**DECLARATION OF EMERGENCY**

**Department of Health**
**Bureau of Health Services Financing**

Hospital Services
Outpatient Hospital Services
Other Rural Hospitals
(LAC 50:V.Chapter 79)

The Department of Health, Bureau of Health Services Financing hereby adopts LAC 50:V.Chapter 79 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:962, and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Effective September 16, 2024, this Emergency Rule will ensure that other rural hospitals remain financially viable so that the access to medical care that they provide to Medicaid beneficiaries in their communities will continue to be available and will improve in the future. Without these proposed rate increases, impacted hospitals could be forced to close which will jeopardize the health and welfare of citizens living in the communities that they serve.

It is anticipated that this Emergency Rule will result in a fiscal impact of $10,405,408 to the Medicaid Program for state fiscal year 2024-2025.

**Title 50**
**PUBLIC HEALTH—MEDICAL ASSISTANCE**
**Part V. Hospital Services**
**Subpart 5. Outpatient Hospital Services**
**Chapter 79. Other Rural Hospitals**

**§7901. Qualifying Criteria**

A. In order to qualify as an other rural, non-state hospital effective for dates of service on or after October 1, 2024 the hospital shall meet the following criteria:

1. is a non-state owned hospital;

2. has no more than 60 licensed beds as of October 1, 2024, excluding distinct part psychiatric unit beds, distinct part rehabilitation unit beds, and nursery bassinets;

3. does not qualify as a rural hospital as defined in R.S. 40:1189.3;

4. is not located within one of Louisiana's delineated metropolitan statistical areas (MSA) per the 2023 American Community Survey's census estimates program;

5. has an operational emergency room; and

6. is located in a city with a population of less than 23,000 per the 2020 United States Census.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 51:

**§7903. Reimbursement Methodology**

A. Effective for dates of service on or after September 16, 2024, reimbursement rates paid to other rural, non-state hospitals for outpatient hospital services shall be as follows.

1. Surgery Services. The reimbursement amount for outpatient hospital surgery services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

2. Clinic Services. The reimbursement amount for outpatient hospital facility fees for clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

3. Laboratory Services. The reimbursement amount for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.

4. Rehabilitation Services. The reimbursement amount for outpatient rehabilitation services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

5. Other Outpatient Hospital Services. The reimbursement amount for outpatient hospital services other than surgery services, clinic services, clinical diagnostic laboratory services, and rehabilitation services shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

B. If a qualifying hospital's outpatient costs is greater in subsequent cost reporting periods than the initial implementation year cost report period's cost, outpatient costs shall be subjected to a cap prior to determination of cost settlement amount. Calculation of reimbursable costs shall be as follows.

1. An average cost per Medicaid outpatient unduplicated encounter per day shall be established using Medicaid cost report and paid claims data from the initial cost report period of implementation. The average unduplicated encounter cost per day shall be calculated by dividing the total outpatient allowable costs for all Medicaid outpatient services by the number of paid unduplicated encounters per day. Clinical diagnostic laboratory services and vaccines are not included in this calculation.

2. To determine the capped limit for each subsequent year's allowable cost settlement reimbursement, the base year outpatient per unduplicated encounter per day cost shall be multiplied by the unduplicated encounters from the applicable subsequent cost reporting period's Medicaid paid claims data and then increased by 3 percent cumulatively for each year subsequent to the initial implementation year.

3. Final reimbursement shall be 95 percent multiplied by the lesser of capped cost amount calculated per §7903.B.2 or allowable reimbursable cost calculated per §7903.A.

B. A 3 percent cost increase threshold shall be applied to reimbursement after the initial year of implementation. Calculation shall be as follows.

1. An outpatient per unit cost shall be established using Medicaid cost report and paid claims data from the initial year of implementation. The outpatient per unit cost shall be calculated by dividing the total outpatient reimbursable costs (95 percent of allowable costs) for all Medicaid outpatient services by the number of paid claim units. Clinical diagnostic laboratory services are not included in this calculation.

2. To determine the threshold for each subsequent year's allowable cost settlement reimbursement, the base year outpatient per unit cost shall be multiplied by the units from current Medicaid cost report and paid claims data and then increased by 3 percent for each year subsequent to the initial implementation year.

3. Reimbursement shall be the lesser of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process for the applicable year or the threshold calculated per §7903.B.2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 51:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

**Public Comments**

Kim Sullivan, Bureau of Health Services Financing, is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Michael Harrington, MBA, MA
Secretary

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