NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Medicaid Program Integrity
Fraud, Waste and Abuse Recovery
(LAC 50:I.Chapters 41-46)

The Department of Health, Bureau of Health Services Financing proposes to repeal the current LAC 50:I.Subpart 5 in the Medical Assistance Program and promulgate a new Subpart and Chapter 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 repeal the existing language relating to Provider Fraud and Recovery and to codify current practices. This is being done in accordance with Act 192 of the 2024 Regular Legislative Session and EXO JML 25-38, which require the department to review rules to ensure they are consistent with departmental guidelines and use plain language.

The proposed Rule text below has been drafted utilizing plain language principles to ensure clarity and accessibility for all users. It has also been reviewed and tested for compliance with web accessibility standards.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part I. Administration

Subpart 5. Medicaid Program Integrity

Chapter 41. Fraud, Waste and Abuse Recovery

Subchapter A. General Provisions

§4101. Definitions

A. In addition to the definitions provided for in R.S. 46:437.3, and unless otherwise provided, the following terms shall mean:

Affiliate—any person who has a direct or indirect relationship or association with a provider. A person is a presumed *affiliate* if the person:

a. directly or indirectly influences or controls a provider or has the power to do so;

b. has a direct or indirect ownership interest in a provider; or

c. shares in the proceeds or has the right to share in the proceeds of a provider.

Bureau of Health Services Financing (BHSF)—the division within the Department of Health responsible for administering the Louisiana Medicaid program.

Contractor—any person with whom the provider has an agreement to perform a service for the provider. A *contractor* is presumed to be an agent of the provider.

Conviction—shall have the same meaning as provided in 42 U.S.C. 1320a-7(i).

Corrective Action Plan—a mutual, written agreement between the department and provider to remedy a provider's aberrant or prohibited practices.

Credible Allegation of Fraud—has the same meaning as provided in 42 CFR §405.370.

Department—the Department of Health inclusive of the BHSF director and the program integrity unit section chief.

Discover—the date a reasonably prudent person should have obtained knowledge or become aware of the facts in question.

Division of Administrative Law (DAL)—the division of government referenced in R.S. 49:991 et seq.

Final Sanction—a sanction for which the time to exercise appeal rights has expired; or, if appealed, upon the imposition of a final order in the matter.

Health Oversight Agency—shall have the same meaning as provided in 45 CFR §164.501.

Indirect Ownership—an ownership interest, in whole or in part, through some other entity.

Managed Care Provider—any provider participating in the Medicaid program through enrollment with one or more of the State's Managed Care Organizations. For the purposes of this Chapter, the terms provider, provider-in-fact, agent, billing agent, and contractor also applies to the managed care providers.

Medicaid—any medical assistance program instituted under Title XIX, section 1900 et seq. of the Social Security Act.

Medicaid Fraud Control Unit (MFCU)—the entity of state government established pursuant to 42 U.S.C 1396b(q).

Notice of Action—a written notification of an action taken or to be taken by the department.

Overpayment—an amount a provider received in excess of amounts properly payable for the services provided.

Per Member per Month (PMPM)—the payment made to a Medicaid Managed Care Organization (MCO) or Managed Care Entity (MCE) for a Medicaid recipient enrolled with a MCO or MCE.

Person—any natural person or juridical entity. This includes any company, corporation, partnership, firm, association, group, or other legal entity provided for by law.

Program—any program authorized under the Medicaid Program.

Program Integrity Unit (PIU)—the PIU within the department, its predecessor and successor.

Provider—for the purposes of this Chapter, when the term "Provider" is used it is inclusive of provider, provider-in-fact, a provider's agent(s), contractors and affiliates, managed care providers, or other persons potentially liable under this chapter or the Medical Assistance Programs Integrity Law, R.S. 46:437.1 et seq.

Publicly Funded Healthcare Program—any healthcare program funded in whole or in part with federal or state government funds.

Service—when the term "service" is used, it includes all goods, services, or supplies purportedly provided to a recipient.

Statistically Valid Random Sample (SVRS)—a clearly defined universe of claims where each sampling unit has a known, non-zero probability of selection.

Sub–regulatory Guidance—any policy, procedure, or rules LDH issues and the provider is required to comply with pursuant to his or her Medicaid enrollment or participation agreement.

Violation—any conduct, practice, or activity not in accordance with the requirements established by law, regulation,

or sub-regulatory guidance, including the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4103. Applicability of Statutes, Regulations, Policies

A. No person may waive or alter a requirement or condition established by statute.

B. Unless provided for in the regulation, any requirements or conditions imposed by a regulation may only be waived or modified through formal promulgation of a new or amended regulation.

C. Only the secretary may waive or modify any sub-regulatory guidance.

1. To be effective, the waiver or modification shall be in writing.

2. No provider may rely on or use an unwritten waiver or modification of any program’s sub-regulatory guidance as a defense in any action brought pursuant to this Chapter.

D. In any instance where the secretary or the BHSF director is required to make a decision, the secretary or the BHSF director may delegate that authority in writing to a designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4105. Medicaid Payment Review

A. The department or other health oversight agency may review any payments the Medicaid program makes to providers. This is inclusive of any payments the managed care organizations make to any managed care providers. The PIU will administer the review process within the department pursuant to this chapter.

B. Any claim not supported by documentation demonstrating the medical necessity and the actual provision of the services claimed, is subject to recovery and other sanctions pursuant to this chapter.

C. Payment of a claim does not constitute acceptance that the claim is a valid claim.

D. No person has a property interest in any Medicaid program’s reimbursements or payments determined to be an overpayment or subject to payment review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4107. Material

A. Incorrect claim submissions are “material” when the incorrect submissions are five percent or more of the universe of claims under review.

B. Either party may use statistical sampling to determine materiality.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4109. Statistically Valid Random Sample (SVRS), Extrapolation

A. A SVRS may be used to extrapolate the number of violations and/or the amount of an overpayment.

B. If the department chooses to extrapolate, the department’s notice of action shall describe:

1. the sampled claims universe; and

2. the extrapolation method used to derive the number of violations and/or the overpayment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

Subchapter B. Reviews and Investigations

§4201. Investigations, Claims, and Compliance Review

A. Investigations, pre-payment, post-payment, and compliance reviews are conducted at the discretion of the department or other health oversight agency. They may be initiated without cause and require no justification.

B. Unless consent is obtained from the investigating agency, no information regarding an active criminal or outside government investigation shall be disclosed to the provider.

C. The DAL shall not require information related to an active criminal or outside governmental investigation be disclosed as part of any appeal. The DAL shall not use the non-disclosure as grounds to overturn any department assessed sanction.

D. If a provider has been assessed a non-monetary sanction, including suspension or exclusion due to an active criminal or outside governmental investigation, certification from the investigating agency that the investigation is still active is sufficient cause to maintain the sanction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4203. Claims Review

A. The department may require a provider’s claims be subject to a pre-payment or post-payment review.

B. The decision to implement a pre-payment or post-payment review is not a sanction, cannot be appealed, and is not subject to an informal hearing.

C. Pre-payment and post-payment review may be limited to specific items or procedures. It may also include all billings or claims a provider submits.

D. The duration a provider is on pre-payment or post-payment review shall be at the discretion of the BHSF director or the PIU section chief.

E. A department assessed sanction resulting from a post-payment review is appealable and subject to an informal hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4205. Compliance Review

A. The department or a health oversight agency may conduct a compliance investigation. A compliance review ensures the provider conducts its business in conformity with the Medicaid program’s laws, rules, regulations, and sub-regulatory guidance.

B. A compliance review may be initiated as its own matter or as part of an investigation, pre-payment or post-payment review.

C. A sanction the department assesses as part of a compliance investigation is appealable and subject to an informal hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4207. Mandatory Self Audits

A. The department may require a provider to conduct a self-audit of its claims submissions and supporting documentation. The self-audit shall be conducted in the manner the department instructs.

B. A direction to conduct a mandatory self-audit is not a sanction and is not subject to an informal hearing or appeal.

C. A direction to conduct a mandatory self-audit is done at the absolute discretion of the PIU section chief.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

Subchapter C. Provider Obligations and Prohibited Conduct

§4209. Provider Obligations

A. The provider shall maintain all records necessary to demonstrate the services were provided in the quantity and quality claimed.

B. The provider bears the burden to prove its submitted claims were for services:

1. provided to a recipient in the quantity and quality claimed;

2. were medically necessary;

3. authorized by a qualified individual;

4. provided by an individual qualified to provide the service; and

5. in the case of a claim based on a cost report, prove each entry is complete, accurate, and supported by the necessary documentation.

C. Supporting documentation for services provided shall be accessible, legible, and comprehensible.

D. All records requiring signatures must be signed and dated at the time the services were provided.

E. Providers shall initial all rubber stamp signatures.

1. Paid claims not accompanied by timely signatures and/or documentation will be recovered. Late signatures without proper justification will not be accepted.

2. An error made in the record may be corrected by drawing a single line through the incorrect information. The word “error” shall be written by the strike-through, initialed, and dated. The original erroneous information shall remain visible and legible. Correction fluid or correction tape shall not be used to correct a record.

3. An explanation describing the necessity of the correction must accompany any corrected record. Supporting documentation for the correction shall be included with the explanation.

E. Records shall be maintained for the period required by law, regulation, and sub-regulatory guidance. Providers who fail to comply with the documentation standards are subject to any sanction allowed by this chapter.

F. Providers shall review their claims prior to submission to ensure:

1. the claims to be submitted are accurate;

2. they are supported by documentation showing the services were medically necessary;

3. they were provided by a person qualified to provide the service; and

4. they were provided in the quantity and quality being claimed.

G. Providers shall notify the department of any overpayment it discovers within 60 days of discovery. For the purposes of this subsection, identifying the final overpayment is not required if it is an unknown amount at the time of notification.

H. Providers shall repay any overpayment the department identifies within:

1. 60 days of a final overpayment decision; or

2. if the department has consented to a longer repayment schedule, according to the agreed upon payment schedule.

I. The provider must maintain and make available for inspection all documents required to demonstrate a claim is valid.

1. The documentation must be maintained for the period required by law, regulation, or sub-regulatory guidance.

2. Claims lacking supporting documentation the law, rule, or sub-regulatory guidance requires are not Medicaid reimbursable and shall be recovered.

3. Any sanction provided for in this Chapter may be imposed on a provider submitting claims for undocumented services.

J. Providers and recipients shall obey and follow all laws, rules, regulations, and sub-regulatory guidance.

K. Providers shall provide accurate contact information to receive correspondence. The provider shall inform BHSF, the fiscal intermediary, and the MCOs of any changes in its address prior to actual change of address.

L. Providers are presumed to know the applicable program's laws, rules, and sub-regulatory guidance. Ignorance of the applicable laws, rules, or sub-regulatory guidance is not a defense to any administrative action. Knowledge of any amendments to the laws, rules, and sub-regulatory guidance will be presumed if:

1. notice of the changes was mailed to the address on the provider's enrollment form;

2. the changes were posted to the department's or the fiscal intermediary's website, or

3. the changes were published in the State or Federal Register, the *Louisiana Administrative Code*, the Code of Federal Regulations, or State or Federal Statute.

M. Providers shall conduct all employee screening requirements that state or federal law, regulation, or sub-regulatory guidance requires. This includes:

1. criminal background searches,

2. federal and state exclusion searches, and

3. adverse action checks.

N. All employee screening shall be done in the frequency the law or regulation requires.

1. The background and exclusion searches shall include prospective and current employees.

2. The provider shall ensure criminal background and exclusion checks are performed on any non-employee performing any function or work for the provider.

O. If a provider discovers they have employed or otherwise affiliated with an excluded or disqualified person, the provider shall immediately terminate the relationship.

1. Within 10 business days of the discovery, the provider shall inform BHSF in writing of:

a. the person’s identifying information;

b. the date range of the prohibited affiliation;

c. the claims that the provider submitted for services the person provided; and

d. the amount paid for the claims attributable to the excluded or disqualified person.

O. The provider shall inform BHSF in writing of all changes in ownership, control, or managing employee of the provider.

P. The provider shall inform BHSF of the following within 10 business days of discovery of:

1. any federal, state or territorial administrative sanctions imposed on the provider;

2. any criminal charges and convictions filed against the provider; and

3. any civil judgments, fines, or penalties entered against the provider.

Q. When a license or certification is required, the provider shall be properly licensed, certified, or otherwise qualified to provide the services claimed.

1. The provider is responsible for ensuring any person working on the provider’s behalf possesses necessary licenses or qualifications.

2. Any claims submitted for services provided by a person lacking required credentials will be recovered.

R. The provider shall cooperate with any investigation or claims review the department or other health oversight agency institutes. When requested, the provider shall:

1. make all records requested available for review or copying. This includes the provider’s financial or other business records and/or any and all records related to the recipients;

2. make the providers, contractors, agents, employees, and other affiliates available for interviews. This

may be done at the provider's ordinary place of business or any other mutually agreeable location;

3. allow the department or any other health oversight agency to take statements from the provider; and

4. allow the department or any other health oversight agency to take statements from any recipients the provider has claimed to have provided services.

S. The provider shall comply with all employment laws and regulations, including proper classification of employees and payment of all employer taxes or other assessments the law or regulations obligate an employer to pay.

T. The provider shall maintain all insurance policies the law or regulations require.

U. Services shall be provided in compliance with the law and a licensing or certification entity's regulations, rules, policies, or procedures governing the services provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4203. Prohibited Conduct

A. A provider shall not:

1. fail to comply with any federal and/or state laws, regulations, policy, or sub-regulatory guidance of the Medicaid program;

2. fail to comply with the terms or conditions contained in the provider’s enrollment agreement. This includes any enrollment agreement executed with a MCO and any other document executed by or on behalf of the provider setting forth the terms and conditions for participation in the Medicaid program;

3. fail to notify BHSF, within 10 business days of discovery, of employment or affiliation with an excluded person. If it is determined the failure to disclose this information was intentional, the provider’s enrollment may be voided back to the date of the concealment;

3. fail to inform BHSF within 10 business days of discovery of any:

a. administrative sanction;

b. criminal charge(s);

c. criminal conviction(s);

d. civil judgement;

e. civil fines; or

f. monetary penalties imposed on the provider;

4. if it is determined a failure to disclose required information was intentional, the provider's enrollment may be voided back to the effective date of the adverse action.

5. make a false, fictitious, untrue, or misleading statement, or conceal information, during the application process;

6. fail to fully disclose all information requested on any form the department or its contractors require for enrollment in the Medicaid program. This includes, but is not limited to, the information required under R.S.46:437.11-437.14;

7. engage in conduct in violation of an official sanction applied by a licensing authority, professional peer group, or peer review board or organization. The provider shall not continue such conduct following notification by the licensing or reviewing body that said conduct should cease;

8. employ, contract, or affiliate with any person who has been convicted of a crime related to the provision of services or submission of claims involving the expenditure of public funds. This prohibition includes convictions for an attempt or conspiracy to commit such a crime;

9. hire, contract with, or affiliate with any person who:

a. has been excluded by the federal government, or any state or territorial government, from a publicly funded healthcare program;

b. has a disqualifying conviction that would prohibit that person or entity from being hired under federal or state law; or

c. has had an adverse action taken against them by a professional licensing or certification entity or board of this or another state that would disqualify the person from providing services a license requires;

10. have been convicted of a crime of violence or misappropriation of property through fraudulent or exploitive means;

a. this includes any attempt or conspiracy to commit the crime;

b. this prohibition includes, but is not limited to, the following criminal conduct:

i. bribery or extortion;

ii. sale, distribution, or importation of a substance or item prohibited by law;

iii. tax evasion or fraud;

iv. money laundering;

v. securities or exchange fraud;

vi. wire or mail fraud;

vii. violence against a person;

viii. act against the aged, juveniles or infirmed;

ix. any crime involving public funds;

x. identify theft, or

xi. other criminal conduct involving deceit, fraud, or a crime of violence;

11. violate any settlement agreement with a health oversight agency. This includes any settlement executed pursuant to the Medical Assistance Programs Integrity Law, R.S. 46:437.1 et seq, the Federal False Claims Act, 31 USC 3729 et seq., or any other statutes pertaining to the submissions of false claims to a publicly funded healthcare program;

12. fail to correct deficiencies listed in a notice of action;

13. fail to comply with the provisions of a corrective action plan;

14. engage in any practice prohibited by R.S. 46:438.2, 438.3, 438.4, or the Federal False Claims act 31 U.S.C. 3729 et seq;

15. engage in any practice prohibited by any anti-referral statute or regulation similar to the conduct described in 42 USC 1395nn;

16. fail to repay, or arrange to repay, an overpayment or other erroneous payment within 60 business days of discovery;

17. fail to pay any administrative or court ordered restitution, damages, criminal or civil fines, monetary penalties, costs of investigation or prosecution, and expenses;

18. fail to pay any assessed provider fee or payment;

19. fail to maintain or make available for inspection, audit, or copying records for services provided to Medicaid program recipients for the period under review;

20. fail to allow BHSF, its contractors or any other health oversight agency to inspect, audit, or copy those records;

21. fail to produce to BHSF, its contractors or other health oversight agencies, information or documents requested within five business days from receipt of the request unless an extension is granted;

22. fail to cooperate with BHSF, its contractors, or any other health oversight agency during a claims review or investigative process, including any informal hearing, administrative appeal, or other legal process;

a. the exercising of a constitutional or statutory right is not a failure to cooperate;

b. requests for scheduling changes or asking questions are not grounds for failure to cooperate;

23. make, or cause to be made, a false or misleading statement in connection with a claims review or investigation. This includes any informal hearing, administrative appeal, or other legal process;

24. knowingly make, or cause to be made, a false, fictitious or misleading statement of material fact in connection with the administration of the Medicaid program. This includes, but is not limited to, the following:

a. claiming costs for non-covered or non-chargeable services disguised as covered items;

b. billing for services provided to person(s) who are ineligible to receive the services;

c. misrepresenting dates, descriptions, or the identity of the person(s) who rendered the services;

d. submitting duplicate claims for services for which the provider has already received payment;

e. up-coding services provided;

f. misrepresenting a recipient's need or eligibility to receive services;

g. unbundling services for billing purposes;

h. misrepresenting the quality or quantity of services claimed;

i. knowingly submitting claims for services provided to persons not eligible to receive the service when the service was provided;

j. furnishing or causing to be furnished medically unnecessary, grossly inadequate, or unauthorized services;

k. providing services in a manner or form not within the normal scope and range of the standards used in the applicable profession; or

l. billing for services in a manner inconsistent with the standards established in relevant billing codes or practices;

25. fail to provide all medically necessary services needed by a recipient and to which the recipient is entitled when operating as a managed care provider or under a voucher;

26. submit claims to the Medicaid program on behalf of an excluded person;

27. submit claims to the Medicaid program for services an excluded person provided, either in whole or in part;

28. engage in a systematic abusive or fraudulent billing practice that maximize costs to the Medicaid program;

29. engage in any physical abuse, neglect, or exploitation of any recipient receiving services from the provider; and

30. fail to meet the terms of an agreement entered into under this state's Medical Assistance Program Integrity Law or this regulation.

B. Any provider who engages in conduct this section prohibits shall be subject to any of the sanctions allowed by law and this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

Subchapter D. Administrative Sanctions and Appeals

§4401. Extension/Imputation of Violations and Sanctions

A. Attributing, imputing, extending, or imposing violations shall be done at the discretion of the BHSF director or PIU section chief. Violations of a provider’s obligations or prohibited conduct may be imputed in the following manner.

1. The conduct of a provider-in-fact or a managing employee is always attributable to the provider.

2. The conduct of a provider’s agent, billing agent, or affiliates may be imputed to the provider or provider-in-fact if the conduct:

a. was performed within the course of his duties for the provider; or

b. was effectuated by or with the knowledge or approval of the provider.

3. The conduct of any person or entity operating on behalf of a provider may be imputed to the provider.

4. The provider is responsible for the conduct of his officers, employees, contractors, agents, or affiliates. The conduct of these persons may be imputed to the provider.

5. A violation or sanction under one provider number or NPI may be extended to all provider numbers or NPIs the provider possesses or obtains.

6. On fee-for-service claims, recoveries may be obtained by offsetting remittances due to the provider from any provider number or NPI the provider holds or obtains. On managed care claims, if provided for in the contract between the MCO and LDH, recoveries may be obtained through PMPM offsets, and the MCO may recover those offsets from the provider.

7. All sanctions imposed on a provider remain in effect until the sanctions have been satisfied.

8. Any person who purchases, merges, or otherwise consolidates with a sanctioned provider assumes liability for those sanctions.

9. Any person who employs or affiliates with a sanctioned provider assumes liability for those sanctions to the extent that person receives payment for services the sanctioned employee or affiliate provides.

10. A referring provider may be held responsible for overpayments the referral causes if the referring provider knew that such overpayments were likely to occur.

11. Providers which are legal entities may be held solidarily liable for monetary sanctions assessed on any person within that legal entity if the entity received any economic benefit related to the overpayment.

12. Payment withholdings on a provider may be extended to all provider and/or NPI numbers the provider holds or obtains.

13. A monetary sanction owed to the department can be imputed to a group or entity to which the provider is linked.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4403. Final Sanctions

A. Any provider who fails to comply with any obligation this Chapter requires or engages in any conduct this Chapter prohibits is subject to one or more of the following sanctions:

1. require the provider receive prior authorization for any or all services provided under the Medicaid program;

2. require some or all of the provider’s claims be subject to manual review;

3. require the provider post a bond or other security as a condition of continued enrollment;

4. require the provider terminate its association with a provider-in-fact, employee, agent, contractor, or affiliate as a condition of continued enrollment;

5. prohibit the provider from associating, employing, or contracting with a specific person or entity as a condition of continued participation in the Medicaid program;

6. prohibit the provider from performing specified tasks, providing services at designated locations, or providing services to designated recipients or classes or types of recipients;

7. prohibit the provider from referring recipients to another designated person or purchasing services from designated persons;

8. recovery;

9. exclusion from the Medicaid program;

10. suspension from the Medicaid program;

11. require the forfeiture of a bond or other security;

12. imposition of monetary penalties up to $10,000 per violation; or

13. imposition of an administrative fine up to three times the overpayment.

B. Unless stated otherwise in this Chapter, the sanction(s) imposed is within the discretion of the PIU section chief with the concurrence of the BHSF director.

C. When a sanction is imposed pursuant to this Section, the provider shall be responsible for reasonable costs of investigation the department incurred. This includes costs for the department’s time and expenses its employees, agents, or contractors incurred. The department may waive recovery of costs and expenses when resolving a matter.

D. Providers shall be assessed judicial interest on any outstanding recovery at the maximum rate provided by R.S. 13:4202. The department may waive or agree to reduce the amount of any interest assessed.

E. The department may obtain payment on any monetary sanction by offsetting any remittance due to a provider on a fee-for-service payment. If provided for in the contract between the MCO and LDH, the department may obtain payment on any monetary sanction due from a managed care provider by offsetting PMPMs due to the MCO.

1. The amount and duration of any offset is within the discretion of the PIU section chief or the BHSF director.

2. The amount and duration of an offset is not a separate sanction and it is not subject to an informal hearing or appeal.

F. In determining the sanction, the PIU section chief and/or the BHSF director may consider the totality of circumstances, including but not limited to:

1. seriousness of the violation(s);

2. extent of the violation(s);

3. history of prior violation(s);

4. prior imposition of sanction(s);

5. prior provision of education;

6. willingness to obey program rules;

7. actions taken or recommended by peer review groups or licensing boards;

8. adverse actions an MCO has assessed on a provider;

9. cooperation with departmental or other healthcare oversight agency reviews or investigations;

10. willingness to repay the identified overpayment; and

11. ability to repay identified overpayments.

G. Unless stated otherwise in this Chapter, the sanction imposed is within the discretion of the PIU section chief with the concurrence of the BHSF director.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4405. Exclusion; Effect

A. Exclusion precludes a person from providing any services paid through a publicly funded health program. This prohibition includes:

1. services provided directly to a Medicaid recipient;

2. any service for which the Medicaid program pays any part of the reimbursement; and

3. administrative and managerial activities or functions associated with delivering services for which the Medicaid program reimburses.

B. Any person receiving any payments this section prohibits shall immediately repay them to the Medicaid program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4407. Imposition of Sanction(s)

A. The imposition of non-mandatory sanction(s) shall be at the discretion of the PIU section chief with the concurrence of the BHSF director. The imposition of one sanction does not preclude the imposition of another sanction for the same or different violations.

B. At the discretion of the BHSF director and the PIU section chief:

1. one or more sanctions may be assessed on each violation;

2. multiple violations may be combined into a single violation; or

3. any combination of the above may be imposed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4409. Mandatory Exclusion

A. The BHSF director and the PIU section chief shall exclude any provider from the Medicaid program if the provider has:

1. been charged or convicted in court of a criminal offense related to the individual’s participation in any publicly funded healthcare program;

2. been excluded from any publicly funded healthcare program;

3. been charged with or convicted of a criminal offense related to neglect or abuse of patients in connection with the delivery of a health care item or service;

4. agreed to be excluded as part of a resolution of a matter pursued by any health oversight agency; or

5. failed to meet the terms and conditions of an agreement or judgment related to participation in a publicly funded healthcare program requiring the payment of money to the government.

B. No informal hearing or appeal is available when law or regulation requires an exclusion, except to contest the identity of the persons to whom the sanction applies.

C. No informal hearing or appeal is available when the excluded party consented to the exclusion in a written agreement.

D. An exclusion under this section is automatic. It may be longer, but not shorter in time, than:

1. in the case of a conviction, the criminal sentence imposed;

2. the exclusion for the federal or other state publicly funded healthcare program;

3. the length of time allowed for repayment; or

4. in the case of an agreed to exclusion, the length of time in the written agreement.

E. The exclusion is retroactive to the date of the event for which the exclusion is required. Proof of the charging, conviction, plea, exclusion, default of a repayment, settlement agreement, or judgment related to the Medicaid program can be made through provision of the documents evidencing the above or via affidavit.

F. Upon written request from an excluded individual, a mandatory exclusion shall be removed if the criminal matter upon which an exclusion is based is dismissed, overturned, set aside, or reversed on appeal.

1. The excluded individual shall submit supporting documentation that the criminal matter was dismissed, overturned, set aside, or reversed on appeal.

2. A dismissal based on Louisiana Code of Criminal Procedure article 893 or 894, or any other federal or state deferred adjudication provision, is not subject to this provision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4411. Permissive Exclusion

A. In addition to the authorities provided in this Chapter, the department may permissively exclude a provider for any reason listed in 42 U.S.C 1320a-7(b).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4413. Mandatory Payment Suspension

A. A provider who knowingly fails to comply with an information request from the department or any other health oversight agency shall be suspended from the program until the provider supplies the information requested.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4415. Effective Date of a Sanction

A. Except as provided in this Section, all sanctions subject to an appeal are effective upon the mailing of the results of the informal hearing.

1. The timely filing of an administrative appeal does not suspend the imposition of a sanction(s).

2. A sanction becomes a final administrative adjudication if:

a. an administrative appeal has been filed and a final order has been entered; or

b. the time for filing an administrative appeal has expired and an appeal was not filed.

B. An exclusion not related to a conviction related to the provision of a healthcare service is effective when:

1. a final order has been issued as part of an administrative adjudication, or

2. upon expiration of the time to file an appeal, and an appeal has not been filed.

C. In the case of a timely filed appeal, a sanction becomes a final administrative adjudication upon the secretary's signing of the order on appeal. An appeal is timely filed if it was filed within the time LAC 50:I.4423 requires.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4417. Withholding of Payments

A. A provider's remittance may be withheld or the department may instruct an MCO to withhold payments to a provider if:

1. an overpayment to the provider may have occurred;

2. the department has reason to believe an overpayment to the provider may occur;

3. a provider has failed to cooperate in an investigation or claims review;

4. a provider attempted to delay or obstruct an investigation or claims review; or

5. the department has reason to believe the provider used fraudulent or abusive practices.

B. Payments to the provider shall be withheld if a prosecuting authority informs the department, in writing, that the provider is under investigation for potential criminal activities relating to a publicly funded healthcare program.

1. The department may find good cause exists to continue payments to the provider.

2. The “good cause” determination is within the BHSF director’s and PIU section chief’s discretion. This determination is not subject to an informal hearing or appeal, and the DAL shall not overturn the department’s determination.

3. “Good cause” reasons to continue payments to a provider include but are not limited to:

a. law enforcement officials request a payment suspension not be imposed because the payment suspension may compromise or jeopardize an investigation;

b. other available remedies more effectively or quickly protect Medicaid funds;

c. the BHSF director and PIU section chief determine, based upon the submission of written evidence by the provider subject to the payment withhold, the withhold should be removed; or

d. recipient access to items or services would be jeopardized by a payment suspension because of any of the following:

i. a provider is the sole community physician or the sole source of essential specialized services in a community;

ii. a provider serves a large number of recipients within a Health Resources and Services Administration(HRSA)designated medically underserved area;

iii. law enforcement declines to certify that a matter continues to be under investigation; or

iv. the BHSF director and PIU section chief determine the withhold is not in the best interest of the Medicaid program.

C. Withholding of payments may occur prior to notifying the provider. Withholding due to a credible allegation of fraud shall follow the notice requirements in 42 C.F.R. 455.23(b). For all other payment withholds, the provider shall be notified

within five business days of the first withheld payment. The notice shall:

1. be in writing;

2. state that payments are being withheld;

3. state the general allegation or reason forming the basis for the withholding;

4. state that the withholding is for a temporary period;

5. cite the circumstances upon which the withholding will be terminated;

6. inform the provider of their rights to submit written evidence for the department’s consideration; and

7. inform the provider of their appeal rights.

D. Specific information regarding any ongoing investigation or the source of the allegations is not required. If the withholding is based on a criminal investigation, certification from the investigating agency that the investigation is on-going is sufficient to support and maintain the withholding.

E. Failure to provide timely notice to the provider may be grounds for overturning the withholding until the deficiency is corrected. This shall not apply if the withholding was at the request of a law enforcement agency.

F. All withholdings of payment under this Chapter will be temporary and shall not continue after:

1. the PIU section chief has determined insufficient information exists to warrant the withholding;

2. the provider has posted a bond or other security deemed adequate to cover all past and future projected overpayments; or

3. in the case of a final order of monetary sanction, a sufficient amount has been offset to satisfy the full amount of each monetary sanction.

G. In the case of a withholding based on written notification of a criminal investigation or prosecution, the withholding may continue for as long as the criminal investigation or prosecution is active and ongoing.

H. The BHSF director and the PIU section chief shall determine the amount of the withholding.

1. The amount to be withheld may be increased or decreased at any time once a decision to withhold has been made.

2. The department may consider the provider’s viability to continue operations when determining the amount to withhold.

I. In the event a recipient cannot receive needed services from another source, arrangements shall be made to ensure the recipient can receive any medically necessary

services. The provider has the burden to demonstrate they are the sole source who can provide services to their recipient(s). This showing shall be made at the informal hearing.

J. The provider shall be notified of the amount withheld every 90 calendar days.

K. Denial or refusals to pay individual claims as a result of the edit or audit system are not withholdings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4419. Effect of Withholding on the Status of a Provider or with the Medicaid Program

A. Unless excluded or suspended, a provider may continue to provide and submit claims for services during a withholding period.

B. Withheld amounts, bonds, or other security posted may be used to satisfy any monetary sanction imposed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4421. Requirements for Suspension of Payments for a Credible Allegation of Fraud

A. The BHSF director and PIU section chief shall suspend all Medicaid payments to a provider under investigation upon a determination there is a credible allegation of fraud. The Department may waive the requirement to suspend payments if it determines there is good cause not to do so.

B. The requirements for the issuance of a withholding pursuant to LAC 50:I.4149 shall be applicable to a suspension of payments for a credible allegation of fraud, except:

1. At the written request of a law enforcement agency, notice of the suspension of payments may be delayed by 30 calendar days. The law enforcement agency may renew a 30-day delay request twice.

2. In no event may a delay of notice exceed 90 calendar days from the date of the initial payment suspension.

3. The notice must include a statement indicating payments are being suspended in accordance with 42 CFR 455.23.

C. In addition to the reasons provided in LAC 50:I.4417(B)(3), the BHSF director and the PIU section chief may rely on any of the good cause exceptions in 42 C.F.R. 405.371(b) to decide not to suspend payments. They may also adjust the scope of the payment suspension by either reducing a full

suspension to a partial one or increasing partial suspension up to a full suspension.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4423. Informal Hearing

A. A provider who has received a notice of sanction may request an informal hearing.

1. The informal hearing is not intended to be a contradictory or adversarial hearing, and the rules of evidence do not apply.

2. The request for an informal hearing shall be submitted in writing and as directed in the notice.

B. A request for an informal hearing shall be within 15 calendar days of receipt of a notice of action, unless an extension is granted. Prior to or at the informal hearing the provider may:

1. present a rebuttal to the matters raised in the notice of action;

2. be afforded the opportunity to talk with the department's personnel involved in the investigation;

3. review pertinent documents on which the alleged violations are based; and

4. ask questions and seek clarification on the notice of action.

C. A provider may be represented by counsel or other person at the informal hearing.

D. Following the informal hearing, the department shall inform the provider of the results of the informal hearing.

1. Any modification of the notice resulting from the informal hearing shall be in writing and signed by the BHSF director and PIU section chief.

2. If a finding is dropped from the notice, no additional time will be granted to the provider to prepare for the informal hearing.

E. At any time prior to the issuance of the informal hearing results, the original notice may be modified.

1. If additional reasons or sanctions are added, the provider shall have an additional 10 business days to respond to the new reasons or sanctions.

2. The provider may waive the 10-day period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4425. Administrative Appeal

A. The provider may seek an appeal from the imposition of any sanction. The appeal shall be filed with the DAL. For an appeal to be timely, it must be filed:

1. if an informal hearing was requested, 30 calendar days from the mailing of the results of the informal hearing, or

2. if an informal hearing was not requested, 30 calendar days from the mailing of the notice of action.

B. To be considered adequate, each appeal must specify the basis for the appeal and the actions being challenged. Each challenged finding and the basis for the challenge must be separately stated in the appeal.

C. Except for a permissive exclusion, the lodging of a timely and adequate request for an administrative appeal does not affect the imposition of a sanction.

1. All sanctions imposed are effective upon the mailing of the informal hearing results.

2. If an informal hearing is not requested, the sanctions are effective upon the expiration of time to request in informal hearing.

D. In the case of an exclusion, the BHSF director and the PIU section chief may suspend the provider during the pendency of the appeal if:

1. it is determined that allowing the provider to participate during the pendency of the appeal threatens the Medicaid program’s fiscal or programmatic integrity; or

2. the continued participation of the provider poses a threat to the health, welfare, or safety of any recipient.

E. If the exclusion is mandatory, a threat to the Medicaid program or recipients is presumed.

1. The “threat” determination shall be made following the informal hearing.

2. If no informal hearing is requested, the determination shall be made after the delay for requesting an informal hearing has passed.

F. Failure to lodge a timely and adequate request for an administrative appeal results in the imposition of all sanctions noticed in the informal hearing results. If an informal hearing was not requested, all sanctions in the original notice of action are effective upon the expiration of time to file an appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

Subchapter E. Actions Not Considered Sanctions

§4501. Corrective Actions Plans

A. The BHSF director and the PIU section chief may issue a notice of corrective action to a provider. This notice will outline specific issues that may constitute violations of law, regulations or sub-regulatory guidance.

B. A corrective action plan must be in writing and contain a description of the violations and the corrective actions the provider must implement.

C. Corrective action plans may:

1. impose any restrictions the BHSF director and PIU section chief deem appropriate;

2. include one or more sanctions allowed by this Chapter; and

3. include any other provision mutually agreed to between the provider and the department.

D. Within 10 business days of receipt the provider must notify the department, in writing, of whether it agrees with the corrective action plan.

1. Failure to respond within 10 business days will be deemed a rejection of the corrective action plan.

2. The provider may propose an alternate corrective plan for the department’s consideration. The department shall

respond to any counter proposal within 10 business days of receipt.

E. If the parties are unable to agree on a corrective action plan, the department may issue any sanction allowed by this Chapter.

F. The inability to come to an agreement on a corrective action plan shall not be considered a failure to cooperate with the department.

G. The issuance of a notice of corrective action plan is not a sanction. It may not be appealed and there is no right to an informal hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4503. Education and Warning Letters

A. At the department’s discretion, it may issue a warning or education notice to a provider whose conduct potentially violates any of the Medicaid program’s laws, rules, or sub-regulatory guidance.

B. Education or warning notices are not sanctions and are not subject to an informal hearing or appeal.

C. Education or warning notices may be used to show evidence of knowledge for future violations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4505. Initial Findings Report (IFR)

A. In any investigation or claims review, the department may issue an IFR to the provider. This report is intended to:

1. notify the provider of the department’s preliminary findings; and

2. provide an opportunity for the provider to address the findings prior to the issuance of a sanction.

B. If an IFR is issued, the provider shall have 15 calendar days to submit a written rebuttal. The department may consider the rebuttal in its assessment of whether to impose any sanctions on the provider. As part of the rebuttal, the provider shall provide any additional documentation that supports the rebuttal.

C. The issuance of an IFR is not a sanction and is not subject to an informal hearing or appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4507. Other Actions not Subject to Administrative Appeal and Review

A. The following actions are not sanctions nor subject to an informal hearing or appeal:

1. referral to a state, federal, or professional licensing authority;

2. referral to the MFCU or any other law enforcement or prosecutorial authority;

3. referral to governing boards, peer review groups, or similar entities;

4. requirements the provider receives education and training in laws, rules, policies, and procedures, including billing;

5. prepayment review;

6. placement on manual claims review prior to payment being made;

7. require the provider to receive prior authorization prior to providing any services;

8. remove or restrict the provider’s use of electronic billing;

9. an increase of any required bond or other security already posted as a condition of continued enrollment; and

10. any restrictions, terms, or conditions a provider agrees to.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

Subchapter F. Miscellaneous

§4601. Repayment

A. Final overpayments and other monetary sanctions must be made within 60 calendar days of the date the sanction becomes final unless an extended payment term is agreed to.

B. The PIU section chief may agree to a longer repayment term, not to exceed six months.

C. The BHSF director or the secretary must approve any payment plan exceeding six months.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4603. Extended Payment Term

A. Any extended payment term allowed by LAC 50.I.4155.B and C of this Chapter shall be in writing and contain at the minimum:

1. the amount to be repaid;

2. the person(s) responsible for making the repayments;

3. a specific time table for making the repayment; and

4. if installment payments are involved, the date upon which each installment payment is to be made and the amount of the installment payment.

B. The PIU section chief must approve, in writing, any modification to an arrangement to repay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4605. Tip Rewards

A. The secretary may approve a reward of up to $2,000 to a person who submits information to the secretary resulting in a recovery under this Chapter or the Medical Assistance Programs Integrity Law.

B. Any award shall be granted from monies appropriated for this purpose from the Medical Assistance Programs Fraud Detection Fund for that purpose.

C. The approval of a reward is solely at the discretion of the secretary.

D. When determining a reward, the secretary shall consider the extent to which the information contributed to the investigation and recovery of monies.

E. The person providing the information need not have requested a reward to be considered for an award.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4607. Persons not Eligible for Rewards

A. No reward shall be made to any person if:

1. the information was previously known to the department or criminal investigators;

2. the person planned or participated in the action resulting in the investigation;

3. the person is, or was at the time of the tip, excluded from the Medicaid program,

4. the person was subject to a recovery under this Chapter or the Medical Assistance Programs Integrity Law; or

5. the person is or was a public employee or public official:

a. acting on behalf of the state; and

b. who has or had a duty or obligation to report, investigate, or pursue allegations of wrongdoing or misconduct by health care providers or Medicaid recipients.

c. if the person has not had such duties and obligations for two years prior to providing the information, that person is not excluded from a reward.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4609. Mailing

A. Mailing refers to the sending of correspondence or other documents via any means. This includes but is not limited to “mailing” through:

1. the U.S Post Office;

2. commercial carrier;

3. facsimile;

4. hand delivery; or

5. to the provider’s email address.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4611. Confidentiality

A. All contents of investigations and reviews conducted pursuant to this Chapter shall remain confidential until entry of the final sanction. The only persons that may review the contents of an investigatory file are:

1. the parties to a matter or their authorized agents and representatives;

2. persons authorized by law or regulation to access those files;

3. authorized health oversight agencies;

4. law enforcement or other government investigatory agencies; or

5. specific individuals within the department the BHSF director or PIU section chief authorize to have access to such information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4613. Severability Clause

A. If any provision of this Chapter is declared invalid or unenforceable for any reason by any court of proper venue and jurisdiction, the provision shall not affect the validity of the entire regulation or other provisions thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

§4615. Effect of Promulgation

A. This Chapter, when promulgated, shall supersede all other departmental regulations which conflict with the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 46:437.1-46:440.3.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 52:

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 and 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 Tangela Womack, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. Ms. Womack is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is March 23, 2026.

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 March 12, 2026. 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 April 1, 2026, in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after March 20, 2026. 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.

Bruce D. Greenstein

Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Medicaid Program Integrity

Fraud, Waste and Abuse Recovery

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

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 25-26. It is anticipated that

$8,165 ($4,083 SGF and $4,082 FED) will be expended in FY 25-26 for the state’s administrative expense for promulgation of this proposed rule and the final rule.

This proposed rule repeals the current language in LAC 50:I.Subpart 5, Provider Fraud and Recovery, and codifies current practices. This is being done in accordance with Executive Order JML 25-38 and Act 192 of the 2024 Regular Legislative Session requirements to review rules to ensure they are consistent with departmental guidelines and use plain language. It will have no fiscal impact since it is only updating language and not changing existing practices.

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

It is anticipated that implementation of this proposed rule will have no effect on revenue collections other than the federal share of the promulgation costs for FY 25-26. It is anticipated that $4,082 will be collected in FY 25-26 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)

This proposed rule repeals the current language in LAC 50:I.Subpart 5, Provider Fraud and Recovery, and codifies current practices. This is being done in accordance with Executive Order JML 25-38 and Act 192 of the 2024 Regular Legislative Session requirements to review rules to ensure they are consistent with departmental guidelines and use plain language. Since this is only updating language and not changing existing practices, this rule is not anticipated to result in a fiscal impact to affected persons, small businesses, or non-governmental groups in FY 25-26, FY 26-27, or FY 27-28.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

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