Chapter 40. Provider Fees

§4001. Specific Fees

A. Definitions

Emergency Ground Ambulance Service Provider-a non-public, non-federal provider of emergency ground ambulance services.

Net Operating Revenue—Repealed.

Quarter—for purposes of this Chapter, quarters shall be constituted as follows.

First Quarter	December, January, February
Second Quarter	March, April, May
Third Quarter	June, July, August
Fourth Quarter	September, October, November

a. Exception. For purposes of hospital and emergency ground ambulance services, quarters shall be constituted as follows.

First Quarter	July, August, September
Second Quarter	October, November, December
Third Quarter	January, February, March
Fourth Quarter	April, May, June

B. Nursing Facility Services

1. A fee shall be paid by each facility licensed as a nursing home in accordance with R.S. 40:2009.3 et seq., for each occupied bed on a per day basis. A bed shall be considered occupied, regardless of physical occupancy, based upon payment for nursing facility services available or provided to any individual or payer through formal or informal agreement. For example, a bed reserved and paid for during a temporary absence from a nursing facility shall be subject to the fee. Likewise, any bed or beds under contract to a Hospice shall be subject to the fee for each day payment is made by the Hospice. Contracts, agreements, or reservations, whether formal or informal, shall be subject to the fee only where payment is made for nursing services available or provided. Nursing facilities subject to the fee shall provide documentation quarterly, on a form provided by the department, of occupied beds in conjunction with payment of the fee.

2. The fee imposed for nursing facility services shall not exceed 6 percent of the net patient revenues received by providers of that class of services and shall not exceed $12.08 per occupied bed per day. The fee amount shall be calculated annually in conjunction with updating provider reimbursement rates under the Medical Assistance Program. Notice to providers subject to fees shall be given in conjunction with the annual rate setting notification by the Bureau of Health Services Financing.

C. Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/DD) Services

1. A fee shall be paid by each facility licensed as an intermediate care facility for individuals with developmental disabilities in accordance with R.S. 46:2625 et seq., for each occupied bed per day. A bed shall be considered occupied, regardless of physical occupancy, based on payment for ICF/DD facility services available or provided to any individual or payer through formal or informal agreement. For example, a bed reserved and paid for during a temporary absence from a facility shall be subject to the fee. Likewise, any bed or beds under contract to a hospice shall be subject to the fee for each day payment is made by the hospice. Contracts, agreements, or reservations, whether formal or informal, shall be subject to the fee only where payment is made for ICF/DD facility services available or provided. ICF/DD facilities subject to fees shall provide documentation quarterly, on a form provided by the department, of occupied beds in conjunction with payment of the fee.

2. The fees imposed for ICF/DD facility services shall not exceed 6 percent of the net patient revenues received by providers of that class of service and shall not exceed $30 per occupied bed per day. The fee amount shall be calculated annually in conjunction with updating provider reimbursement rates under the Medical Assistance Program. Notice to providers subject to fees shall be given in conjunction with the annual rate setting notification by the Bureau of Health Services Financing.

D. Pharmacy Services. A fee shall be paid by each pharmacy and dispensing physician for each out-patient prescription dispensed. The fee shall be $0.10 per prescription dispensed by a pharmacist or dispensing physician. Where a prescription is filled outside of Louisiana and not shipped or delivered in any form or manner to a patient in the state, no fee shall be imposed. However, out-of-state pharmacies or dispensing physicians dispensing prescriptions which are shipped, mailed or delivered in any manner inside the state of Louisiana shall be subject to the $0.10 fee per prescription. The fee only applies to prescriptions which are dispensed for human use. Pharmacies and dispensing physicians subject to the fees shall provide documentation quarterly, on a form provided by the department, in conjunction with payment of fees.

E. Emergency Ground Ambulance Services. Effective August 1, 2016, a fee shall be imposed on emergency ground ambulance service providers in accordance with R.S. 46:2626

1. The total assessment for the initial state fiscal year in which the assessment is charged shall not exceed the lesser of the following:

a. the state portion of the cost, excluding any federal financial participation, of the reimbursement enhancements provided for in R.S. 46:2626 that are directly attributable to payments to emergency ground ambulance services providers; or

b. 1 1/2 percent of the net operating revenue of all emergency ground ambulance service providers assessed relating to the provision of emergency ground ambulance transportation.

2. Except for the first year maximum fee of 1 1/2 percent of the net operating revenue, the department shall not impose any new fee or increase any fee on any emergency ground ambulance service provider on or after July 1, 2016, without first obtaining either of the following:

a. prior approval of the specific fee amount by record vote of two-thirds of the elected members of each house of the legislature while in regular session;

b. written agreement of those providers subject to the fee which provide a minimum of 65 percent of the emergency ground ambulance transports.

3. After the initial year of assessment, the assessment shall be a percentage fee, determined at the discretion of the secretary and subject to the provisions below in collaboration with the express and written mutual agreement of the emergency ground ambulance service providers subject to the assessment and which make up a minimum of 65 percent of all emergency ground ambulance transports in the state of Louisiana.

a. the maximum fee allowable in any year shall not exceed the percentage of net patient service revenues permitted by federal regulation pursuant to 42 CFR 433.68 as determined by the department, as reported by the provider and subject to audit for the previous fiscal year of the provider. The department will arrive at net patient services revenue by using net operating revenue as defined in R.S. 46:2626.

4. Prior to levying or collecting the assessment for the applicable assessment period, the department shall publish in the official state journal the total amount of the assessment and the corresponding applicable percentage of net operating revenue that will be applied to the assessed providers.

F. Hospital Services

1. Effective January 1, 2017, a hospital stabilization assessment fee shall be levied and collected in accordance with article VII, section 10.13 of the Constitution of Louisiana and any legislation setting forth the hospital stabilization formula.

a. The total assessment for each state fiscal year shall be equal to, but shall not exceed, the lesser of the following:

i. the state portion of the cost, excluding any federal financial participation and any costs associated with full Medicaid pricing, of payments for healthcare services through the implementation of a health coverage expansion of the Louisiana Medical Assistance Program that meets all the necessary requirements necessary for the state to maximize federal matching funds as set forth in 42 U.S.C. 1396(d)y of title XIX of the Social Security Act, which are directly attributable to payments to hospitals; or

ii. one percent of the total inpatient and outpatient net patient revenue of all hospitals included in the assessment, as reported in the Medicare cost report ending in state fiscal year 2015.

2. The assessment shall be allocated to each assessed hospital on a pro rata basis by calculating the quotient of the total assessment divided by the total inpatient and outpatient hospital net patient revenue of all assessed hospitals, as reported in the Medicare cost report ending in state fiscal year (SFY) 2015, and multiplying the quotient by each assessed hospital's total inpatient and outpatient hospital net patient revenue. If a hospital was not required to file a Medicare cost report or did not file a Medicare cost report ending in SFY 2015, the hospital shall submit to the department its most applicable calendar year total of inpatient and outpatient hospital net patient revenue in a form prescribed by the department.

3. The assessment will be levied and collected on a quarterly basis and at the beginning of each quarter that the assessment is due. Prior to levying or collecting the assessment for the applicable quarterly period, the department shall publish in the *Louisiana Register* the total amount of the quarterly assessment and the corresponding percentage of total inpatient and outpatient hospital net patient revenue that will be applied to the assessed hospitals.

4. Hospitals meeting the definition of a rural hospital, as defined in R.S. 40:1189.3, shall be excluded from this assessment.

5. No licensed facility, which is prohibited from participating in the Medicare Program set forth in 42 U.S.C. 1396, shall be assessed or levied any fee for the hospital stabilization authorized in Article VII, Section 10.13 of the Constitution of Louisiana. This provision is specifically subject to the approval of any waiver required by the Centers for Medicare and Medicaid Services and approval by the Department of Health.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and P.L. 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 20:51 (January 1994), LR 26:1478 (July 2000), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:100 (January 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887, 1888 (November 2016), LR 43:73 (January 2017), repromulgated LR 43:323 (February 2017), amended LR 44:1015 (June 2018), LR 44:1894 (October 2018).

§4003. Due Date for Submission of Reports and Payment

A. Quarterly reports and fees shall be submitted to the department and shall be due on the twentieth calendar day of the month following the close of the quarter and shall be deemed delinquent on the thirtieth calendar day of that month. Even if no fee is due, submission of the report is still mandatory.

B. For hospital and emergency ground ambulance services, payment is due 30 days from the notification of the amount owed.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 26:1479 (July 2000), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887 (November 2016), LR 44:1017 (June 2018).

§4005. Delinquent and/or Unfiled Reports

A. Penalty Assessment. In the case a report has been determined delinquent, the specific penalty shall be 5 percent of the total fee due on the report for every 30 days that the report is not filed, not to exceed 180 days. When a report is not received within 180 days from the due date, the report shall be deemed not filed and there shall be cause for an audit, investigation or examination to be made by the department.

B. Estimation of Provider Fee Due. In those cases in which a health care provider fails to file the quarterly report, the department will estimate the provider fee due. The department will, by certified mail, notify the provider of the estimated fee due, the method used to calculate the estimated fee and the department's intent to collect the delinquent fee. The provider shall have 15 days from the date of the notice to file a provider fee report with the department. Any provider who fails to file the quarterly report within 15 days of the date of the department's estimated provider fee notice shall waive any and all rights to appeal the department's action and to contest payment of the estimated fee.

C. Incorrect Reporting. If a provider submits a quarterly report required by the provisions of this Chapter and the report made and filed does not correctly compute the amount of the fee owed, there shall be cause for an audit, investigation or examination to be made by the department.

D. False or Fraudulent Reporting. When a provider files a quarterly report that is false or fraudulent or grossly incorrect, there shall be imposed, in addition to any other sanctions allowed under rule or law, a specific penalty of 50 percent of the fee due.

E. Reimbursement of Audit, Hearing, and Witness Costs. If actions by a provider cause the department to examine books, records, or documents, or undertake an audit thereof, and/or conduct a hearing, and/or subpoena witnesses, then the provider shall be assessed an amount as itemized by the department to compensate for all costs incurred in making such examination or audit, and/or in holding such hearing, and/or in subpoenaing and compensating witnesses.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 26:1479 (July 2000), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1017 (June 2018).

§4007. Delinquent and/or Unpaid Fees

A. When the provider fails to pay the fee due, or any portion thereof, on or before the date it becomes delinquent, interest at the rate of 1 1/2 percent per month compounded daily shall be assessed on the unpaid balance until paid.

B. Collection of Delinquent Fees

1. For those health care providers enrolled in the Louisiana Medical Assistance Program (Medicaid), collection of delinquent provider fees will be as follows.

a. The department will withhold from the provider's Medicaid reimbursement, an amount equal to 50 percent of the reimbursement or the actual amount of the delinquent provider fee, including interest and penalty, whichever is less.

b. By enrolling and participating in the Louisiana Medical Assistance Program (Medicaid) a provider agrees that during the period of time delinquent provider fees are being collected, no additional provider fee delinquency will occur. If the provider becomes further delinquent, the department will withhold 100 percent of the Medicaid reimbursement or the actual amount of the delinquent provider fees, including interest and penalty, whichever is less.

2. For those health care providers not enrolled in the Louisiana Medical Assistance Program (Medicaid), the department will avail itself of any and all appropriate legal and judicial remedies in the collection of delinquent provider fees.

C. Nonsufficient Fund (NSF) Checks in Payment of Fee. A specific service charge, in accordance with R.S. 9:2782(B) as it may be amended from time to time, shall be imposed on all NSF checks. The tender of three NSF checks shall be cause for an audit, investigation or examination to be made by the department, and the provider will be required to make payment thereafter by certified check or money order.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 20:1114 (October 1994), LR 26:1479 (July 2000), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887 (November 2016), LR 44:1017 (June 2018).

§4009. Appeals

A. Any provider aggrieved pursuant to the provisions determined herein shall have the right to administrative appeal as specified in R.S. 46:107.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), repromulgated LR 26:1480 (July 2000).

§4011. Exceptions

A. The secretary may exempt any assessment of penalty and interest described in this Chapter.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 26:1480 (July 2000).

§331. Enhanced Reimbursements for Qualifying Emergency Ground Ambulance Service Providers

A. Effective for dates of service on or after August 1, 2016, qualifying emergency ambulance service providers assessed a fee as outlined in LAC 48:I.4001.E.1.a-d shall receive enhanced reimbursement for emergency ground ambulance transportation services rendered during the quarter through the Supplemental Payment Program described in Louisiana Medicaid State Plan Amendment Transmittal Number 11-23.

B. Calculation of Average Commercial Rate

1. The enhanced reimbursement shall be determined in a manner to bring the payments for these services up to the average commercial rate level as described in Subparagraph C.3.h. The average commercial rate level is defined as the average amount payable by the commercial payers for the same service.

2. The department shall align the paid Medicaid claims with the Medicare fees for each healthcare common

procedure coding system (HCPCS) or current procedure terminology (CPT) code for the ambulance provider and calculate the Medicare payment for those claims.

3. The department shall calculate an overall Medicare to commercial conversion factor for each ambulance provider by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.

4. The commercial to Medicare ratio for each provider will be re-determined at least every three years.

C. Payment Methodology

1. The enhanced reimbursement to each qualifying emergency ground ambulance service provider shall not exceed the sum of the difference between the Medicaid payments otherwise made to these providers for the provision of emergency ground ambulance transportation services and the average amount that would have been paid at the equivalent community rate.

2. The enhanced reimbursement shall be determined in a manner to bring payments for these services up to the community rate level.

a. *Community Rate*—the average amount payable by commercial insurers for the same services.

3. The specific methodology to be used in establishing the enhanced reimbursement payment for ambulance providers is as follows.

a. The department shall identify Medicaid ambulance service providers that qualify to receive enhanced reimbursement Medicaid payments for the provision of emergency ground ambulance transportation services.

b. For each Medicaid ambulance service provider identified to receive enhanced reimbursement Medicaid payments, the department shall identify the emergency ground ambulance transportation services for which the provider is eligible to be reimbursed.

c. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the department shall calculate the reimbursement paid to the provider for the provision of emergency ground ambulance transportation services identified under Subparagraph C.3.b of this Section.

d. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the department shall calculate the provider's equivalent community rate for each of the provider's services identified under Subparagraph C.3.b of this Section.

e. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the department shall subtract an amount equal to the reimbursement calculation for each of the emergency ground ambulance transportation services under Subparagraph C.3.c of this Section from an amount equal to the amount calculated for each of the emergency ground ambulance transportation services under Subparagraph C.3.d of this Section.

f. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the department shall calculate the sum of each of the amounts calculated for emergency ground ambulance transportation services under Subparagraph C.3.e. of this Section.

g. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the department shall calculate each provider's upper payment limit by totaling the provider's total Medicaid payment differential from Subparagraph C.3.f of this Section.

h. The department shall reimburse providers identified in Subparagraph C.3.a of this Section up to 100 percent of the provider's average commercial rate.

D. Effective Date of Payment

1. The enhanced reimbursement payment shall be made effective for emergency ground ambulance transportation services provided on or after August 1, 2016. This payment is based on the average amount that would have been paid at the equivalent community rate.

2. After the initial calculation for fiscal year 2015-2016, the department will rebase the equivalent community rate using adjudicated claims data for services from the most recently completed fiscal year. This calculation may be made annually but shall be made no less than every three years.

E. Maximum Payment

1. The total maximum amount to be paid by the department to any individually qualified Medicaid ambulance service provider for enhanced reimbursement Medicaid payments shall not exceed the total of the Medicaid payment differentials calculated under Subparagraph C.3.f of this Section

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 42:1890 (November 2016).