DIGEST

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SB 507 Engrossed 2018 Regular Session Mills

Proposed law provides that a Medicaid managed care organization shall be liable to a provider for payment of claims to the provider when the provider followed instructions of the managed care organization to his detriment and did not act with fault or fraudulent intent regarding enrollment, credentialing, or accreditation.

Proposed law provides that a Medicaid managed care organization shall be liable to the state for any payment to providers when the provider acts with fault or fraudulent intent regarding enrollment, credentialing, or accreditation. Stipulates that failure to execute the responsibility to mitigate fraud and waste is not considered a risk of the managed care organization.

Proposed law provides that the Medicaid managed care organization is not precluded from recouping and retaining improper payments and overpayments to a provider after the state has been reimbursed.

Proposed law requires the managed care organization to cover the expense of reimbursement to the provider or to the state from the administrative funding allocated to the managed care organization. Requires the La. Department of Health (LDH) to impose penalties on Medicaid managed care plans for the infractions established in proposed law in accordance with rules and regulations promulgated by the department.

Proposed law requires each Medicaid managed care organization to report every instance of fraud, waste, or abuse to LDH and the attorney general.

Proposed law gives the attorney general authority to investigate, enforce, impose sanctions upon, and seek recoupment from the Medicaid managed care plans. Provides for the return of recouped monies to LDH and deposit of all other monies received from the Medicaid managed care organizations into the Medical Assistance Programs Fraud Detection Fund.

Proposed law provides that nothing in proposed law prevents LDH or the attorney general from enforcing and imposing penalties otherwise provided for in law or regulation.

Proposed law applies exclusively to providers that have received written notification indicating that they have been credentialed by a Medicaid managed care organization.

(Adds R.S. 46:460.72)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Health and Welfare to the original bill

1. Provides that failure to execute the provisions of the managed care organization's contractual responsibility to mitigate fraud and waste is not considered a risk of the managed care organization.

2. Provides that the Medicaid managed care organization is not precluded from recouping and retaining improper payments and overpayments to a provider after the state has been reimbursed.

3. Requires each Medicaid managed care organization to report every instance of fraud, waste, or abuse to the Louisiana Department of Health and the attorney general.

4. Clarifies that among the attorney general's enforcement authority is the ability to impose penalties, civil monetary penalties, and additional recoveries or costs of investigations.

5. Clarifies that the Louisiana Department of Health or the attorney general shall not be precluded from enforcing and imposing penalties otherwise provided for in law or regulation.

6. Replaces "monetary sanctions" with "penalties".

7. Removes the word "irrefutably" from the burden of proof provision regarding false information submitted by the provider to the managed care organization.

Summary of Amendments Adopted by House

The Committee Amendments Proposed by House Committee on Health and Welfare to the engrossed bill:

1. Stipulate that the party to which a provider must prove absence of fault or fraudulent intent is the La. Department of Health.

2. Require the La. Department of Health to determine whether a provider relied in good faith upon misinformation by a managed care organization as provided in proposed law.

3. Limit the applicability of proposed law such that it would apply only to a provider who has received written notification indicating that he has been credentialed by a managed care organization.

4. Make technical changes.