RÉSUMÉ DIGEST

HCR 8 **2022 Regular Session** **Schexnayder**

Provides for a hospital stabilization formula pursuant to Art. VII, §10.13 of the Constitution of La., including assessments and reimbursement enhancements.

If the Centers for Medicare and Medicaid Services (CMS) approves the state's proposed directed payment arrangement, authorizes the La. Dept. of Health (LDH) to levy and collect an assessment upon certain hospitals in accordance with the approved arrangement. Requires any such assessment to be collected on a quarterly basis.

Requires LDH to calculate, collect, and levy an assessment from hospitals to be calculated as the product of the rates set forth below and the respective hospitals' inpatient net patient revenue and outpatient net patient revenue as reported in the Medicare cost report ending in state Fiscal Year 2019:

(1) Long-term acute care, psychiatric and rehabilitation hospitals: 1.13% of inpatient net patient revenue, and 1.13% of outpatient net patient revenue.

(2) Hospital Service Districts not classified as rural hospitals as defined in existing law (R.S. 40:1189.1 et seq.): 2.03% of inpatient net patient revenue and outpatient net patient revenue up to $125 M, and 1.13% of inpatient net patient revenue and outpatient net patient revenue over $125 M.

(3) All other acute care hospitals: 2.64% of inpatient net patient revenue up to $125 M, 2.74% of outpatient net patient revenue up to $125 M, and 1.13% of inpatient net patient revenue and outpatient net patient revenue over $125 M.

Exempts the following hospitals from the assessment:

(1) Non-rural, small urban private acute hospitals with 40 licensed beds or less, either as reported in the Medicare cost report ending in state fiscal year 2019 or as licensed by LDH.

(2) Freestanding psychiatric Medicaid disproportionate share hospitals.

(3) Rural hospitals as defined in existing law (R.S. 40:1189.1 et seq.).

Restricts the levy of the assessment to only the quarters in which directed payments are made to hospitals.

Authorizes LDH to continue the current assessment methodology until the new assessment and direct payments are approved by CMS and implemented, and to promulgate any rules and regulations necessary to levy the assessment.

Requires ratification by the Joint Legislative Committee on the Budget (JLCB) of any changes made by CMS in the approved directed payments pre-print that results in alterations to the assessment as established in this Resolution prior to any levy of such assessment.

Requires LDH to submit a Medicaid assessment report to JLCB on a quarterly basis.

Provides for reimbursement enhancements as follows:

(1) Implementation of directed payments pursuant to 42 CFR 438.6 utilizing a uniform percentage increase methodology for both acute and post-acute hospitals.

    (a) For acute care hospitals, the methodology is implemented in the manner set forth in the directed payment arrangement submitted to CMS on March 31, 2022.

    (b) For post-acute care hospitals, the methodology is implemented in the manner set forth in the directed payment arrangement submitted to the CMS on May 13, 2022.

(2) Payment for healthcare services through the implementation of Medicaid expansion.

(3) Payment of hospital reimbursement rates in an amount no less than the reimbursement rates in effect for dates of service on or after Jan. 1, 2022, with the exception of certain exclusions.

Requires LDH to submit any state plan amendment necessary in order to implement the provisions of the assessment within 120 days of the adoption of this Resolution. Further requires LDH to promulgate any rules and regulations necessary to implement the provisions of the assessment. Further provides that final adoption of such rules is not required in order to implement and carry out the provisions of the assessment.

Requires LDH to publish on the department's website the approved CMS directed payment arrangements within 10 days of receiving approval. If CMS approves a preprint such that the content differs from this Resolution, LDH must seek JLCB ratification of such changes prior to implementation.

Requires LDH to publish no later than 30 days after the end of each quarter a report on the reimbursement enhancements provided in the assessment containing data on the following:

(1) The total Medicaid enrollment on a monthly basis.

(2) The average monthly premium paid to managed care organizations providing benefits and services to eligible Medicaid enrollees and the portion of premium related to hospital payments included in the assessment.

(3) The aggregate total of Medicaid claims payments by provider type.

(4) The total amount of inpatient and outpatient Medicaid claims paid to hospitals broken out by each individual hospital Medicaid provider number.

(5) The amount of directed payments received by each hospital.

(6) Other supplemental payments received by each hospital.