DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

NOV 30 2016

Mrs. Jen Steele, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 16-0014

Dear Mrs. Steele:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 16-0014. The amendment proposes to revise the provisions governing qualifying criteria for disproportionate share hospitals (DSH) payments to Louisiana Low-Income Academic Hospitals.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

Based upon the information provided by the State, Medicaid State plan amendment 16-0014 is approved effective July 1, 2016. We are enclosing the CMS-179 and the new plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **16-0014**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **July 1, 2016**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY **2016** **$0**
b. FFY **2017** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Item 1, Page 10 f
Attachment 4.19-A, Item 1, Page 10 k (3)
Attachment 4.19-A, Item 1, Pages 10 k (4) and 10 k (5)
Attachment 4.19-A, Item 1, Page 10 k (5)a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SAME (TN 10-28)
SAME (TN 14-12)
SAME (TN 14-25)
NONE – New Page

10. SUBJECT OF AMENDMENT: **The SPA proposes to revise the provisions governing qualifying criteria for disproportionate share hospital (DSH) payments to Louisiana Low-Income Academic Hospitals and the DSH payment methodology.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Rebekah E. Gee MD, MPH

14. TITLE:
Secretary

15. DATE SUBMITTED:
September 27, 2016

16. RETURN TO:
Jen Steele, Medicaid Director
State of Louisiana
Department of Health
628 N. 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 27, 2016

18. DATE APPROVED:
NOV 30 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Kristin Fan

22. TITLE:
Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

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.

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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.

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DSH REIMBURSEMENT METHODOLOGIES (continued)

f. Louisiana Low-Income Academic Hospitals

Qualifying Criteria

A. Hospitals Located Outside of the **Baton Rouge and New Orleans** Metropolitan Statistical Area

Effective for dates of service on or after July 1, 2016, a hospital may qualify for this category by:

1. being a private acute care general hospital that is located outside of the Baton Rouge and New Orleans Metropolitan Statistical Area (MSA) which are University Health Shreveport, University Hospitals and Clinics, Our Lady of the Angels, Lake Charles Memorial Hospital, and University Health Conway and:
   - increases its provision of inpatient Medicaid and uninsured services by providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or
   - is formerly a state owned and operated hospital whose ownership change to non-state privately owned and operated prior to July 1, 2014;
2. having Medicaid inpatient days utilization greater than 18.9 percent. Qualification shall be calculated by dividing the Medicaid inpatient days by the total inpatient days reported on the Medicaid as filed cost report ending during state fiscal year (SFY) 2015, received by April 30, 2016, and shall include traditional, shared, and managed care Medicaid days per the worksheet S-3 part I, lines 1 through 18. Column 7 shall be used to determine allowable Medicaid days and column 8 shall be used to determine total inpatient days; and
3. having a ratio of intern and resident full time equivalents (FTEs) to total inpatient beds that is greater than .08. Qualification shall be based on the total inpatient beds and intern and resident FTEs reported on the Medicare/Medicaid cost report ending during SFY 2015. The ratio of interns and resident FTEs shall be calculated by dividing the unweighted intern and resident FTEs as reported on the Medicare Cost Report Worksheet E-4, Line 6 by the total inpatient beds, excluding nursery and Medicare designated distinct part psychiatric unit beds, reported on worksheet S-3, column 2, lines 1 through 18.

B. Hospitals Located In the New Orleans Metropolitan Statistical Area

Effective for dates of service on or after July 1, 2016, a hospital may qualify for this category by:

1. being a private acute care general hospital that is located in the New Orleans MSA which is University Medical Center- New Orleans and:
   - increases its provision of inpatient Medicaid and uninsured services by providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or
   - is formerly a state owned and operated hospital whose ownership changed to non-state privately owned and operated prior to July 1, 2014;

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2. having Medicaid inpatient days utilization, greater than 45 percent. Qualification shall be calculated by dividing the Medicaid inpatient days by the total inpatient days reported on the Medicaid as filed cost report ending during SFY 2015, received by April 30, 2016, and shall include traditional, shared, and managed care Medicaid days per the worksheet S-3 part I, lines 1 through 18. Column 7 shall be used to determine allowable Medicaid days and column 8 shall be used to determine total inpatient days; and
3. having a ratio of intern and resident FTEs to total inpatient beds that is greater than 1.25. Qualification shall be based on total inpatient beds and intern and resident FTEs reported on the Medicare/Medicaid cost report ending during SFY 2015. The ratio of interns and resident FTEs shall be calculated by dividing the unweighted intern and resident FTEs as reported on the Medicare Cost Report Worksheet E-4, Line 6 by the total inpatient beds, excluding nursery and Medicare designated distinct part psychiatric unit beds, reported on worksheet S-3, column 2, lines 1 through 18.

Payment Methodology

A. Each qualifying hospital shall be paid DSH adjustment payments equal to 100 percent of allowable hospital specific uncompensated care costs
   1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the Department.
   2. Costs and lengths of stay shall be reviewed by the Department for reasonableness before payments are made.

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.

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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.

F. A pro rata decrease necessitated by conditions specified in l.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 the qualifying hospitals in this section based on these reported audit results. If the 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 hospitals in this section.

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