STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

1. **Rehabilitation Services:** 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. **Other Outpatient Hospital Services:** For outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees, reimbursement shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

The above payment rates are contingent on the hospital continuing to meet all qualifying criteria set forth above. 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.

High Medicaid Utilization Academic Hospitals

Qualifying Criteria

Effective for dates of service on or after July 1, 2024, the hospital shall meet the following criteria per the Medicare/Medicaid as filed cost report for their fiscal year ended in state fiscal year 2023:

1. have a Medicaid inpatient utilization of at least 39 percent; and
2. have an approved graduate medical education program with at least 400 intern and resident full time equivalents (FTEs). The intern and resident FTE count must be included on the Medicare/Medicaid cost report on worksheet E-4, line 6 plus worksheet E-3, Part II, line 6.

Qualifying hospitals shall not add additional locations under their license, without prior written approval of the Department. The addition of any off-site campus, beyond an outpatient primary care clinic, to the license of the hospital will invalidate the provisions of this reimbursement methodology.

Reimbursement Methodology

Reimbursement for outpatient hospital services to qualifying high Medicaid academic hospitals that meet all of the criteria above 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.

These rates are conditional on the hospital continuing to meet all qualifying criteria listed above. 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 the criteria listed above are no longer met.

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