NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Managed Care Organization Payment Accountability and Provider Credentialing
(LAC 50.I.1501)

The Department of Health, Bureau of Health Services Financing proposes to amend LAC 50:I.1501 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 46:460.73.A 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.

Act 489 of the 2018 Regular Session of the Louisiana Legislature directed the Department of Health to establish provisions which: 1) require managed care organizations (MCOs) participating in the Medical Assistance Program to ensure that providers contracted or enrolled with the MCO comply with all Medicaid provider enrollment, credentialing and accreditation requirements; and 2) establish a process and timeline for affected providers to request departmental review of MCO-identified credentialing deficiencies.

In compliance with the requirements of Act 489, the Department of Health, Bureau of Health Services Financing

proposes to adopt provisions governing MCO payment accountability and provider credentialing.

Title 50

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

Chapter 15. Provider Screening and Enrollment

§1505. Managed Care Organization Payment Accountability and Provider Credentialing

A. In compliance with the requirements of Act 489 of the 2018 Regular Session of the Louisiana Legislature, the Department of Health adopts the following payment accountability and provider credentialing requirements for managed care organizations (MCOs) participating in the Medical Assistance Program:

1. Managed care organizations shall ensure that contracted or enrolled providers have met and continue to meet Medicaid provider enrollment, credentialing and accreditation requirements and other applicable state or federal requirements in order to receive reimbursement for services provided to Medicaid recipients.

2. Managed care organizations that fail to ensure proper compliance with Medicaid provider enrollment, credentialing or accreditation requirements shall be liable for reimbursement to providers for services rendered to Medicaid

recipients, until such time as the deficiency is identified by the MCO and notice is issued to the provider pursuant to R.S. 46:460.72.

3. Managed care organizations shall withhold reimbursement for services provided during the 15 day remedy period after notice of the deficiency is identified by the MCO, or during a longer period if allowed by LDH, if the provider elects to continue rendering services while the deficiency is under review.

a. If the deficiency is remedied, the MCO shall remit payment to the provider.

b. If the deficiency is not remedied, nothing in this Section shall be construed to preclude the MCO from recouping funds from the provider for any period in which the provider was not properly enrolled, credentialed or accredited.

c. If the deficiency cannot be remedied within 15 days, the provider may seek review by the department if he/she believes the deficiency was caused by good faith reliance on misinformation by the MCO and asserts that he/she acted without fault or fraudulent intent, there is no deficiency, or because of reliance on misinformation from the MCO, an exception should be made to allow reasonable time to come into compliance so as to not disrupt patient care.

i. After the initial notification of deficiency, the provider shall notify the department of his/her intent to appeal the decision within 10 calendar days of receipt of the MCO's notification, and provide a detailed request for departmental review with supporting documents within 15 calendar days of receipt of the MCO's notification.

(a). The provider shall prove absence of fault or fraudulent intent by producing guidance, applications or other written communication from the MCO that bears incorrect information, including whether the misinformation or guidance was contradictory to applicable Medicaid manuals, rules, or policies.

ii. The department shall review all materials and information submitted by the provider and shall review any information necessary that is in the custody of the MCO to render a written decision within 30 days of the date of receipt for review submitted by the provider.

(a). If the department's decision is in favor of the provider, a written decision shall be sent to the provider and the MCO via certified mail and the provider shall be afforded reasonable time to remedy the deficiency caused by the misinformation of the MCO. During this time, the provider shall be allowed to provide services and submit claims for reimbursement.

(i). The MCO shall be responsible for payment to the provider and may be subject to penalties by the department in accordance with contract provisions, or rules and regulations promulgated pursuant to the Administrative Procedure Act.

(b). If the department's decision is in favor of the MCO, the provider's contract shall be terminated immediately, pursuant to the notice provided for in R.S. 46:460.72(C).

(c). If the department's decision is that the provider acted with fault or fraudulent intent, the provisions of R.S. 46:460.73(B) shall apply.

(d). The written decision by the department is the final administrative decision and no appeal or judicial review shall lie from this final administrative decision.

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 44:920 (May 2018), LR 45:

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 the submission to CMS for review and approval is required.

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.

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.

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, but may increase direct or indirect cost to the provider to provide the same level of service if credentialing deficiencies results in termination of provider enrollment. The proposed Rule may also have a negative impact on the provider's ability to provide the same level of

service as described in HCR 170 if the termination in payments adversely impacts the provider's financial standing.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, December 27, 2018 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary