Chapter 40. Provider Fees

§4001. Specific Fees

A. Definition

Net Operating Revenue—the gross revenues of an emergency ground ambulance service provider for the provision of emergency ground ambulance transportation services, excluding any Medicaid reimbursement, less any deducted amounts for bad debts, charity care and payer discounts.

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

B. Nursing Facility Services

1. A bed fee shall be paid by each facility licensed as a nursing home in accordance with R.S. 40:2009.3 et seq., for each bed utilized for the provision of care on a daily basis. The fee shall be imposed for each bed per day utilized for the provision of care. A bed shall be considered in use, regardless of physical occupancy, based on payment for nursing 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 bed fee shall provide documentation quarterly, on a form provided by the department, of utilization for all licensed beds in conjunction with payment of the fee.

2. The provider fee imposed for nursing facility services shall not exceed 6 percent of the average 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-Mentally Retarded (ICF-MR) Services

1. A bed fee shall be paid by each facility licensed as an intermediate care facility for the mentally retarded in accordance with R.S. 28:421 et seq., for each bed utilized for the provision of care on a daily basis. The fee shall be imposed for each bed per day utilized for the provision of care. A bed shall be considered in use, regardless of physical occupancy, based on payment for ICF-MR 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-MR facility services available or provided. ICF-MR facilities subject to bed fees shall provide documentation quarterly, on a form provided by the department, of utilization for all licensed beds in conjunction with payment of the fee.

2. The provider fees imposed for ICF-MR facility services shall not exceed 6 percent of the average 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 prescription 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 and sold for human use. Pharmacies and dispensing physicians subject to prescription fees shall provide documentation quarterly, on a form provided by the department, of utilization for all medications dispensed in conjunction with payment of fees.

E. Medical Transportation Services. Effective for dates of service on or after August 1, 2016, qualifying emergency ground ambulance service providers shall be assessed a fee of 1 1/2 percent of the net operation revenue.

1. Qualifying Criteria. Ambulance service providers must meet the following requirements in order to be assessed a fee of 1 1/2 percent of the net operating revenue. The ambulance service provider must be:

a. licensed by the state of Louisiana;

b. enrolled as a Louisiana Medicaid provider;

c. a provider of emergency ground ambulance transportation services as defined in 42 CFR 440.170 and Medical and Remedial Care and Services Item 24.a; and

d. a non-federal, non-public provider in the State of Louisiana, as defined in 42 CFR 433.68(c)(1), of emergency ground ambulance services that is contracted with a unit of local or parish government in the state of Louisiana for the provision of emergency ground ambulance transportation on a regular 24 hours per day and 7 days per week basis.

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 House Concurrent Resolution (HCR) 51 of the 2016 Regular Session of the Louisiana Legislature 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, of the reimbursement enhancements provided for in HCR 51, 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.

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), amended by the Department of Health, Bureau of Health Services Financing, LR 43:73 (January 2017), repromulgated by the Department of Health, Bureau of Health Services Financing, LR 43:323 (February 2017).

§4003. Due Date for Submission of Reports and Payment of Fees

A. The department will mail a Quarterly Utilization Report to each licensed provider covered under the scope of this statute at the address given in the last report filed pursuant to the provisions of R.S. 46:2601-2605. The provider shall promptly notify the department of any change of address. Quarterly Utilization 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. Medical Transportation Services. Effective August 1, 2016, qualified ambulance service providers will be assessed a fee at the end of each quarter not to exceed 1 1/2 percent of the net operating revenue of emergency ground ambulance service providers.

1. Qualified ambulance service providers will provide the Department of Health (department) a monthly net operating revenue report for emergency ground ambulance transportation services by the fifteenth business day of the following month.

2. Qualified ambulance service providers will be issued a quarterly notice within 30 days from the end of the quarter. Payment will be due to the department by qualified ambulance service providers within 30 days from date of notice.

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).

§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 or fraction thereof that the report is not filed, not to exceed 150 days. When a report is not received within 150 days from 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 Utilization 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 estimate and the department's intent to collect the delinquent fee. The provider shall have 10 days from the date of receipt of the notice to file a provider fee report with the department. Any provider who fails to file the Quarterly Utilization Report within 10 days of the date of receipt 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 report required by the provisions of this Chapter and the report made and filed does not correctly compute the liability of the provider 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 report that is false or fraudulent or grossly incorrect and the circumstances indicate that the provider had intent to defraud the state of Louisiana of any fee due under this Chapter, there shall be imposed, in addition to any other penalties provided, 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).

§4007. Delinquent and/or Unpaid Fees

A. Interest on Unpaid Provider Fees Other Than Medical Transportation Provider Fees. 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. In the case of interest on a penalty assessed, such interest shall be computed beginning 15 days from the date of notification of assessment until paid.

B. Collection of Delinquent Provider Fee other than Medical Transportation Provider Fees

1. For those enrolled as health care providers 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 check, an amount equal to 50 percent of the reimbursement check 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.

D. The department shall refund any overpayment to the provider.

E. Emergency Ground Ambulance Service Provider Fees

1. Penalties and Interest for Non-Payment of Assessment

a. If the department audits a qualifying ambulance service provider’s records and determines the net operating revenue reported is incorrect for the assessment collected, the department shall fine the qualifying ambulance service provider .15 percent of the corrected assessment. The fine is payable within 30 days of the invoice.

b. If a qualifying ambulance service provider fails to fully pay its assessment on or before the due date, the department shall assess a late penalty of .15 percent of the quarterly calculated assessment. The department shall reserve the right to suspend all Medicaid payments to a qualifying ground ambulance service provider until the provider pays the assessment and penalty due in full or until the provider and the department reach a negotiated settlement.

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.

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