RULE

Department of Health
Bureau of Health Services Financing

Early and Periodic Screening, Diagnosis and Treatment
Personal Care Services
Personal Care Workers Wage Enhancement
(LAC 50:XV.7321)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.7321 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 5. Early and Periodic Screening, Diagnosis and Treatment

Chapter 73. Personal Care Services

§7321. Reimbursement

A. – A.2. …

B. – B.1.b. Repealed.

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 and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:179 (February 2003), amended LR 33:2202 (October 2007), repromulgated LR 33:2425 (November

2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2561 (November 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:908 (July 2019), LR 49:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Healthcare Services Provider Fees
Hospital Fee Assessments
(LAC 48:I.4001 and 4007)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.4001 and §4007 as authorized by R.S. 36:254. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 48
PUBLIC HEALTH—GENERAL
PART I. General Administration
Subpart 1. General

Chapter 40. Provider Fees

§4001. Specific Fees

A. – E.3.a. ...

F. Hospital Services

1. Effective July 1, 2022, a hospital stabilization assessment fee shall be levied and collected in accordance with article VII, section 10.13 of the Constitution of Louisiana, any legislation setting forth the hospital stabilization formula, and departmental requirements relative to directed payments.

a. Subject to written approval by the Centers for Medicare and Medicaid Services (CMS) of a directed payment arrangement pursuant to 42 C.F.R. 438.6, the Department of Health shall levy and collect an assessment from those hospitals

subject to the approved directed payment arrangement. Each approved directed payment arrangement is effective for one Healthy Louisiana Medicaid managed care contract rating period.

i. Prior to the levy of any assessment pursuant to this Subsection, the Department of Health shall submit a Medicaid assessment report to the Joint Legislative Committee on the Budget. The Medicaid assessment report shall include a description of the proposed assessment, the basis for the calculation of the assessment, and a listing of each hospital included in the proposed assessment. The hospital assessment shall be calculated in accordance with the annual hospital stabilization formula set forth by the Legislature of Louisiana and enacted pursuant to article VII, section 10.13 of the Constitution of Louisiana.

ii. An assessment levied pursuant to this Subsection shall be levied only for the quarters that directed payments are actually paid to qualified hospitals pursuant to 42 C.F.R. 438.6 directed payment arrangements approved by CMS.

2. Individual hospitals subject to an assessment under this Subsection shall be obligated to pay such assessment regardless of whether a directed payment is actually paid to the hospital for the quarter for which the assessment is levied.

3. The assessment will be levied and collected on a quarterly basis and at the beginning of each quarter that the assessment is due.

4. – 5. Repealed.

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, R.S. 36:254, and Article VII, Section 10.13 of the Constitution of Louisiana.

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), LR 45:1597 (November 2019), LR 49:

§4007. Delinquent and/or Unpaid Fees

A. – C. ...

D. In accordance with departmental requirements relative to directed payments, hospitals that fail to pay the assessment due, or any portion thereof, may be subject to one or more of the following:

1. exclusion from participation in any directed payment arrangement approved by the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. 438.6;

2. revocation of the hospital’s license; or

3. termination of the hospital’s enrollment in the Medical Assistance Program (Medicaid).

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), LR 49:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services
Urban Metropolitan Statistical Area Facility–New Orleans Area
(LAC 50:V.Chapter 21)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:V.Chapter 21 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH–MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospitals Services

Chapter 21. Urban Metropolitan Statistical Area (MSA) Facility–New Orleans Area

§2101. Qualifying Criteria

A. In order to qualify as an urban metropolitan statistical area (MSA) facility–New Orleans area, effective as of October 5, 2022, the hospital must:

1. be designated a non-rural hospital service district located in LDH region 1, with a facility type code of acute, Medicaid enrolled, with an original hospital license date

before July 13, 2014, but after July 1, 2014, located in zip code 70127;

2. be a hospital that is located an urban MSA as defined by United States Office of Management and Budget;

3. have an operational emergency room; and

4. not add additional locations under this license, without prior written approval of the department.

a. The addition of any off-site campus, beyond an outpatient primary care clinic, to the license of this hospital will invalidate the provisions of this reimbursement methodology.

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 49:

§2103. Reimbursement Methodology

A. The inpatient hospital per diem rate paid for acute care services to qualifying urban MSA hospitals-New Orleans area who meet all of the criteria in §2101 shall be increased by indexing annually to 95 percent of the small rural hospital acute per diem rate in effect.

B. The inpatient hospital per diem rate paid for psychiatric services to qualifying urban MSA hospitals–New Orleans area who meet all of the criteria in §2101 shall be

increased by indexing annually to 95 percent of the small rural hospital psychiatric per diem rate in effect.

C. These rates are conditional on the hospital continuing to meet all qualifying criterial included in §2101. If the hospital no longer qualifies, payments will revert back to appropriate non-rural, non-state hospital assigned rates effective on the date that the qualification(s) in §2101 are no longer met.

D. The department may review all above provisions every three years, at a minimum to evaluate continuation of these enhanced reimbursements.

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 49:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Hospital Directed Payments
(LAC 50:I.3113)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:I.3113 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 31. General Provisions

§3113. Directed Payments

A. Hospital Directed Payments

1. Subject to written approval by the Centers for Medicare and Medicaid Services (CMS), the Department of Health (hereafter referred to as “the department” and/or “LDH”) shall provide directed payments to qualifying hospitals that participate in the Healthy Louisiana Medicaid managed care program, in accordance with the applicable section 438.6(c)

preprint(s) approved by CMS, federal regulations, and departmental requirements. Each CMS approved directed payment arrangement is effective for one Healthy Louisiana Medicaid managed care contract rating period.

2. *Qualifying Hospital*—either of the following:

a. an in-state provider of inpatient and outpatient hospital services (excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals) that meets the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements; or

b. an in-state hospital provider of long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements.

3. The department shall assign qualifying hospitals to provider classes based upon criteria specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying hospitals shall have no right to an administrative appeal regarding any issue related to provider classification, including, but not limited to, provider class

assignment, the effective date of provider class assignment, or qualifying determinations.

4. The department shall utilize an interim payment process, whereby interim directed payments will be calculated based on provider class assignment utilizing the data and methodology specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying hospitals shall have no right to an administrative appeal regarding calculation of interim directed payments.

5. The department shall cause interim directed payments to be paid on a quarterly basis to the Healthy Louisiana Medicaid managed care organizations (MCOs), in accordance with departmental requirements.

a. The MCOs shall pay interim directed payments to qualified hospitals within 10 business days of receipt of quarterly interim directed payment information from LDH. If a barrier exists that will not allow the MCO to pay the interim directed payments within 10 business days of receipt, the MCO shall immediately notify LDH. LDH at its sole discretion will determine if penalties for late payment may be waived.

b. The qualifying hospital may request that the MCOs deposit their interim directed payments into a separate

bank account owned/held by the qualifying hospital. Interim directed payments shall not be deposited into a bank account that is owned/held by more than one qualifying hospital.

6. In accordance with the applicable section 438.6(c) preprint(s) approved by CMS, federal regulations, and departmental requirements, directed payments must be based on actual utilization and delivery of services during the applicable contract period.

a. Within 12 months of the end of each state fiscal year (SFY), LDH shall perform a reconciliation as specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements.

i. Qualifying hospitals shall have no right to an administrative appeal regarding any issue related to reconciliation, including, but not limited to, the timing and process.

b. Qualified hospitals are strongly encouraged to submit claims as quickly as possible after SFY end.

7. If a qualifying hospital that is subject to a reconciliation will not be participating in a directed payment arrangement in the future, the qualified hospital shall pay all amounts owed to LDH, if any, within 30 calendar days' notice of the amount owed, in accordance with departmental requirements.

a. In addition to all other available remedies, LDH has the authority to offset all amounts owed by a qualifying hospital due to a reconciliation against any payment owed to the qualifying hospital, including, but not limited to, any payment owed by the MCOs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:245 and Title XIX of the Social Security Act

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 49:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Outpatient Hospital Services
Urban Metropolitan Statistical Area Facility–New Orleans Area
(LAC 50:V.Chapter 75)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:V.Chapter 75 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 5. Outpatient Hospital Services

Chapter 75. Urban Metropolitan Statistical Area (MSA) Facility–New Orleans Area

§7501. Qualifying Criteria

A. In order to qualify as an urban metropolitan statistical area (MSA) facility–New Orleans area, effective October 5, 2022, a hospital must:

1. be designated a non-rural hospital service district located in LDH region 1, with a facility type code of acute, Medicaid enrolled, with an original hospital license date

before July 13, 2014, but after July 1, 2014, located in zip code 70127;

2. be a hospital that is located in an MSA as defined by United States Office of Management and Budget;

3. have an operational emergency room; and

4. not add additional locations under this license, without prior written approval of the department.

a. The addition of any off-site campus, beyond an outpatient primary care clinic, to the license of this hospital will invalidate the provisions of this reimbursement methodology.

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 49:

§7503. Reimbursement Methodology

A. Payments for outpatient services to qualifying urban MSA hospitals–New Orleans area who meet all of the criteria in §7501 shall be made as follows:

1. Outpatient Surgery. 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 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 clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

B. The department may review all above provisions every three years, at a minimum, to evaluate continuation of these enhanced reimbursements.

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 49:

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.

Dr. Courtney N. Phillips

Secretary