional payments or recoupments, as needed, shall be made after the finalization of the CMS mandated DSH audit for the state fiscal year.

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

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g. RESERVED

h. Low Income and Needy Care Collaborating Hospitals

1) In order to participate under the Low Income and Needy Care Collaborating Hospital DSH category a hospital must be party to a Low Income and Needy Care Collaboration Agreement with the Department of Health and Hospitals. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2) DSH payments to Low Income and Needy Care Collaborating Hospitals shall be calculated as follows:

   a) In each quarter, the Department shall divide hospitals qualifying under this DSH category into two pools. The first pool shall include hospitals that, in addition to qualifying under this DSH category, also qualify for DSH payments under any other DSH category. Hospitals in the first pool shall be eligible to receive DSH payments under the

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provisions of subsection b). The second pool shall include all other hospitals qualifying under this DSH category. Hospitals in the second pool shall be eligible to receive DSH payments under the provisions of subsection c).

b) In each quarter, to the extent the Department appropriates funding to this DSH category, hospitals that qualify under this subsection shall receive 100 percent of the total amount appropriated by the Department for this DSH category.

i) If the net uncompensated care costs of these hospitals exceed the amount appropriated for this pool, payment shall be made based on each hospital's pro rata share of the pool. The pro rata share shall be calculated by dividing the hospital's net uncompensated care costs by the total of the net uncompensated care costs for all hospitals qualifying under this subsection and multiplying by the amount appropriated by the Department.

ii) If the amount appropriated for this DSH category exceeds the net uncompensated care costs of all hospitals qualifying under this subsection, payment shall be made up to each hospital's net uncompensated care costs.

iii) Any amount available after all distributions are made under the provisions in this subsection shall be distributed subject to the provisions in subsection c) below.

c) In each quarter, to the extent distributions are available, and after all distributions are made under provisions in the previous subsection b), distributions under the provisions of this subsection c) shall be made according to the following terms.

i) If the net uncompensated care costs of all hospitals qualifying for payment under the provisions of this subsection exceed the amount available for this pool, payment shall be made based on each hospital's pro rata share of the pool. The pro rata share shall be calculated by dividing its net uncompensated care costs by the total of the net uncompensated care costs for all hospitals qualifying under this subsection.

ii) If the amount available for payments under this subsection exceeds the net uncompensated care costs of all qualifying hospitals, payments shall be made up to each hospital's net uncompensated care costs and the remaining amount shall be

used by the Department to make disproportionate share payments under this DSH category in future quarters.

d) In the event it is necessary to reduce the amount of disproportionate share payments under this DSH category to remain within the federal disproportionate share allotment in any quarter, the Department shall calculate a pro rata decrease for each hospital qualifying under the provisions of subsection c). The pro rata decrease shall be based on a ratio determined by:

i) dividing that hospital's DSH payments by the total DSH payments for all hospitals qualifying under subsection c) in that quarter; and

ii) multiplying the amount of DSH payments calculated in excess of the federal disproportionate share allotment.

If necessary in any quarter, the Department will reduce Medicaid DSH payments under these provisions to zero for all applicable hospitals.

e) After the reduction in subsection d) has been applied, if it is necessary to further reduce the amount of DSH payments under this DSH category to remain within the federal disproportionate share allotment in any quarter, the Department shall calculate a pro rata decrease for each hospital qualifying under subsection b). The pro rata decrease shall be based on a ratio determined by:

i) dividing that hospital's DSH payments by the total DSH payments for all hospitals qualifying under subsection b) in that quarter; and

ii) multiplying the amount of DSH payments calculated in excess of the federal disproportionate share allotment.

If necessary in any quarter, the Department shall reduce Medicaid DSH payments under these provisions to zero for all applicable hospitals.

f) Qualifying hospitals must submit costs and patient specific data in a format specified by the Department. Costs and lengths of stay will be reviewed for reasonableness before payments are made.

g) Payments shall be made on a quarterly basis, however, each hospital's eligibility for DSH and net uncompensated care costs shall be

determined on an annual basis.

h) Payments to hospitals qualifying under this DSH category shall be made subsequent to any DSH payments for which a hospital is eligible under another DSH category.

i) Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit. The remaining payments shall be redistributed to the other hospitals in accordance with these provisions.

i. Freestanding Psychiatric Hospitals

Qualifying Criteria: Effective for dates of service on or after January 1, 2013, a Medicaid enrolled non-state (including private hospitals) owned and operated free standing psychiatric hospital may qualify for this category:

1). assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility (Meridian Behavioral Health dba Northlake Behavioral); or

2). providing services that were previously delivered and terminated or reduced by a state owned and operated facility (River Oaks Hospital, and Community Care Hospital).

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DATE EFF 1-2-2013
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Reimbursement Methodology: Qualifying hospitals shall be paid a per diem rate of $581.11 per day for each uninsured patient. Qualifying hospitals must submit costs and patient specific data in a format specified by the Department. Cost and lengths of stay will be reviewed for reasonableness before payments are made. Payments shall be made on a monthly basis. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit.

Effective for dates of service on or after October 1, 2015, the per diem rate in effect as of September 30, 2015, shall be reduced by five percent. The new per diem rate shall be $552.05 per day.

Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit.

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

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

CITATION	Medical and Remedial Care and Services Item 1
42 CFR 447.253 OBRA-90 P.L. 101-508 Sections 4702-4703	

F. Distinct Part Psychiatric Units

1. Effective for services on or after January 1, 1989, psychiatric units within an acute care general hospital which meet the criteria for exemption from Medicare's Prospective Payment System (PPS) shall have admissions to this unit carved out and handled separately as a sub-provider. A separate provider number shall be assigned to differentiate admissions to these units and their related costs from other hospital admissions and costs. Separate cost centers must be established as costs related to Distinct Part Psychiatric Unit admissions shall not be allowed in the cost settlement process applicable to other admissions. Rather, reimbursement for inpatient services provided in these units shall be a prospective statewide per diem rate.

2. Effective for dates of service October 21, 2003, the reimbursement is increased for inpatient psychiatric hospital services provided in a state owned or operated free-standing psychiatric hospital or distinct part psychiatric unit to a per diem rate based on the 50th percentile facility for costs as reported on the cost report for the year ending between July 1, 2001 and June 30, 2002. The costs utilized to determine the 50th percentile facility will include all free-standing psychiatric hospitals and distinct part psychiatric units providing services to Medicaid recipients in the state. Costs will be trended to the midpoint of the rate year using the Medicare PPS Market Basket Index.

CITATION	Medical and Remedial Care and Services Item 1 (cont'd.)
42 CFR 447.253	

3. Effective March 1, 1994, a unit in a PPS exempt hospital which meets PPS exempt psychiatric unit criteria as specified II.B.2. shall also be considered a Distinct Part Psychiatric Unit included in the methodology described above.

4. Effective for dates of service on or after July 1, 2004, the reimbursement is increased for inpatient psychiatric hospital services provided in private and public non-state owned and operated distinct part psychiatric units based on the weighted average for costs reported on the cost report ending in SFY 2002. The costs utilized to determine the weighted average shall include all free-standing psychiatric hospitals and distinct part psychiatric units providing services to Medicaid recipients in the state. Costs shall be trended to the midpoint of the rate year using the Medicare PPS Market Basket Index.

5. Effective for dates of services on or after August 1, the inpatient psychiatric per diem rates paid to private hospitals are increased by 3.85% of the rates in effect on July 31, 2006.

6. For dates of service on or after September 1, 2007, the prospective per diem rate paid to non rural private (non-state) distinct part psychiatric units shall be increased by 4.75 percent of the rate on file for August 31, 2007.

7. Effective for dates of service on or after July 1, 2008, distinct part psychiatric services provided in small rural hospitals as defined in D.3.b. shall be reimbursed at a prospective per diem rate. The per diem rate shall be the median cost plus ten percent which shall be calculated based on each hospital's year-end cost report period ending in calendar year 2006. If the cost reporting period is not a full period (twelve months), the latest filed full period cost report shall be used. The Medicaid cost per inpatient psychiatric day for each small rural hospital shall be inflated from their applicable cost reporting period to the midpoint of the implementation year (December 31, 2008) by the Medicare market basket inflation factor for PPS hospitals, then arrayed from high to low to determine the median inpatient acute cost per day for all small rural hospitals. The payment rate for inpatient psychiatric services in small rural hospitals shall be the median cost amount plus ten percent. The median cost and rates shall be rebased at least every other year using the latest filed full period cost reports as filed in accordance with Medicare timely filing guidelines.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

8. Effective for dates of service on or after February 20, 2009, the prospective per diem rate paid to non-rural, non-state distinct part psychiatric units shall be reduced by 3.5 percent of the rate on file as of February 19, 2009. Distinct part psychiatric units that operate within an acute care hospital that qualifies as a high Medicaid hospital, as defined below, are exempt from the rate reduction.

   a. High Medicaid hospitals as defined in Louisiana R.S. 46.979. For the purposes of qualifying for the exemption to the reimbursement reduction as a High Medicaid hospital, the following conditions must be met.

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

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

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

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

10. In-state Children's Specialty Hospitals

   a. In order to qualify to receive Medicaid reimbursement as an in-state children's specialty hospital, a non-rural, non-state acute care hospital must meet the following criteria. The hospital must:

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

      (2) not qualify for Medicare disproportionate share hospital payments; and

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

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

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

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

d. Qualifying and receiving reimbursement as a children's specialty hospital shall not preclude these hospitals from participation in the Medicaid Program under the high Medicaid or graduate medical education supplemental payments provisions.

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11. Effective for dates of service on or after October 1, 2009, the prospective per diem rate paid to non-rural, non-state distinct part psychiatric units shall be increased by 3 percent of the rate on file.

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

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

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

15. Effective for dates of service on or after February 10, 2012, a Medicaid enrolled non-state acute care hospital that enters into a Cooperative Endeavor Agreement (CEA) with the Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to Medicaid and uninsured patients, and which also assumes operation and management of a state owned and formerly state operated hospital distinct part psychiatric unit, shall be paid a per diem rate of $581.11 per day.

G. Transplant Services

Routine operating costs and ancillary charges associated with an approved transplant are carved out of the hospital's cost report. Reimbursement is limited to the lesser of cost or the hospital-specific per diem limitation for each type of transplant. Cost is defined as the hospital-specific ratio of cost to charges from the base period multiplied by the covered charges for the specific transplant type.

Per diem limitation is calculated by deriving the hospital's per diem for the transplant type from the hospital's base period trended forward using the Medicare target rate percentage for PPS-exempt hospitals each year.

The base period is the cost reporting period for the hospital fiscal year ending September 30, 1983 through August 31, 1984 or the first cost report filed subsequently that contains costs for that type of transplant.

* Due to typographical error, pen and ink change requested by Keydra Singleton, Medicaid Program Manager, on 5/25/12.

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING RATES - IN-PATIENT HOSPITAL CARE

CITATION	Medical and Remedial	H. Hospital Intensive Neurological Rehabilitation Care Units
42 CFR	Care and Services	
447.252	Item 1 (cont'd.)	

Effective for services on or after January 1, 1993, reimbursement for neurological rehabilitation services provided by a Hospital Intensive Neurological Rehabilitation Care (HINRC) unit within an acute care general hospital is available separately from other hospital services. Establishment of such a unit is optional. Reimbursement for HINRC units is all inclusive and is not in addition to the hospital rate.

Admissions for neurological rehabilitation services provided by an enrolled HINRC unit shall be carved out and handled separately as a subprovider. A separate provider number shall be assigned to differentiate admissions to these units and their related costs from other hospital admissions and costs. Separate cost centers must be established as costs related to exempt neurological units shall not be allowed in the cost settlement process applicable to other admissions. Reimbursement for inpatient services provided in these units shall be a prospective statewide per diem.

An interim rate is established using reported partial year cost report data from state fiscal year 92-93. The prospective per diem rate is established using the audited statewide weighted average cost per day for all costs associated with HINRC units, using cost reporting periods ending in state fiscal year 93-94 as a base period. All payments made utilizing the interim rate shall be retroactively adjusted to concur with the prospective rate. Rates for subsequent years will be updated annually effective January 1 of each year by increasing the previous year's prospective per diem rate by HCFA's target rate percentage of non-PPS (PPS exempt) hospitals/units for the current federal fiscal year. The subsequent application

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4-15-99
EFF 1-1-99
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CITATION	Medical and Remedial Care and Services Item 1 (cont'd.)	
42 CFR 447.252		of the inflationary adjustment shall apply only in years when the state legislature allocates funds for this purpose. The inflationary adjustment shall be made by applying the inflation factor applicable to the current fiscal year to the most recently ipaid per diem rate.

New units enrolling will be paid the statewide prospective per diem rate in effect at the time of enrollment.

If a unit enrolls at a time other than the beginning date for the hospital's new fiscal year, partial-year cost reports shall be submitted by the hospital for the pre-HINRC time period, and by the hospital and the HINRC unit for the period from the enrollment date of the HINRC unit through the end of the hospital's fiscal year.

Effective for dates of services on or after August 1, 2006, the statewide prospective per diem reimbursement rate shall be increased by 3.85% of the rates in effect on July 31, 2006.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

I. Supplemental Payments for Low Income and Needy Care Collaboration Hospitals

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

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement.

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

   b. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Reimbursement Methodology. 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.

CITATION
42 CFR
Sec. 447
Subpart C

II. Standards for Payment

A. To be eligible for full participation in the Bureau's vendor payment plan, a hospital in Louisiana:

1. Shall be licensed by the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section; **and**
2. Shall have been approved and accepted by the Bureau as a participating hospital under Title XIX; **and**
3. Shall be eligible for certification for the Hospital Insurance Program, Medicare Title XVIII-A; **and**
4. Shall agree not to accept payment, except for collectible insurance, from any source other than this Bureau for services for which this Bureau pays.

B. To be eligible for reimbursement for inpatient psychiatric services (including substance abuse treatment) in an acute care general hospital:

1. The services must be provided in a Distinct Part Psychiatric Unit, **except** reimbursement to an acute care general hospital may be available when limited to emergency admissions which must be stabilized and transferred to an appropriate facility; **and**

42 CFR
Sec 412.25
42 CFR Sec. 447
Subpart C

2. The Distinct Part Psychiatric Unit shall be Medicare PPS exempt certified or, if in a Medicare PPS exempt hospital, meet PPS exempt psychiatric unit criteria as stated at 42 CFR 412.25 [except 412.25(a)(1)(ii)] and be certified by Medicaid only.

3. Effective for dates of service on or after February 10, 2012, a Medicaid enrolled non-state acute care hospital that enters into a Cooperative Endeavor Agreement (CEA) with the Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to Medicaid and uninsured patients, and which also assumes operation and management of a state owned and formerly state operated hospital distinct part psychiatric unit , may make a one-time increase in its number of beds.

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

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

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

* Due to typographical error, pen and ink change requested by Keydra Singleton, Medicaid Program Manager, on 5/25/12.

C. To be eligible for reimbursement for services provided by a **Hospital Intensive Neurological Rehabilitation Care (HINRC) unit**, a hospital must:

1. Meet the requirements of A. above;
and

2. Be accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) and by the Commission on Accreditation of Rehabilitation Facilities (CARF);
and

3. Contain a unit that meets the requirements for a HINRC unit as described in Attachment 3.1-A, Item 1;
and

4. Enroll the HINRC unit separately as a Medicaid provider of Hospital Intensive Neurological Rehabilitation Care.

D. To be eligible for reimbursement for services provided by a **major teaching hospital**, a hospital must:

1. Meet the requirements of A. above;
and

2. Have a documented affiliation agreement with a Louisiana medical school accredited by the Liaison Committee on Medical Education (LCME). These facilities must be a major participant in at least four approved medical residency programs and maintain at least 15 interns and resident un-weighted full time equivalent positions. Full time equivalent positions will be calculated as defined in 42 CFR 413.78. At least two of the programs must be in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, emergency medicine or psychiatry; or

3. Maintain at least 20 intern and resident unweighted full time equivalent positions, with an approved medical residency program in family practice located more than 150 miles from the medical school accredited by the LCME. Full time equivalent positions will be calculated as defined in 42 CFR 413.78.

4. For the purposes of recognition as a major teaching hospital, a facility shall be considered a "major participant" in a graduate medical education program if it meets the following criteria.

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DATE EFF 7-1-2013
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DATE EFF 7-1-2013
TN# 13-29
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The facility must participate in residency programs that:

a. require residents to rotate for a required experience, and

b. require explicit approval by the appropriate Residency Review Committee (RRC) of the medical school with which the facility is affiliated prior to utilization of the facility, and

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

E. To be eligible for reimbursement for services provided by a **minor teaching hospital,** a hospital must:

1. Meet the requirements of A. above;

and

2. Have a documented affiliation agreement with a Louisiana medical school accredited by the Liaison Committee on Medical Education (LCME). These facilities must participate significantly in at least one approved medical residency program. Maintain at least six intern and resident unweighted full time equivalent positions. Full time equivalent positions will be calculated as defined in 42 CFR 413.78. At least one of these programs must be in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, emergency medicine, or psychiatry.

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

a. require residents to rotate for a required experience, and

b. require explicit approval by the appropriate Residency Review Committee (RRC) of the medical school with which the facility is affiliated prior to utilization of the facility, and

c. provide residency rotations of more than one-sixth of the program length or more than a total of six months at the facility and are listed as part of an accredited program in the *Graduate Medical*

Education Directory of the Accreditation Council for Graduate Medical Education (ACGME). If not listed, the sponsoring institution must have notified ACGME, in writing, that the residents rotate through the facility and spend more than one-sixth of the program length or more than a total of six months at the facility.

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

1. Is approved by one of the national organizations listed in 42 CRF 415.152;2.

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

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

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

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

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

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HCFA 179 13-29

G. To be eligible for reimbursement for services provided by a **specialty hospital,** a hospital must:

1. Meet the requirements of A. above; and

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2. Be recognized as a rehabilitation hospital, long-term (ventilator) hospital, or children's hospital recognized by Medicare as a PPS-exempt hospital. A specialty hospital is always classified in the appropriate specialty hospital peer group, irrespective of technical qualification to be included in any other peer group. The Medicaid Agency obtains verification from the Medicare fiscal intermediary of Medicare PPS-exempt status initially and annually thereafter prior to calculation of the next state fiscal year's rate.

The following regulations are applicable:

Loss of Medicare P.P.S.-exempt status: The hospital must report loss of Medicare P.P.S.-exempt status within 15 days of notice from Medicare. Hospitals will be placed into the appropriate peer group effective with the date of the change. Any resulting overpayment will be recouped.

Newly-obtained Medicare P.P.S.-exempt status: The hospital must report acquisition of Medicare P.P.S.-exempt status at least 90 days prior to the beginning of the State fiscal year to be eligible for consideration of placement into the appropriate specialty hospital peer group.

H. To be eligible for reimbursement for services provided by a **Burn Care Unit**, the unit must meet the following qualifications:

1. The hospital in which the unit is located must meet the requirements of A. above; and
2. The unit must meet the criteria specified in the hospital services provider manual.

STATE Louisiana
DATE REC'D 12-12-04
DATE APPR'D 1-18-05
DATE EFF 10-1-04
HCFA 179 04-21
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I. To be eligible for reimbursement for services provided by a **Neonatal Intensive Care (NICU) Unit**, the unit must meet the following qualifications:

1. The hospital in which the unit is located must meet the requirements of A. above; and
2. The unit must be rated at one of four levels of care based on severity of illness and intensity of service grouped by guidelines developed by the Louisiana Perinatal Commission and described in the *Hospital Services Manual.*

J. To be eligible for reimbursement for services provided by a **Pediatric Intensive Care (PICU) Unit**, the unit must meet the following qualifications:

1. The hospital in which the unit is located must meet the requirements of A. above; and

2. The unit must be rated at one of two levels of care based on severity of illness and intensity of service described in the *Hospital Services Manual.*

K. To be eligible for reimbursement for services provide by a **Transplant Unit**, the hospital must meet the following qualifications:

1. The hospital in which the unit is located must meet the requirements of A. above; and

2. The unit meets the requirements for an Organ Transplant Unit described in Attachment 3.1-A, Item 1; and

3. The hospital meets the criteria to qualify as a Medicare-designated transplant center.

NOTE: The Bureau's Health Standards Section may grant an exception to the qualifying criteria for a hospital whose transplant program was recognized by Medicaid of Louisiana prior to July 1, 1994.

STATE Louisiana
DATE REC'D 12-10-04
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DATE EFF 10-1-04
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A

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES
METHODS AND STANDARDS FOR ESTABLISHING RATES - IN-PATIENT HOSPITAL CARE

CITATION	Medical and Remedial Care and Services Item 1 (cont'd)
42 CFR Sec. 447 Subpart C	

III. Appeals Procedure

1. A hospital owner, administrator, board, or other governing body may appeal the rates determined for the hospital for inpatient services.

2. Appeals will be heard by the Department of Health and Hospitals Appeals Bureau.

3. The appeal procedures are as follows:

   a. An appeal must be filed within thirty (30) days of receipt of notice of rate determination. The appeal must be in writing and shall be submitted to the Chief Administrative Law Judge, Department of Health and Hospitals Appeals Bureau. The appeal must contain the specific points and grounds of the appeal.

STATE Louisiana
10-3-96
2-1-99
7-1-96
94-032
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CITATION
42 CFR
Sec. 447
Subpart C

MEDICAL AND REMEDIAL CARE AND SERVICES
Item 1 (Cont'd.)

b. Upon receipt of an appeal, the Chief Administrative Law Judge shall schedule an informal discussion between the hospital and/or its representative(s) and state agency officials within (30) thirty days of receipt of the appeal. The hospital is required to participate in this discussion and may present the grievance(s) contained within the appeal at this discussion. The hospital shall also be provided the opportunity to talk to agency personnel involved in the rate determination, to review pertinent documents on which the rate is based, to ask questions and seek clarifications, or to provide additional information which may impact the target rate.

c. Following the informal discussion, the agency shall inform the hospital in writing of the results of the informal discussion including such information as the names and identification of participants, place, date and time of meeting and summary of items discussed and information provided by the Department of Health and Hospitals, Bureau of Health Services Financing and the Appellant.

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STATE LA
DATE RECD DEC 20 1989
DATE APPVD JAN 30 1990
EFFECTIVE OCT 1 1989
TN# 89-39

CITATION	MEDICAL AND REMEDIAL CARE AND SERVICES Item 1 (Cont'd.)
42 CFR Sec.447 Subpart C	

If the informal discussion does not resolve all of the hospital's grievances, the hospital has the right to request an administrative hearing within (30) thirty days of the written notice of the results of the informal discussion.

d. Requests for an adminstrative hearing shall be submitted in writing to the Department of Social Services/Department of Health and Hospitals Appeals Bureau within thirty (30) days of the agency's written notice of the results of the informal discussion. The request must contain a statement setting forth the grievance(s) of the hospital regarding the rate determination and must be accompanied by supporting documents.

Unless a timely and proper request is received by the Department of Social Services/Department of Health and Hospitals Appeals Bureau, the findings of the Agency shall be considered a final and binding administrative decision.

e. Any party may appear and be heard at any proceeding described herein through an attorney-at-law or through a designated representative.

STATE LA
DATE RECD DEC 28 1989
DATE APPVD JAN 26 1990
EFF DATE OCT 1 1989
TN# 89-39
A

CITATION
42 CFR
Sec. 447
Subpart C

MEDICAL AND REMEDIAL
CARE AND SERVICES
Item 1 (Cont'd.)

f. When an administrative hearing is scheduled, the DSS/DHH Appeals Bureau shall notify the provider and/or his attorney in writing of the date, time and place of the hearing. Notice shall be mailed not less than ten calendar days before the scheduled date of the hearing.

g. The administrative hearing shall be conducted by a hearing officer who is authorized to conduct such hearings in accordance with the procedures and policy of the DSS/DHH Appeals Bureau, and La. R.S. 49:951 - et. seq..

h. A complete record of the proceedings shall be reproduced when directed by the hearing officer. The record will also be transcribed and reproduced at the request of a party to the hearing provided he bears the cost of the copy of the transcript.

i. Within sixty (60) days of the hearing, the DSS/DHH Appeals Bureau shall make a recommendation to the Secretary which addresses each grievance and the grounds for any recommended rate change, or will notify the appealing party of the reason why a recommendation cannot be made within that time period.

j. Within ninety (90) days of the hearing, the decision of the DSS/DHH Appeals Bureau shall be provided in writing to the appealing party or the appealing party will be notified of the reason why a decision cannot be made within that time period.

STATE LA
DATE RECD DEC 29 1989
DATE APPVD JAN 26 1990
DATE EFF OCT 1 1989
HCFA TN 89-39

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—IN-PATIENT HOSPITAL CARE

CITATION	MEDICAL AND REMEDIAL CARE AND SERVICES Item 1 (cont'd.)
42 CFR Sec.447 Subpart C	The decision of the DSS/DHH Appeals Bureau shall be final subject only to judicial review by the courts as provided in La. R. S. 49:951 et. seq..

k. Subsequent to the decision of DSS/DHH Appeals Bureau, the hospitals's rate for inpatient services shall be adjusted accordingly.

STATE LA
DATE REC'D DEC 0 9 1999
DATE APPV'D JAN 2 6 1999
DATE EFF OCT 1 1999
TN # 89-39

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STATE OF LOUISIANA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE — IN PATIENT HOSPITAL CARE

Citation

42 CFR 440.10

IV. Blood

The cost of all blood while hospitalized, if not covered by other source or replaced in the amount used, shall be reimbursed on the basis of reasonable cost.

APPROVED BY DHHS/HCFA/DRO
DATE: 2-5-87
TRANSMITTAL NO: 86-25