NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Provider Screening and Enrollment
(LAC 50:I.Chapter 15)

The Department of Health, Bureau of Health Services Financing proposes to amend LAC 50:I.Chapter 15 as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing provider screening and enrollment in order to comply with U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) requirements to align the provisions governing out-of-state enrollment and single case agreements with the Medicaid Provider Enrollment Compendium, to codify provisions for informal hearings and appeal rights for provider enrollment denials and terminations, and to ensure that the administrative Rule is consistent with current practices.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 1. General Provisions

Chapter 15. Provider Screening and Enrollment

§1501. General Provisions

A. Pursuant to the provisions of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, 42 C.F.R. § Part 455, Subpart E, and the 21st Century Cures Act, the Medicaid Program adopts the following provider enrollment and screening requirements. The Centers for Medicare and Medicaid Services (CMS) has established guidelines for provider categorization based on an assessment of potential for fraud, waste, and abuse for each provider type. The Medicaid Program shall determine the risk level for providers and will adopt these federal requirements in addition to any existing requirements. Providers must comply with all applicable federal regulations and state requirements for their provider type prior to enrollment with the Medicaid Program. Additional enrollment requirements may be adopted in the future.

B. In accordance with PPACA and federal regulations, the Medicaid Program shall screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation, utilizing the following guidelines. If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

1. Provider types shall be categorized by the following risk levels:

a. high categorical risk—categories of service that pose a significant risk of fraud, waste, and abuse to the Medicaid Program;

b. moderate categorical risk—categories of service that pose a moderate risk of fraud, waste, and abuse to the Medicaid Program;

c. limited categorical risk—categories of service that pose a minor risk of fraud, waste, and abuse to the Medicaid Program.

C. Screening activities for the varying risk levels shall include the following mandates.

1. High risk level screening activities shall include:

a. fingerprinting submission by the provider and any person with a 5 percent or more direct or indirect ownership interest in the provider, within 30 days upon request from CMS or the Department of Health (LDH);

b. criminal background checks for all disclosed individuals;

c. site visits before and after enrollment by LDH and/or CMS, its agents, or designated contractors; and

i. – v. Repealed.

d. verification of provider-specific requirements including, but not limited to:

i. license verification;

ii. national plan and provider enumeration system (NPPES) national provider identifier (NPI) registry check;

iii. Office of Inspector General (OIG) exclusion check;

iv. disclosure of ownership/controlling interest information;

v. the Social Security Administration’s death master file (SSA DMF) check;

vi. Medicaid and Children’s Health Insurance Program (CHIP) state information sharing system (MCSIS) check;

vii. systems for award management (SAM) check;

viii. LA adverse actions check; and

ix. provider enrollment, chain, and ownership system (PECOS) check.

2. Moderate risk level screening activities shall include:

a. site visits before and after enrollment by LDH and/or CMS, its agents, or designated contractors; and

b. verification of provider-specific requirements including, but not limited to:

i. ...

ii. NPPES NPI check;

iii. ...

iv. disclosure of ownership/controlling interest information;

v. SSA DMF check;

vi. MCSIS check;

vii. SAM check;

viii. LA adverse actions check; and

ix. PECOS check.

3. Limited risk level screening activities shall include, but are not limited to:

a. verification of provider-specific requirements including:

i. ...

ii. NPPES NPI check;

iii. ...

iv. disclosure of ownership/controlling interest information verification;

v. SSA DMF check;

vi. MCSIS check;

vii. SAM check;

viii. LA adverse actions check; and

ix. PECOS check.

D. The Medicaid Program may rely on, but is not limited to, the results of provider screenings performed by:

1. ...

2. other Medicaid agencies; or

3. CHIP of other states.

E. Updated Medicaid enrollment forms may require additional information for all disclosed individuals.

F. Providers shall be required to revalidate their enrollments with the Medicaid Program at a minimum of five year intervals. A more frequent revalidation requirement, a minimum of three year intervals, shall apply to durable medical equipment (DME) providers and pharmacy providers with DME or home medical equipment (HME) specialty enrollments. All providers shall be required to revalidate their enrollment under PPACA and Medicaid criteria.

1. Repealed.

G. Provider Screening Application Fee

1. In compliance with the requirements of the PPACA and 42 C.F.R. § 455.460, the department shall collect an application fee for provider screening prior to executing provider agreements from prospective or re-enrolling providers other than:

a. individual physicians or non-physician practitioners; or

G.1.b. – G.2. ...

H. After deactivation of a provider enrollment number for any reason, before the provider's enrollment may be reactivated, the department must re-screen the provider and require payment of associated provider application fees.

I. Any enrolled provider is subject to CMS, its agents, its designated contractors, or the department conducting unannounced on-site inspections of any and all provider locations.

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, Bureau of Health Services Financing, LR 39:1051 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:920 (May 2018), LR 50:

§1503. Termination or Denial of Provider Enrollment

A. The department will deny or terminate a provider's enrollment in the Medical Assistance Program in accordance with 42 C.F.R. § 455.416.

1. – 2.a. Repealed.

B. The department may deny or terminate a provider's enrollment in the Medical Assistance Program for any of the grounds listed in R.S. 46:437.14.

1. – 2. Repealed.

C. The department may deny a provider’s application for enrollment in the Medical Assistance Program if, based on the grounds listed in R.S. 46:437.14, the secretary determines that the denial is in the best interest of the Medical Assistance Program and the department specifies the reasons for denial, as permitted by R.S. 46:437.13(C)(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 and Hospitals, Bureau of Health Services Financing, LR 39:1052 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 50:

§1505. Informal Hearing

A. A provider, or their agent, who seeks to appeal a notice of action issued by the department may first request an informal hearing with the department.

1. – 3.c.ii.(d). Repealed.

B. A provider, or their agent, who has received a notice of action shall be provided with an informal hearing if the provider, or their agent, makes a written request to the department for an informal hearing within 15 days of the date of the notice of action.

C. The notice of action is presumed to be received by the provider if the notice is mailed to the provider’s mailing

address listed with the Medicaid Program or if the notice is electronically mailed to the provider’s e-mail address listed with the Medicaid Program.

D. The request for an informal hearing must be made in writing and sent in accordance with the instructions in the notice of action.

E. The time and place for the informal hearing will be set out in the notice of setting of the informal hearing.

F. The informal hearing is designed to provide the opportunity:

1. for the provider or agent of the provider to informally review the situation and action proposed by the department;

2. for the department to offer alternatives based on information presented by the provider or agent of the provider, if any; and

3. for the provider or agent of the provider or other person to evaluate the necessity for seeking an administrative appeal. During the informal hearing, the provider or agent of the provider may be afforded the opportunity to talk with the department’s personnel involved in the situation, to review pertinent documents on which the alleged violations are based, to ask questions, to seek clarification, to provide additional information and be represented by counsel or other

person. Upon agreement of all parties, an informal discussion may be recorded or transcribed.

G. At any time prior to the issuance of the written results of the informal hearing, the notice of action may be modified by the department.

1. If a finding or reason is removed from the notice of action by the department, no additional time will be granted to the provider, or their agent, to prepare for the informal hearing.

2. If additional reasons or actions are added to the notice of action prior to, during, or after the informal hearing, the provider, or their agent, shall be granted an additional 10 working days to prepare responses to the new reasons or actions proposed by the department, unless the 10-day period is waived by the provider, or their agent.

H. Notice of the Results of the Informal Hearing. Following the informal hearing, the department shall inform the provider, or their agent, in writing of the results of the informal hearing, which could range from modifying or upholding the termination, denial, or other actions contained in the notice. The notice of the results of the informal hearing must be signed by the director of the Bureau of Health Services Financing (BHSF) or their designee and the section chief of Medicaid Program Operations and Compliance or their designee.

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 45:273 (February 2019), amended LR 50:

§1507. Administrative Appeal

A. The provider, or their agent, has the right to request an administrative appeal within 30 days of the date of the notice of action or within 30 days of the date of the notice of the results of the informal hearing.

B. The appeal request must be adequate as to form and timely lodged with the Division of Administrative Law.

C. The notice of action and the notice of the results of the informal hearing are presumed to be received by the provider if the notice is mailed to the provider’s mailing address listed with the Medicaid Program or if the notice is electronically mailed to the provider’s e-mail address listed with the Medicaid Program.

D. The department shall not terminate an existing Medicaid provider agreement unless the provider, or their agent, has exhausted their appeal rights, the timeframe for an appeal has expired, or the termination is permitted due to the imposition of sanction(s) by the department and the director of Program Integrity pursuant to LAC 50:I.4101 et seq.

E. The provider’s termination or denial in the Medicaid Program will become final if the provider, or their agent, does not timely request an appeal in accordance with the appeal deadlines described in this Subpart or once the provider’s appeal rights are otherwise exhausted.

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 50:

§1509. Basis of Administrative Appeal

A. A provider, or their agent, may only appeal to the Division of Administrative Law a notice of action or a notice of the results of the informal hearing issued by the department that terminates or denies the provider’s enrollment in Medicaid. Other actions by the department related to Medicaid provider enrollment and screening are not appealable.

1. If the provider, or their agent, timely requests an administrative appeal, then the provider, or their agent, has the right to challenge the basis for the termination or denial imposed by the department related to the provider’s Medicaid enrollment, provider enrollment application, and/or the revalidation application.

2. The provider, or their agent, must specifically state the basis for the appeal and the actions challenged on appeal.

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 50:

§1511. Out-of-State Medicaid Provider Enrollment

A. An out-of-state provider is a provider located in a state other than Louisiana whose services are rendered in that state, excluding Louisiana Medicaid trade areas.

B. An out-of-state provider who wishes to participate in the Louisiana Medicaid Program must enroll with the Louisiana Medicaid Program and be assigned an identification number.

C. To enroll, the provider must submit a provider enrollment application to Louisiana Medicaid.

D. A retroactive provider enrollment date of no more than 365 days may be considered for approval by the department under the following circumstances:

1. A provider requests that the enrollment be retroactive to a specific date.

2. The provider submits proof of service rendered to a Louisiana Medicaid beneficiary within 365 days prior to the application received date, via submission of the claim.

3. All risk screening activities support that the provider was eligible as of the requested date of enrollment.

E. Out-of-state providers must accept Louisiana Medicaid reimbursement as payment in full for the covered services authorized. The department reserves the right to set rates for services.

F. Out-of-state providers who furnish services to Medicaid beneficiaries are not required to be enrolled if they meet the following criteria as detailed in the CMS Medicaid Provider Enrollment Compendium:

1. the item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state practice location;

2. the furnishing provider’s NPI is on the claim;

3. the furnishing provider is enrolled and in an approved status in Medicare or in another state’s Medicaid plan;

4. the claim represents services furnished; and

5. the claim represents either:

a. a single instance of care furnished over a 180-day period; or

b. multiple instances of care furnished to a single beneficiary over a 180-day period.

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 50:

§1513. Out-of-Network Providers

A. Out-of-network providers under single case agreements are not considered network providers and therefore are not subject to the requirements at 42 C.F.R. § 438.602(b). Out-of-network providers do not have to be screened and/or enrolled in the department’s fee-for-service program. Additionally, emergency room physicians are only subject to 42 C.F.R. § 438.602(b) to the extent they meet the definition of a network provider in 42 C.F.R. § 438.2.

B. The department may adopt limits or thresholds that require out-of-network providers to convert to an in-network status upon reaching a specific threshold of services provided to a network beneficiary or beneficiaries. A provider’s conversion to an in-network status triggers the requirement for the provider to be screened and enrolled pursuant to 42 C.F.R. § 438.602(b)(1).

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 50:

§1515. Temporary Moratoria

A. The department will comply with 42 C.F.R. § 455.470, which pertains to the imposition of temporary moratoria on the enrollment of new providers or provider types as implemented by the secretary of the U.S. Department of Health and Human Services (HSS).

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 50:

§1517. Managed Care Organization Payment Accountability and Provider Credentialing

A. All managed care organizations (MCOs) participating in the Medical Assistance Program must comply with all requirements described in R.S. 46.460.72 and R.S. 46:460.73, which pertain to provider notices and payment accountability.

B. A provider who receives a notification of deficiency from a Medicaid MCO as described in R.S. 46:460.73(A)(1) may seek review of the matter to the department if the conditions of R.S. 46:460.73(A)(2) apply. The provider must notify the department of their intent to appeal the notification within 10 calendar days of the date of the MCO’s notification and provide a detailed request for departmental review with supporting documents within 15 calendar days of the date of the MCO’s notification.

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 50:

§1519. Definitions

A. As used in this Subpart the following terms shall have the following meanings:

1. *Agent*—a person who is employed by or has a contractual relationship with a provider or who acts on behalf of the provider.

2. *Beneficiary*—an individual who is enrolled to receive health care through the Medical Assistance Program.

3. *Claim*—any request or demand, including any and all documents or information required by federal or state law or by rule made against Medical Assistance Program funds for payment. A claim may be based on costs or projected costs and includes any entry or omission in a cost report or similar document, book of account, or any other document which supports, or attempts to support, the claim. Each claim may be treated as a separate claim, or several claims may be combined to form one claim.

4. *Department*—the Louisiana Department of Health (LDH).

5. *Disclosed Individuals*—persons required to be disclosed to the department, as the Medicaid agency, by the provider, such as, but not limited to:

a. *Agents or Managing Employees*–Pursuant to 42 C.F.R. § 455.106(a), a provider must disclose to the Medicaid agency the identity of each person who is an agent or managing employee of the provider and has been convicted of certain crimes. An agent or managing employee is any individual who exercises operational or managerial control, conducts day-to-day operations of the provider agency, or any person with authority to obligate or act on behalf of the disclosing entity, such as, but not limited to, a general manager, business manager, administrator, board member, chief operating officer, trustee, or partner.

b. *Persons with Ownership or Control Interest*–Pursuant to 42 C.F.R. §455.104(b), a provider must disclose the identity of all persons that have an ownership or control interest (either separately or in combination) of 5 percent or more in the provider.

6. *Division of Administrative Law*—the Louisiana Division of Administrative Law, which operates as Louisiana's centralized administrative hearings panel for disputes between government agencies and regulated individuals and entities.

7. *Federal Regulations*—the provisions contained in the Code of Federal Regulations (C.F.R.) or the Federal Register (FR).

8. *Informal Hearing*—an informal conference between the provider, or other persons and the section chief of Medicaid Program Operations and Compliance or his/her designee and the Medicaid director or his/her designee.

9. *Medical Assistance Program or Medicaid*—the Medical Assistance Program (Title XIX) of the Social Security Act administered by the Department of Health, commonly referred to as Medicaid, the Medicaid Program, or Bureau of Health Services Financing (BHSF).

10. *Notice of Action*—a written notification of an action taken or to be taken by the department or BHSF, including a notice of termination of enrollment in the Medicaid Program or a notice of denial of enrollment in the Medicaid Program.

11. *Person*—any natural person, company, corporation, partnership, firm, association, group, or other legal entity or as provided by law.

12. *Provider*—a health care provider as defined in R.S. 46:437.3(A)(9).

13. *Provider Agreement*—the document(s), including electronic documents, signed by or on behalf of the provider in accordance with R.S. 46:437.11-437.14, which enrolls the

provider in the Medical Assistance Program and grants to the provider a provider number and the privilege to participate in the Medical Assistance Program. This definition shall not be construed to conflict with the definition of provider agreement included in R.S. 437.3(A)(21).

14. *Provider Enrollment*—the process through which a person or provider becomes enrolled in the Medical Assistance Program through the department for the purpose of providing goods, services, or supplies to one or more Medicaid beneficiaries.

15. *Provider Number*—a provider's billing or claim reimbursement number issued by the department through BHSF under the Medical Assistance Program.

16. *Rule or Regulation*—any rule or regulation promulgated by the department in accordance with the Administrative Procedure Act and any federal rule or regulation promulgated by the federal government in accordance with federal law.

17. *Secretary*—the Secretary of the Department of Health.

18. *Termination*—the termination or revocation of the provider agreement with the department to participate in the Medical Assistance Program. In a termination action, the state Medicaid agency has taken an action to revoke the provider's

billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to:

a. fraud;

b. integrity; or

c. quality.

19. *Trade Areas*—Arkansas, Mississippi, and Texas counties directly touching Louisiana parish borders. Trade areas are treated with the same criteria as in-state providers.

20. *General Terms*—Definitions contained in applicable federal laws and regulations shall also apply to this Subpart and all department regulations. In the case of a conflict between federal definitions and departmental definitions, the department’s definition shall apply unless the federal definition, as a matter of law, supersedes a departmental definition. Definitions contained in applicable state laws shall also apply to this and all departmental definitions. In the case of a conflict between a state statutory definition and a departmental definition, the departmental definition shall apply unless the state statutory definition, as a matter of state law, supersedes the departmental definition.

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 50:

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.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Small Business Analysis

In compliance with the Small Business Protection Act, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule will have no impact on small businesses.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to Kimberly Sullivan, JD, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030. Ms. Sullivan, JD, is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is at 4:30 p.m. on May 30, 2024.

Public Hearing

Interested persons may submit a written request to conduct a public hearing by U.S. mail to the Office of the Secretary

ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629; however, such request must be received no later than 4:30 p.m. on May 10, 2024. If the criteria set forth in R.S. 49:961(B)(1) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on May 30, 2024 in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after May 10, 2024. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing.

Ralph L. Abraham, M.D.

Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

Person Preparing Statement:	Lyrica Johnson	Dept.:	Health
Phone:	342-6375	Office:	Bureau of Health Services Financing
Return Address:	P.O. Box 91030	Rule Title:	Provider Screening and Enrollment
	Baton Rouge, LA		
		Date Rule Takes Effect:	July 20, 2024

SUMMARY
(Use complete sentences)

In accordance with Section 961 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a fiscal and economic impact statement on the rule proposed for adoption, repeal or amendment. THE FOLLOWING STATEMENTS SUMMARIZE ATTACHED WORKSHEETS, I THROUGH IV AND WILL BE PUBLISHED IN THE LOUISIANA REGISTER WITH THE PROPOSED AGENCY RULE.

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 23-24. It is anticipated that $2,592 ($1,296 SGF and $1,296 FED) will be expended in FY 23-24 for the state's administrative expense for promulgation of this proposed rule and the final rule.

The proposed rule amends the provisions governing provider screening and enrollment in order to comply with U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) requirements to align the provisions governing out-of-state enrollment and single case agreements with the Medicaid Provider Enrollment Compendium, to codify provisions for informal hearings and appeal rights for provider enrollment denials and terminations, and to ensure that the administrative rule is consistent with current practices.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no impact on revenue collections other than the federal share of the promulgation costs for FY 23-24. It is anticipated $1,296 will be collected in FY 23-24 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NON-GOVERNMENTAL GROUPS (Summary)

The proposed rule amends the provisions governing provider screening and enrollment in order to comply with U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) requirements to align the provisions governing out-of-state enrollment and single case agreements with the Medicaid Provider Enrollment Compendium, to codify provisions for informal hearings and appeal rights for provider enrollment denials and terminations, and to ensure that the administrative rule is consistent with current practices. It is anticipated that implementation of this proposed rule will not result in costs to Medicaid providers or small businesses in FY 23-24, FY 24-25, and FY 25-26, but will be beneficial by codifying an informal hearings and appeal process and ensuring that the *Louisiana Administrative Code* aligns with CMS requirements.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule has no known effect on competition and employment.

Signature of Head or Designee

Kimberly Sullivan, JD
Medicaid Executive Director
Typed Name & Title of Agency Head or Designee

4.8.24
Date of Signature

Legislative Fiscal Officer or Designee

4/09/2024
Date of Signature

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

The following information is required in order to assist the Legislative Fiscal Office in its review of the fiscal and economic impact statement and to assist the appropriate legislative oversight subcommittee in its deliberation on the proposed rule.

A. Provide a brief summary of the content of the rule (if proposed for adoption, or repeal) or a brief summary of the change in the rule (if proposed for amendment). Attach a copy of the notice of intent and a copy of the rule proposed for initial adoption or repeal (or, in the case of a rule change, copies of both the current and proposed rules with amended portions indicated).

The proposed rule amends the provisions governing provider screening and enrollment in order to comply with U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) requirements to align the provisions governing out-of-state enrollment and single case agreements with the Medicaid Provider Enrollment Compendium, to codify provisions for informal hearings and appeal rights for provider enrollment denials and terminations, and to ensure that the administrative rule is consistent with current practices.

B. Summarize the circumstances, which require this action. If the Action is required by federal regulation, attach a copy of the applicable regulation.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing provider screening and enrollment in order to comply with U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) requirements to align the provisions governing out-of-state enrollment and single case agreements with the Medicaid Provider Enrollment Compendium, to codify provisions for informal hearings and appeal rights for provider enrollment denials and terminations, and to ensure that the administrative rule is consistent with current practices.

C. Compliance with Act 11 of the 1986 First Extraordinary Session

(1) Will the proposed rule change result in any increase in the expenditure of funds? If so, specify amount and source of funding.

No. It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 23-24. In FY 23-24, $2,592 is included for the state's administrative expense for promulgation of this proposed rule and the final rule.

(2) If the answer to (1) above is yes, has the Legislature specifically appropriated the funds necessary for the associated expenditure increase?

(a) _____ YES. If yes, attach documentation.

(b) _____ NO. If no, provide justification as to why this rule change should be published at this time

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

I. A. COSTS OR SAVINGS TO STATE AGENCIES RESULTING FROM THE ACTION PROPOSED

1. What is the anticipated increase (decrease) in costs to implement the proposed action?

COSTS	FY 24	FY 25	FY 26
PERSONAL SERVICES	$0	$0	$0
OPERATING EXPENSES	$2,592	$0	$0
PROFESSIONAL SERVICES	$0	$0	$0
OTHER CHARGES	$0	$0	$0
EQUIPMENT	$0	$0	$0
MAJOR REPAIR & CONSTR.	$0	$0	$0
TOTAL	$2,592	$0	$0
POSITIONS (#)	0	0	0

2. Provide a narrative explanation of the costs or savings shown in "A. 1.", including the increase or reduction in workload or additional paperwork (number of new forms, additional documentation, etc.) anticipated as a result of the implementation of the proposed action. Describe all data, assumptions, and methods used in calculating these costs.

In FY 23-24, $2,592 will be spent for the state's administrative expense for promulgation of this proposed rule and the final rule.

3. Sources of funding for implementing the proposed rule or rule change.

SOURCE	FY 24	FY 25	FY 26
STATE GENERAL FUND	$1,296	$0	$0
AGENCY SELF-GENERATED	$0	$0	$0
DEDICATED	$0	$0	$0
FEDERAL FUNDS	$1,296	$0	$0
OTHER (Specify)	$0	$0	$0
TOTAL	$2,592	$0	$0

4. Does your agency currently have sufficient funds to implement the proposed action? If not, how and when do you anticipate obtaining such funds?

Yes, sufficient funds are available to implement this rule.

B. COST OR SAVINGS TO LOCAL GOVERNMENTAL UNITS RESULTING FROM THE ACTION PROPOSED.

1. Provide an estimate of the anticipated impact of the proposed action on local governmental units, including adjustments in workload and paperwork requirements. Describe all data, assumptions and methods used in calculating this impact.

This proposed rule has no known impact on local government.

2. Indicate the sources of funding of the local governmental unit, which will be affected by these costs or savings.

There is no known impact on the sources of local government unit funding.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

II. EFFECT ON REVENUE COLLECTIONS OF STATE AND LOCAL GOVERNMENTAL UNITS

A. What increase (decrease) in revenues can be anticipated from the proposed action?

REVENUE INCREASE/DECREASE	FY 24	FY 25	FY 26
STATE GENERAL FUND	$0	$0	$0
AGENCY SELF-GENERATED	$0	$0	$0
DEDICATED	$0	$0	$0
FEDERAL FUNDS	$1,296	$0	$0
LOCAL FUNDS	$0	$0	$0
TOTAL	$1,296	$0	$0

*Specify the particular fund being impacted.

B. Provide a narrative explanation of each increase or decrease in revenues shown in "A." Describe all data, assumptions, and methods used in calculating these increases or decreases.

In FY 23-24, $1,296 will be collected for the federal share of the administrative expense for promulgation of this proposed rule and the final rule.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

III. COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NONGOVERNMENTAL GROUPS

A. What persons, small businesses, or non-governmental groups would be directly affected by the proposed action? For each, provide an estimate and a narrative description of any effect on costs, including workload adjustments and additional paperwork (number of new forms, additional documentation, etc.), they may have to incur as a result of the proposed action.

The proposed rule amends the provisions governing provider screening and enrollment in order to comply with U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) requirements to align the provisions governing out-of-state enrollment and single case agreements with the Medicaid Provider Enrollment Compendium, to codify provisions for informal hearings and appeal rights for provider enrollment denials and terminations, and to ensure that the administrative rule is consistent with current practices.

B. Also provide an estimate and a narrative description of any impact on receipts and/or income resulting from this rule or rule change to these groups.

It is anticipated that implementation of this proposed rule will not result in costs to Medicaid providers or small businesses in FY 23-24, FY 24-25, and FY 25-26, but will be beneficial by codifying an informal hearings and appeal process and ensuring that the *Louisiana Administrative Code* aligns with CMS requirements.

IV. EFFECTS ON COMPETITION AND EMPLOYMENT

Identify and provide estimates of the impact of the proposed action on competition and employment in the public and private sectors. Include a summary of any data, assumptions and methods used in making these estimates.

This proposed rule has no known effect on competition and employment.