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

Center for Medicaid, CHIP, and Survey & Certification

Mr. Don Gregory, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

SEP 23 2011

Attention: Darlene York

RE: Louisiana 11-18

Dear Mr. Gregory:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-18. The purpose of this amendment is to revise the Disproportionate Share Hospital (DSH) qualifying criteria and payment methodologies for non-rural community hospitals; to revise the state appropriation for certain DSH categories; and to allow for additional payments after completion of the Centers for Medicare and Medicaid Services' mandated DSH independent audit for the state fiscal year.

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. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A. Based upon your assurances, Medicaid State plan amendment 11-18 is approved effective June 21, 2011. We are enclosing the HCFA-179 and the new plan pages.

If you have any questions, please call Sandra Dasheiff, CPA at (214) 767-6490.

Sincerely,

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

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: **11-18**

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 21, 2011**

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 2011 **$44,649.86**
b. FFY 2012 **$0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Item 1, Page 10e	**Same (TN 05-17)**
Attachment 4.19-A, Item 1, Page 10j(2)	**Same (TN 09-38)**
Attachment 4.19-A, Item 1, Page 10j(3)	**Same (TN 05-37)**
Attachment 4.19-A, Item 1, Page 10k	**Same (TN 09-38)**
Attachment 4.19-A, Item 1, Page 10k(1)	**Same (TN 05-17)**
Attachment 4.19-A, Item 1, Page 10k(2)	**Same (TN 08-12)**
Attachment 4.19-A, Item 1, Pages 10k(3), 10k(4), 10k(5)	**Same (TN 10-02)**
Attachment 4.19-A, Item 1, Page 10k(6)	**Same (TN 10-26)**

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to amend the DSH qualifying criteria and payment methodologies for non-rural community hospitals; to revise the state appropriation for certain DSH categories; and to allow for additional payments after completion of the Centers for Medicare and Medicaid Services' mandated independent audit for the state fiscal year.**

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: [redacted]

13. TYPED NAME: **Bruce Greenstein**

14. TITLE: **Secretary**

15. DATE SUBMITTED: **June 27, 2011**

16. RETURN TO:
Don Gregory, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 29 June 2011

18. DATE APPROVED: SEP 23 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUN 21 2011

20. S[redacted]ONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director CMCS

23. REMARKS:

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.

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

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.

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) multiplying by $7,000,000 which is the state appropriation for disproportionate share payments allocated for this pool of hospitals for SFY 2010-2011.

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.

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. Public Non-Rural Community Hospitals

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.

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.

f. **Private Non-Rural Community Hospitals**

1) A Private Non-Rural Community Hospital is a private hospital that meets the qualifying criteria for disproportionate share hospital in I.D.1

2) Private, non-rural community hospitals (other than freestanding psychiatric hospitals) shall be reimbursed as follows:

a) If the hospital's qualifying uninsured cost is less than 4 percent of total hospital cost, the hospital shall not be eligible as a DHS hospital unless it meets the DSH statutory requirements defined in 1923(b) of the Act, in which case the hospital shall be reimbursed under the DSH category "Federally Mandated Statutory Hospitals".

b) If the hospital's qualifying uninsured cost is equal to or greater than 4 percent of total hospital cost but less than 7 percent of total hospital cost, the payment shall be 50 percent of an amount equal to the difference between the total qualifying uninsured cost as a percent of total hospital cost and 4 percent of total hospital cost

c) If the hospital's qualifying uninsured cost is equal to or greater than 7 percent of total hospital cost, but less than or equal to 10 percent of total hospital cost, the payment shall be 80 percent of an amount equal to the difference between the total qualifying uninsured cost as a percent of total hospital cost and 4 percent of total hospital cost.

d) If the hospital's qualifying uninsured cost is greater than 10 percent of total hospital cost, the payment shall be 90 percent of qualifying uninsured cost for the portion in excess of 10 percent of total hospital cost and 80 percent of an amount equal to 5 percent of total hospital cost.

3) The Department shall determine each qualifying hospital's uninsured percentage on a hospital-wide basis utilizing charges for dates of service from the most recent state fiscal year. Qualifying uninsured cost as used for this distribution shall mean the hospital's total charges for care provided to uninsured patients multiplied by the hospital's appropriate cost-to-charge ratio as required by the CMS DHS audit rule for the applicable cost report period.

4) Hospitals shall submit supporting patient specific data in a format specified by the Department, reports on their efforts to collect reimbursement for medical services from patients to reduce gross uninsured costs and their most current year-end financial statements. Those hospitals that fail to provide such statements shall receive no payments and any payment previously made shall be refunded to the Department. Submitted hospital charge data must agree with the hospital's monthly revenue and usage reports which reconcile to the monthly and annual financial statements. The submitted data shall be subject to verification by the Department before DSH payments are made.

5) In the event that the total payments calculated for all recipient hospitals are anticipated to exceed the total amount appropriated, the Department shall reduce payments on a pro rata basis in order to achieve a total cost that is not in excess of the amounts appropriated for this purpose. The $10,000,000 appropriation for the non-rural community hospital pool shall be effective only for state fiscal year 2011 and distributions from the pool shall be considered nonrecurring.

6) Of the total appropriation for the non-rural community hospital pool, $1,000,000 shall be allocated to public and private non-rural community hospitals with a distinct part psychiatric unit and $1,000,000 shall be allocated to freestanding psychiatric hospitals.

a) To qualify for this payment, hospitals must be a public or private non-rural community hospital, as defined in 3.e or 3.f. with uninsured cost of 4percent or greater, and have a Medicaid enrolled distinct part psychiatric unit; or be a Medicaid enrolled free-standing psychiatric hospital accredited by the Joint Commission of Accreditation of Healthcare Organizations.

b) Payment shall be calculated by:

- dividing each qualifying hospital's distinct part psychiatric unit's uninsured days by the sum of all qualifying uninsured days and multiplying by$1,000,000.
- dividing each qualifying freestanding psychiatric hospital's uninsured days by the sum of all qualifying freestanding psychiatric hospital qualifying uninsured days and multiplying by$1,000,000.

c) If the above calculated payment exceeds the hospital specific uncompensated care cost limit, payment shall be reduced accordingly.

g. Mental Health Emergency Room Extensions (MHERE)

1) Medicaid-enrolled non-state, acute care hospitals that establish a Mental Health Emergency Room Extension (MHERE) and sign an addendum to the Provider Enrollment form (PE-50) by July 1, 2010 shall be reimbursed for their net uncompensated care costs for psychiatric services rendered to patients. The net uncompensated care cost is the Medicaid shortfall plus the cost of treating the uninsured.

2) Qualifying non-state, acute care hospitals must:

   a) be located in a region of the state that does not currently have an MHERE; and

   b) not receive funding for their MHERE from another source.

3) The amount appropriated for this pool in SFY 2011 is $6,312,998. If the net uncompensated care costs of all hospitals qualifying for this payment exceeds $6,312,998, payment will be each qualifying hospital's pro rata share of the pool calculated by dividing its net uncompensated care costs by the total of the net uncompensated care costs for all hospitals qualifying for this payment multiplied by $6,312,998.

4) 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.

5) Payments shall be made on a quarterly basis.

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