

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Disproportionate Share—Hospital Payment Methodology



The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following emergency rule under the Medical Assistance Program as authorized by R.S. 46:153 et seq., and pursuant to Title XIX of the Social Security Act and as directed by the 1995-96 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This emergency rule is in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Medicaid Program previously reimbursed private hospitals and publicly-owned or operated hospitals serving a disproportionate share of low income patients via 12 pools with payments based on Medicaid days. This payment methodology was implemented effective February 1, 1994 to comply with the Health Care Financing Administration's policy on Section 1923 (Adjustment in Payments for Inpatient Hospital Services Furnished by Disproportionate Share Hospitals) of the Social Security Act (42 U.S.C. Section 1396r-4). In addition, disproportionate share payments for indigent care based on free care days were made by establishment of a payment methodology which reimbursed providers for indigent care days based on a Medicaid per diem equivalent amount.

The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) amended Section 1923 of the Social Security Act by establishing individual hospital disproportionate share payment limits. To comply with these new provisions, the bureau's disproportionate share payment methodology which included provisions governing the qualifications applicable to private and public hospitals and payment methodology applicable to publicly-owned or operated hospitals was amended effective on July 1, 1994 and was published in the *Louisiana Register* Volume 20, Number 7. In addition, the qualification applicable to both public and private hospitals was included in the July 1, 1994 emergency rule which requires a disproportionate share hospital to have a Medicaid inpatient utilization rate of at least 1 percent is incorporated in the following emergency rule. These regulations continued to govern DSH payments through June 30, 1995.

In order to comply with the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) requirements for the upcoming federal fiscal year and in order to avoid a budget deficit in the medical assistance programs, the bureau has determined that the following changes are necessary in the payment methodologies for public state-operated hospitals, private hospitals and public nonstate hospitals. The following emergency rule replaces all prior regulations governing disproportionate share payment methodologies (excluding disproportionate share qualification criteria).

It is estimated that implementation of this rule will reduce expenditures for disproportionate share payments in the Medicaid Program by approximately \$136,000,000 for state fiscal year 1995-1996 and \$40,312,599 for state fiscal year 1996-1997. Therefore, adoption of the following emergency rule is necessary to avoid a budget deficit in the medical assistance programs as state general fund revenues are not available to expend these additional monies.

Emergency Rule

Effective for dates of service on or after June 24, 1996 the Department of Health and Hospitals, Bureau of Health Services Financing replaces prior regulations governing disproportionate share hospital payment methodologies, excluding disproportionate share qualification criteria and establishes the following regulations to govern the disproportionate share hospital payment methodologies for public state-operated, private hospitals and public nonstate hospitals.

Disproportionate Share Hospital Payments Public State-Operated Hospitals

DSH payments to individual public state-owned or operated hospitals as defined below will be equal to 100 percent of the hospital's net uncompensated costs as defined below subject to the adjustment provision described below.

Definitions:

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

Net Uncompensated Cost—costs incurred during the state fiscal year 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 payor payments and all other inpatient and outpatient payments received from uninsured and Medicaid patients.

Final payment will be based on the uncompensated cost data per the audited cost report for the period(s) covering the state fiscal year.

Private Hospitals and Public Nonstate Hospitals

A. Reimbursement will no longer be provided for indigent care in private hospitals or public nonstate hospitals qualifying for disproportionate share payments.

B. The following pools, public local government acute care hospital and public local government distinct part psychiatric units/free-standing psychiatric hospitals are added to the six pools. These hospitals will no longer receive a DSH payment equal to each hospital's net uncompensated costs. Disproportionate share reimbursement for these qualifying hospitals will be based on methodology described below.

C. Each private or public nonstate hospital qualifying for participation in the eight disproportionate share pools with payments based on Medicaid days will receive payments which are the lesser of 100 percent of its net uncompensated costs of providing services to Medicaid recipients and uninsured patients or their disproportionate share payment calculated by the bureau via the pool methodology.

D. Annualization of days for the purposes of the Medicaid days pools is not permitted. The bureau shall utilize the records of the audit intermediary to determine actual Medicaid days for the months needed to equate to a full year from the previous cost reporting period for existing hospitals with short cost reporting periods.

E. Qualification for and payment adjustment for DSH shall be based on the hospital's year end cost report for the year ended during the period July 1 through June 30 of the previous year.

F. Reimbursement will be based on Medicaid days included (based on qualification) in the eight pools listed in Item I below.

G. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization, but for purposes of disproportionate share hospital payment adjustments, the distinct part psychiatric units shall be placed in the psychiatric pools while the acute medical/surgical unit(s) shall be included in the appropriate teaching or nonteaching pool. Hospitals must meet the criteria for the pool classification based on their fiscal year-end cost report as of June 30 of the previous year.

H. For purposes of the pools defined below, service district hospitals/beds located outside the service district will be classified by the bureau as privately-owned and operated and shall be placed in the appropriate private hospital/unit pools.

I. The eight pools are as follows:

1. *Private Rural Acute Hospitals*—privately-owned acute care general, rehabilitation, and long term care hospitals (exclusive of distinct part psychiatric units) which are designated as a rural hospitals under criteria specified below. This includes public local government acute hospital days attributable to beds/units located in an area which is designated as rural and is located outside the service district area.

2. *Private Rural Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals*—privately-owned distinct part psychiatric units/freestanding psychiatric hospitals which are located in a rural area under criteria specified below. This includes public local governmental psychiatric hospital days attributable to beds/units located in an area which is designated as rural and is located outside the service district area.

3. *Private Teaching Hospitals*—privately-owned acute care, general, rehabilitation, and long term care hospitals (exclusive of distinct part psychiatric units) which are recognized as approved teaching hospitals under criteria specified below. This includes public local government acute hospital days attributable to beds/units located in an area outside the service district area and classified as a teaching hospital.

4. *Private Urban Nonteaching Hospitals*—privately-owned acute care general hospitals and long term care hospitals (exclusive of distinct part psychiatric units) which are designated as urban hospitals and not recognized as approved teaching hospitals, under criteria specified below. This includes private urban nonteaching hospital days attributable to beds/units located in an area which is designated as urban and is located outside the service district area.

5. *Private Teaching Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals*—privately-owned distinct part psychiatric units/freestanding psychiatric hospitals which meet the criteria for recognition as approved teaching hospitals, under criteria specified below. This includes public local government distinct part psychiatric units/free-standing psychiatric hospital days attributable to beds/units located outside the service district area and classified as a teaching hospital.

6. *Private Urban Nonteaching Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals*—privately-owned distinct part psychiatric units/freestanding psychiatric hospitals which are located in an urban area and do not meet the criteria for recognition as approved teaching hospitals, under criteria specified below. This includes public local government psychiatric hospital days attributable to beds/units located in an area which is designated as urban and is located outside the service district area.

7. *Public Local Government Acute Hospitals*—local government-owned acute care general rehabilitation and long term care hospitals (exclusive of distinct part psychiatric units). Only days attributable to beds/units located within the service district area qualify for inclusion to the pool.

8. *Public Local Government Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals*—local government-owned distinct part psychiatric units/freestanding psychiatric hospitals. Only days attributable to beds/units located within the service district area qualify for inclusion in this pool.

J. The definitions for hospital classifications applicable to the above Medicaid days pools are given below.

1. *Teaching Hospital*—A teaching hospital is defined as a licensed acute care hospital in compliance with the Medicare regulations regarding such facilities, or a specialty hospital with a graduate medical education program that is excluded from the prospective payment system as defined by Medicare. A specialty teaching hospital must have a written affiliation agreement with an accredited medical school to provide post graduate medical resident training in the hospital for the specialty services provided in the specialty hospital. The affiliation agreement must contain an outline of its program in regard to staffing, residents at the facility, etc. A distinct part or carve-out unit of a hospital shall not be considered a teaching hospital separate from the hospital as a whole. Teaching specialty hospitals that are not recognized by Medicare as an approved teaching hospital must furnish to the department, copies of graduate medical education program assignment schedules and rotation schedules which document actual on-going resident training throughout the applicable cost reporting period and shall only be included in the teaching hospital pool for those days that graduate medical education is being provided.

2. *Nonteaching Hospital*—an acute care general hospital or specialty hospital not recognized as an approved teaching hospital by the department or under Medicare principles for the fiscal year-end cost report as of June 30 of the previous year.

3. *Urban Hospital*—a hospital located in a Metropolitan Statistical Area as defined per the 1990 census. This excludes any reclassification under Medicare.

4. *Rural Hospital*—a hospital that is not located in a Metropolitan Statistical Area as defined per the 1990 census. This excludes any reclassification for Medicare.

5. *Distinct Part Psychiatric Unit/Free-standing Psychiatric Hospital*—distinct part psychiatric units of acute care general hospitals or psychiatric units in long term care and rehabilitation hospitals meeting the Medicare criteria for PPS exempt units and enrolled under a separate Medicaid provider number and freestanding psychiatric hospitals enrolled as such.

K. Disproportionate share payments for each pool shall be calculated based on the product of the ratio determined by dividing each qualifying hospital's total Medicaid inpatient days for the applicable cost report by the total Medicaid inpatient days provided by all such hospitals in the state qualifying as disproportionate share hospitals in their respective pools, and then multiplying by an amount of funds for each respective pool to be determined by the director of the Bureau of Health Services Financing. Total Medicaid inpatient days include Medicaid nursery days but do not include skilled nursing facility or swing-bed days. Pool amounts shall be allocated based on the consideration of the volume of days in each pool or the average cost per day for hospitals in each pool.

L. If at audit or final settlement of the cost reports on which the pools are based, the above qualifying criteria are not met, or the number of Medicaid inpatient days are reduced from those originally reported, appropriate action shall be taken to recover any over payments resulting from the use of erroneous data. No additional payments shall be made if an increase in days is determined after audit. Recoupment of overpayment from reductions in pool days originally reported shall be redistributed to the hospital that has the largest number of inpatient days attributable to individuals entitled to benefits under the State Plan of any hospitals in the state for the year in which the recoupment is applicable.

M. Hospitals/units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments. Also, hospital/units which reduce their services by 25 percent as compared to their cost report data on services provided shall be eligible for DSH pool payments in accordance with the level of services provided as indicated in the most current available cost report or as documented from claims history obtained from the claims intermediary.

General Provisions

Disapproval of any one of these payment methodology(ies) by the Health Care Financing Administration does not invalidate one remaining methodology(ies).

Disproportionate share payments cumulative for all DSH payments under all DSH payment methodologies shall not exceed the federal disproportionate share state allotment for each federal fiscal year or the state appropriation for disproportionate share payments for each state fiscal year. The department shall make necessary downward adjustments to hospitals' disproportionate share payments to remain within the federal disproportionate share allotment or the state disproportionate share appropriated amount. In the event it is necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment each year, the department shall calculate a pro rata decrease for each public (state) hospital based on the ratio determined by dividing that hospital's uncompensated cost by the total uncompensated cost for all qualifying public hospitals during the state fiscal year and then multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate allotment. A pro rata decrease for nonstate hospitals will be calculated based on the ratio determined by dividing the

hospitals Medicaid days by the days for all qualifying nonstate hospitals and then multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate share allotment or the state disproportionate share appropriated amount.

Interested persons may submit comments to Thomas D. Collins, Office of the Secretary, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this emergency rule.

Bobby P. Jindal
Secretary

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