

RÉSUMÉ DIGEST

HCR 3

2024 Regular Session

McFarland

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

Authorizes the La. Dept. of Health (LDH) to levy and collect an assessment upon certain hospitals in accordance with the state's proposed directed payment arrangement once the Centers for Medicare and Medicaid Services (CMS) approve the 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: 1.38% of inpatient net patient revenue and 1.38% of outpatient net patient revenue.
- (2) Hospital Service Districts not classified as rural hospitals pursuant to existing law (R.S. 40:1189.1 et seq.): 2.48% of inpatient net patient revenue and outpatient net patient revenue up to \$125 M, and 1.38% of inpatient net patient revenue and outpatient net patient revenue over \$125 M.
- (3) All other acute care hospitals: 3.23% of inpatient net patient revenue up to \$125 M and 3.35% of outpatient net patient revenue up to \$125 M.

Exempts the following hospitals from the assessment:

- (1) Nonrural, 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.

Requires LDH to submit a report to the Joint Legislative Committee on the Budget (JLCB) prior to any levy providing details on the calculation of the proposed assessment and a listing of each hospital included in the proposed assessment.

Requires ratification by 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.

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 or before April 30, 2024.
 - (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 or before April 30, 2024.
- (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, 2024.

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 amount of inpatient and outpatient Medicaid claims paid to hospitals broken out by each individual hospital Medicaid provider number.
- (2) The amount of directed payments received by each hospital.
- (3) Other supplemental payments received by each hospital.