John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

September 15, 2016

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

RE: LA SPA TN 16-0018 RAI Response
Disproportionate Share Hospitals - Major Medical Centers

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 16-0018 with the proposed effective date of June 30, 2016. The State Plan amendment (SPA) proposes to revise the provisions governing qualifying criteria for disproportionate share hospital (DSH) payments to major medical centers in central and northern Louisiana and the DSH payment methodology. We are providing the following in response to your request for additional information (RAI) dated September 1, 2016.

FORM-179

1. Form 179, Block 7 – Please provide a detailed analysis of how the FFP determination was made for each new provider, and provide supporting documentation of the calculation for Federal Fiscal Year (FFY) 2016 and 2017.

   RESPONSE:
   The fiscal worksheet has been revised to show the state fiscal year to equal the federal fiscal year (FFY) time periods as the conversion to state fiscal year (SFY) is not applicable for this DSH SPA. The total estimated yearly payments for this SPA is $50,000,000 which is multiplied by the Federal

Medical Assistance Program (FMAP) to get the federal fiscal impact. Please see attached revised Form 179, supporting fiscal worksheet and fiscal breakdown and estimated payments, by provider.

STATE PLAN LANGUAGE

2. Please note that this methodology is not comprehensive. To comply with regulations at 42 CFR 447.252(b), the State plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections.

   The proposed DSH payment methodology on Attachment 4.19-A, Item 1, Page 10 k (5)(a) is not comprehensively described. The plan language should fully describe the cost and patient specific data the hospitals are required to submit, what time period the data is to be from, and when the data is to be submitted by the hospitals. The plan language should also fully describe how the Department will review costs and lengths of stay for reasonableness, how the costs and lengths of stay will be determined to be reasonable, and how the results of the reasonableness review will be used to adjust payments.

   RESPONSE:
   The Department has developed uncompensated care calculation forms and review processes which comply with the provisions in 42 CFR 445.304 and 447.299. Both of which use the latest available cost report data and hospital records to determine interim DSH payments. Comparisons are made to other historical cost and length of stay data for qualifying hospitals and other like hospitals as necessary to validate reasonableness. As also required by these regulations, the interim payments made in accordance with this SPA, as well as all other DSH payments, are subject to an independent audit to determine if the uncompensated care costs upon which DSH payments are based are correct. The state is required to recoup any overpayments that are identified by this annual audit.

   Language has been added to include this clarification. Please see revised Attachment 4.19-A, Item 1, Page 10 k (5)(a).

3. Please list the hospitals that will qualify under this new criteria on Attachment 4.19-A, Item 1, Page 10 k (5)(a).

   RESPONSE:
   There are five qualifying hospitals for the payments to be made under this SPA:
   1. Glenwood Regional Medical Center;

2. **Christus St. Francis Cabrini Hospital;**
3. **Rapides Regional Medical Center**
4. **St. Francis Medical Center**
5. **Willis Knighton Health Systems**

4. On Attachment 4.19-A, Item 1, Page 10 k (5)(a) number 2 it states the following: "have at least 200 inpatient beds as reported on the Medicare/Medicaid cost report, Worksheet S-3, column 2, lines 1 - 18, for the state fiscal year ending June 30, 2015. For qualification purposes, inpatient beds shall exclude nursery and Medicare designated distinct part psychiatric unit beds." Please clarify if the fiscal year end should be 2015 or 2016.

RESPONSE:
The fiscal year end (FYE) is June 30, 2015 as the cost reports for FYE June 30, 2016, are not yet available.

5. CMS wants the State's assurance regarding financial transactions. The following sentence should be included in the reimbursement methodology:

> "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."

RESPONSE:
The language has been added. Please see revised Attachment 4.19-A Item 1, Page 10 k (5)(a).

6. The plan language does not indicate if DSH payments will be made quarterly or annually. Please revise the plan language to indicate when the DSH payments will be made.

RESPONSE:
The language has been revised to specify that the payments will be made on an annual basis. Please see revised Attachment 4.19-A Item 1, Page 10 k (5)(a).

FUNDING QUESTIONS

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan, including payments made outside of those being amended with this SPA.

7. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State

(includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

RESPONSE:

Please see Attachment 4.19-A. There were 38 public, non-state owned hospitals that qualified for disproportionate share hospital (DSH) payments applicable to state fiscal year (SFY) 2015 (10 non-rural hospitals and 28 rural hospitals), and each of these hospitals certified its allowable uncompensated care costs as expenditures eligible for FFP. The reportable DSH amount in SFY 2015 was $166,362,894 (FFP $103,174,244). DSH payments will be limited to 100 percent of each hospital's specific uncompensated care costs in accordance with Section 1923(g) and our approved State Plan. Act 10 of the 2009 regular session of the Louisiana Legislature directed these non-state public hospitals to certify their uncompensated care cost expenditures to be used as matching funds which was continued in Act 16 of the 2015 regular session. Attached is Act 16 of the 2015 regular session (Attachment 1), a listing of the qualifying hospitals in SFY 2015 and the estimated payments/amounts received by the hospitals (Attachment 2). Medicaid payments are made directly to Medicaid providers. Providers retain all of the Medicaid payments. Providers do not return any portion of any payment.

8. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in

accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;

(iv) clarify whether the certifying or transferring entity has general taxing authority; and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

RESPONSE:

Please see Attachment 4.19-A. The Legislature does not appropriate funds for specific line item programs, such as inpatient hospitals. Appropriations for the total Medicaid program are divided into four categories: (1) private provider payments; (2) public providers; (3) Medicare buy-ins, supplements, and clawbacks; and (4) uncompensated care costs. For SFY 2016 (July 1, 2015- June 30, 2016), the amounts appropriated are $6,260,061,407 for private providers, $248,021,546 for public providers, $540,968,657 for Medicare buy-ins, supplements and clawbacks, and $997,662,436 for uncompensated care costs. As indicated in our response to question 1 above, the non-federal share of the estimated $166,362,894 in SFY 2015 of DSH payments was provided using CPEs for hospital payments as set forth in question 1 above. The following steps are taken by Louisiana to verify that the total expenditures certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b):

1. **Each qualifying public hospital completes a "Calculation of Uncompensated Care Costs" Form (Attachment 3) based on cost and payment data per the latest filed Medicare/Medicaid cost report. This form includes a certification statement that the hospital signs. Please see the attached explanation of Louisiana's process for the determination of DSH CPEs (Attachment 4).**

2. **Upon receipt of the completed form, the state Medicaid agency verifies the figures for accuracy utilizing the as filed cost report and paid claims data.**

3. **The Medicaid contract auditor reconciles the uncompensated care costs to the SFY that the DSH payments are applicable to, using initially the as filed cost reports, and ultimately the finalized cost reports for the period. Louisiana Medicaid follows Medicare cost reporting and audit standards.**

The listing of hospitals which provided CPEs in SFY 2015, along with estimated payment amounts and amounts retained by each hospital, is supplied in the attachment which responds to question 1 above. These providers are all hospital service districts (HSDs) which have taxing authority, per Louisiana Revised Statute 46:1064 (Attachment 5). HSDs are not state agencies, there is no funding appropriated by the State.

(SPA 16-0018)
The state portion of the payments made to providers under this SPA will be funded by IGTs from the state owned medical school, Louisiana State University Health Sciences Center, Shreveport (LSU-HSCS) which is estimated to be $18,895,000. LSU-HCSC receives direct appropriations from the state in the annual appropriations bill. LSU-HCSC does not have taxing authority.

9. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan.
If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

RESPONSE:
Our response to question #1, above, also applies to this question.

10. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

RESPONSE:
Please see Attachment 4.19-A. The following steps are used to calculate the Medicare upper payment limit for:

State Hospitals:
1. **Accumulate Medicaid costs, charges, payments, and reimbursement data for each state hospital per the latest filed cost reporting period.**
2. **Subtract the amount paid by Medicaid from the Medicaid costs for each hospital. Trend the difference forward to the midpoint of the current state fiscal year (SFY) using the CMS Market Basket Index for Prospective Payment System (PPS) hospitals.**
3. **The sum of the difference for each hospital, including inflation, is the supplemental payment that can be reimbursed to state hospitals subject**

to the limitations on Medicaid inpatient hospital payments in 42 CFR 447.271 and 447.272.

4. If a change is projected in the volume of inpatient claims in current upper payment limit (UPL) demonstration year covered by managed due to expansion, adjustments are made to each hospital's differential as explained in a–d below:
   a. a report is produced from the Medicaid claims data warehouse which includes the entire universe of non-capitated inpatient claims by hospital for the period covering the dates of service in the UPL demonstration which for state hospitals is the latest cost report period (SFY);
   b. claims for patients that are projected to be covered by managed care in the current year are subtracted from the prior year non-capitated claim total;
   c. the revised non-capitated claim total (determined per "b") is divided by the total universe of claims (described in "a") to develop a ratio of the prior year claims that remain "fee-for-service"; and
   d. the ratio calculated per "c" above is the applied to the inpatient hospital specific differential (#3 above) which reduces the estimated upper payment limits to account for the impact that the managed care expansion has on the non-capitated claims payments.

<u>Non-State Hospitals (Public and Private)</u>:

1. Calculate estimated Medicare payment per discharge for each hospital by totaling a-c below:
   a. Medicare operating payments are calculated by taking the Medicaid claims data and running each claim through the Medicare Severity Diagnostic Related Grouper (MS-DRG) to assign the appropriate DRG and weight from the current Medicare Inpatient PPS. Total Medicare operating payments are then calculated for each hospital by multiplying the Medicaid case mix index under the Medicare weight set by the Medicare current federal fiscal year (FFY) operating rate, using information from the Federal Register current FFY final rule, the Medicare inpatient Public Use File to determine the Core Based Statistical Area (CBSA) of each hospital, and the Medicare Inpatient Pricer to verify the operating rate for each facility. Since this payment includes the current FFY operating rate, no inflation is applied to this payment.
   b. Medicare non-operating acuity-adjusted payments include Medicare payments for Indirect Medical Education (IME) and capital and are taken from the Medicare cost report. The per-discharge payment is calculated by dividing by the Medicare discharges from the same cost report. The Medicare per discharge payment represents reimbursement at the Medicare patient acuity-level, so the calculated per discharge amount is adjusted by multiplying by the ratio of the

Case Mix Index (CMI) of Medicaid claims under the Medicare PPS to the CMI of Medicare claims under the Medicare PPS, which is taken from the Public Use File. This acuity-adjusted per discharge amount represents the estimate of what Medicare would pay for these services at each hospital if specifically for the Medicaid patient population. The acuity-adjusted payment per discharge is then inflated from the cost report period to current year.

c. Non-Acuity based Medicare payments include Medicare reimbursement from the cost report for outliers, DSH, Direct Graduate Medical Education (GME), pass through costs, and reimbursable bad debt. Each payment total is taken from the Medicare cost report and then divided by the Medicare discharges to create an estimated per discharge payment, which is then inflated from the Medicare cost report period to current year.

2. For Critical Access Hospitals, there is insufficient claims data to assign a reliable DRG under the Medicare PPS and the Medicare PPS is an inappropriate model for estimating Medicare payments, so an alternative methodology is used. For each of these facilities, total Medicare cost and Medicare days are taken from the cost report and a cost per day is calculated. The acuity level of this cost is then tied to the hospital's Medicaid population by multiplying by the claim days per discharge from the Medicaid Management Information System (MMIS) to create an estimated cost per discharge for the Medicaid population. This cost per discharge is then inflated from the cost report period to current year.

3. Medicaid allowed payments are estimated from the reported hospital payments and third party liability (TPL) payments on the claims from the latest fiscal year or calendar year, scaled to represent the allowed amount for current year. Allowed payments from the claims data are adjusted by the total effect of each rate adjustment which impacted Medicaid hospital payments from the beginning service dates of the historical claims through current state fiscal year to estimate the amount the claims are paid under the Louisiana Medicaid system in the current year. To calculate total Medicaid payments per discharge for comparison to the Medicare allowed rate, Medicaid outlier payments, GME payments, and supplemental payments for Low-Income and Needy Care Collaboration Agreement (LINCCA), high Medicaid facilities and major teaching facilities were added to Medicaid claim payments. The total payments received from Medicaid are divided by claims discharges in the data set to yield the adjusted Medicaid payments per discharge in current year.

4. To determine the separate aggregate UPL caps for the inpatient non-state public and private hospital groups, each hospital's adjusted Medicaid

payments per discharge is subtracted from their Medicare adjusted payments per discharge. The difference per discharge rate by hospital is multiplied by the hospital's number of claims discharges to determine the individual hospital payments difference between Medicare and Medicaid. The sum of the difference for each hospital for all hospitals in the group is the UPL for that group of hospitals.

5. If a change is projected in the volume of inpatient claims in current UPL demonstration year covered by managed due to expansion, adjustments are made to each hospital's differential as explained in a–d below:
   a. a report is produced from the Medicaid claims data warehouse which includes the entire universe of non-capitated inpatient claims by hospital for the period covering the dates of service in the UPL demonstration
   b. claims for patients that are projected to be covered by managed care in the current year are subtracted from the prior year non-capitated claim total
   c. The revised non-capitated claim total (determined per b) is divided by the total universe of claims (described in a.) to develop a ratio of the prior year claims that remain "fee-for-service"
   d. The ratio calculated per c above is the applied to the inpatient hospital specific differential (#4 above) which reduces the estimated upper payment limits to account for the impact that the managed care expansion has on the non-capitated claims payments.

Below are the ongoing procedures that are in place to ensure that supplemental payments do not exceed either the global or hospital–specific UPL caps:

<u>Global UPL Cap</u>
At the beginning of each SFY, the State utilizes the prior SFY global cap as the basis and makes adjustments that are expected (i.e. Managed Care transition). The UPL global cap is updated in the last quarter of each calendar year to allow for claim lag.

<u>UPL Aggregate Available Cap Summary Spreadsheet</u>
Upon establishment of the UPL global cap, the State maintains an "UPL aggregate available cap summary spreadsheet" for each category (bucket) (inpatient and outpatient) to post all payments/adjustments made during the SFY to ensure that payments do not exceed the global cap for each bucket.

<u>Individual Hospital Specific Limits – Inpatient and Outpatient</u>
The State maintains an individual hospital specific limit worksheet for each hospital. Upon establishment of the individual caps, payments (i.e.

supplemental/DSH) are backed out to show available hospital specific balances.

All supplemental payments are reconciled to the CMS 64.

10. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

RESPONSE:
In accordance with our approved State Plan, both Medicaid and DSH payments to state governmental hospitals are limited to costs. DSH payments to non-state public governmental hospitals are limited to costs, per our approved State Plan and Section 1923(g). Medicaid payments (including those in excess of Medicaid cost) must be deducted from costs in the determination of each hospital's specific DSH limit. The end result is a reconciliation of the Medicaid overpayments against the hospital's DSH limit which causes a corresponding decrease in the amount of DSH paid to the hospital. Only payments determined by audit to exceed allowable payments as defined in our approved State Plan, are identified as overpayments.

Please consider this a formal request to begin the 90-day clock. We trust this additional information will result in the approval of the pending SPA. We look forward to negotiating with CMS to ensure approval.

As always, we appreciate the assistance of Tamara Sampson in resolving these issues. If further information is required, you may contact Darlene A. Budgewater at Darlene.Budgewater@la.gov or by phone (225) 342-3881.

Sincerely,

Jen Steele
Medicaid Director

JS:DAB:JH

Attachments (4)

c: Darlene Budgewater
Cheryl Rupley
Tamara Sampson

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: **16-0018**

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: **June 30, 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 E

7. FEDERAL BUDGET IMPACT:
a. FFY **2016** $31,105.00 ~~$38,881.25~~
b. FFY **2017** **$31,140.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Item 1, Page 10 d
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 15-0012)
None- New page

10. SUBJECT OF AMENDMENT: **The SPA proposes to revise the provisions governing qualifying criteria for disproportionate share hospitals (DSH) payments to major medical centers in central and northern Louisiana 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:
June 30, 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:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: The State requests a pen and ink change to box 7 as indicated above.

FORM HCFA-179 (07-92)

LA TITLE XIX SPA
TRANSMITTAL #: **16-0018 (Revised)**
TITLE: **DSH - Major Medical Centers**
EFFECTIVE DATE: **June 30, 2016**

FISCAL IMPACT:
Increase

	year	% inc.		fed. match	*# mos	range of mos.	dollars
1st SFY	2016			0.00%	12	July 2015- June 2016	$50,000,000
2nd SFY	2017			0.00%	12	July 2016- June 2017	$50,000,000
3rd SFY	2018			0.00%	12	July 2017 - June 2018	$50,000,000

*#mos-Months remaining in fiscal year

Total Increase in Cost FFY **2016**
SFY 2016 $50,000,000 for 12 months July 2015- June 2016 = $50,000,000

FFP (FFY 2016) = **$50,000,000** **X** **62.21%** = **$31,105,000**

Total Increase in Cost FFY **2017**
SFY 2017 $50,000,000 for 12 months July 2016- June 2017 = $50,000,000

FFP (FFY 2017)= **$50,000,000** **X** **62.28%** = **$31,140,000**

SFY 2016 Projected DSH Payments to Major Medical Centers in Northern & Central LA
Effective 6/24/16

Qualifying Hospitals	DHH Administrative Region	Beds per S-3, Excl. DPP & Nursery	Estimated Hospital Specific UCC	X Projected Appropriation $50,000,000
Glenwood	8	214	$30,000,000	$9,819,967
Rapides	6	328	$27,250,000	$8,919,804
St. Francis Cabrini	6	283	$35,500,000	$11,620,295
St. Francis Medical Center	8	482	$30,000,000	$9,819,967
Willis Knighton Health Systems	7	644	$30,000,000	$9,819,967
Totals			**$152,750,000**	**$50,000,000**

Major Medical Centers Located in Central and Northern Areas of the State

Qualifying Criteria

Effective for dates of service on or after June 30, 2016, hospitals qualifying for payments as major medical centers located in the central and northern areas of the State shall meet the following criteria:

1. be a private, non-rural hospital located in Department of Health administrative regions 6, 7, or 8;
2. have at least 200 inpatient beds as reported on the Medicare/Medicaid cost report, Worksheet S-3, column 2, lines 1 – 18, for the state fiscal year ending June 30, 2015. For qualification purposes, inpatient beds shall exclude nursery and Medicare designated distinct part psychiatric unit beds;
3. does not qualify as a Louisiana low-income academic hospital; and
4. such qualifying hospital (or its affiliate) does have a memorandum of understanding executed on or after June 30, 2016, with Louisiana State University – School of Medicine, the purpose of which is to maintain and improve access to quality care for Medicaid patients in connection with the expansion of Medicaid in the state through the promotion, expansion, and support of graduate medical education and training.

Payment Methodology

Effective for dates of service on or after June 30, 2016, each qualifying hospital shall be paid an annual disproportionate share hospital (DSH) adjustment payment which is the pro rata amount calculated by dividing their hospital specific allowable uncompensated care costs by the total allowable uncompensated care costs for all hospitals qualifying under this category and multiplying by the funding appropriated by the Louisiana Legislature in the applicable state fiscal year for this category of hospitals.

Qualifying hospitals must complete and submit uncompensated care costs calculation forms which incorporate the required DSH federal definition of uncompensated care costs. Supporting uninsured patient specific data in the form of a patient log which identifies patient name, social security number, dates of services, charges generated, and any payments received. Historical data from qualifying hospitals and other similar hospitals may be used to validate reasonableness of uncompensated care costs claimed before payments are made.

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. 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.