2018 Regular Session **ENROLLED**

SENATE BILL NO. 507

BY SENATOR MILLS

AN ACT

To enact R.S. 46:460.72 and 460.73, relative to Medicaid managed care organizations; to provide for provider notice requirements; to provide for plan payment accountability; to provide for payment to providers; to provide for obligations by the managed care organizations; to provide for prohibited claims for purposes of rate setting; to provide for authority of the attorney general; to provide for deposits into the Medical Assistance Programs Fraud Detection Fund; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 46:460.72 and 460.73 are hereby enacted to read as follows:

§460.72. Medicaid managed care organization provider notice

A. Each Medicaid managed care organization shall comply with the following notice provisions regarding contracted provider status and ability to begin providing services and submitting claims for reimbursement:

(1) Any Medicaid managed care organization that contracts with or enrolls a provider into its provider network shall furnish written notice to the provider that informs the provider of the effective date of the contract and enrollment.

(2) Unless otherwise authorized by law, a provider shall not submit Medicaid reimbursement claims for any services provided prior to the effective date indicated in the written notice.

(3) The Medicaid managed care organization shall send the written notice required in this Subsection to the last mailing address and last email address submitted by the provider.

B. Each Medicaid managed care organization shall comply with the following notice provisions regarding contracted provider re-credentialing:

(1) Each Medicaid managed care organization shall provide a minimum of three written notices to a contracted provider with information regarding the

re-credentialing process, including requirements and deadlines for compliance. The first notice shall be issued by the Medicaid managed care organization no later than six months prior to the expiration of the provider's current credentialing. The notice shall include the effective date of termination if the provider fails to meet the requirements and deadlines of the re-credentialing process.

(2) The Medicaid managed care organization shall send the written notices required in this Subsection to the last mailing address and last email address submitted by the provider.

(3) If the provider fails to timely submit all required documents and meet all re-credentialing requirements, the Medicaid managed care organization shall send a termination notice to the provider with an effective date of termination to be fifteen days after the date of the notice. The Medicaid managed care association shall send the termination notice via certified mail to the provider's last mailing address as submitted by the provider. The Medicaid managed care organization shall be responsible for paying any claims for services delivered prior to the termination date specified in the notice.

C. If a Medicaid managed care organization terminates a provider and removes a provider from its provider network for reasons other than failure to comply with the re-credentialing process set forth in Subsection C of this Section, the Medicaid managed care organization shall send written notice of the termination via certified mail to the last known mailing address submitted by the provider. The termination notice shall include the effective date of the termination. The termination date shall be fifteen days from the date of the notice if the termination is pursuant to R.S. 46:460.73(A). The termination shall be immediate if the termination is pursuant to R.S. 46:460.73(B) or due to the loss of required license.

D. A provider shall give written notice of any change in licensure or accreditation status to each Medicaid managed care organization with which it is contracted or enrolled in a provider network. The provider shall furnish such

written notice to the Medicaid managed care organization within two business days of the provider's knowledge of the change.

§460.73. Medicaid managed care organization payment accountability

A.(1) Each Medicaid managed care organization shall be responsible for ensuring that any provider it contracts with or enrolls into its network has attained and satisfies all Medicaid provider enrollment, credentialing, and accreditation requirements and all other applicable state or federal requirements in order to receive reimbursement for providing services to Medicaid recipients. Any Medicaid managed care organization that contracts with or enrolls a provider into its provider network and fails to ensure proper compliance with Medicaid provider enrollment, credentialing, or accreditation requirements shall be liable for reimbursement to the provider for any services rendered to Medicaid recipients until such time as the deficiency is identified by the Medicaid managed care organization and notice is issued to the provider pursuant to R.S. 46:460.72. Reimbursement for any services provided during the fifteen-day remedy period after notice of the deficiency was identified by the Medicaid managed care organization, or during a longer period if allowed by the department, shall be withheld if the provider elects to continue providing services while the deficiency is under review. If the deficiency is remedied, the Medicaid managed care organization shall remit payment to the provider. If the deficiency is not remedied, nothing in this Subsection shall be construed to preclude the managed care organization from recouping funds from the provider for any period in which the provider was not properly enrolled, credentialed, or accredited.

(2) If a provider cannot remedy the deficiency within fifteen days and believes that the deficiency was caused by good faith reliance on misinformation by the managed care organization and the provider asserts that he acted without fault or fraudulent intent he may seek review of the matter by the department if he believes there is no deficiency or that because of his reliance on misinformation from the Medicaid managed care organization, he cannot

remedy the deficiency within fifteen days, but that an exception should be made to allow him reasonable time to come into compliance so as to not disrupt patient care. The provider shall prove absence of fault or fraudulent intent by producing guidance, applications, or other written communication from the managed care organization that bears incorrect information, including whether the misinformation or guidance was contradictory to applicable Medicaid manuals, rules, or policies.

(3) 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 Medicaid managed care organization to render a written decision within thirty days of the date of receipt for review submitted by the provider. If the department's decision is in favor of the provider, a reasonable time shall be afforded to the provider to remedy the deficiency caused by the misinformation of the Medicaid managed care organization. During this time, the provider shall be allowed to provide services and submit claims for reimbursement. The written decision issued pursuant to this Paragraph shall be sent to the provider and the Medicaid managed care organization by certified mail.

(4) In addition to the managed care organization being responsible for payment to the provider, the department may impose penalties on the managed care organization in accordance with contract provisions or rules and regulations promulgated pursuant to the Administrative Procedure Act.

(5) If the department's decision is not in favor of the provider, the provider's contract shall be terminated immediately pursuant to the notice provided for in R.S. 46:460.72(C).

(6) If the department's decision is that the provider acted with fault or fraudulent intent, the provisions of Subsection B of this Section shall apply.

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

B.(1) Each Medicaid managed care organization shall be responsible for mitigating fraud, waste, and abuse of the funds it receives in the form of per-member per-month rates for the provision of services to its plan enrollees. Any Medicaid managed care organization that contracts with or enrolls a provider into the provider network and fails to mitigate fraud, waste, and abuse by a provider who acted with fault or fraudulent intent in securing a contract or submitting claims shall void all claims and previous encounters for the provider.

(2) Failure to execute the provisions of their responsibility to mitigate fraud, waste, and abuse shall not be considered a risk of the Medicaid managed care organization for purposes of calculating per-member per-month rates. All claims associated with fraud, waste, and abuse shall be voided. Voided claims shall not be used for purposes of rate setting or by the Medicaid managed care organization to seek an increase in rates or payments.

(3) The provisions of this Subsection do not preclude the Medicaid managed care organization from recouping and retaining improper payments and overpayments to a provider.

(4) In addition to the managed care organization being responsible for voiding all claims and encounters associated with fraud, waste, and abuse for any payments made to a provider, the department may impose penalties on the managed care organization in accordance with contract provisions or rules and regulations promulgated pursuant to the Administrative Procedure Act.

(5) The Medicaid managed care organization shall be liable to the department for any other costs, expenses, claims, or reimbursement incurred or expended by the department due to the provider's fault or fraudulent intent.

C. Each Medicaid managed care organization shall report every instance of suspected fraud, waste, or abuse to the department and the attorney general. In addition to the sanction and enforcement authority of the department pursuant to a properly executed contract or properly promulgated rule, the attorney general shall have the authority to investigate, enforce, impose sanctions upon, and seek recoveries from any Medicaid managed care

organization pursuant to the provisions of this Section and the Medical Assistance Programs Integrity Law, R.S. 46:437.1 et seq. Recoupments shall be returned to the department. All other sanctions, penalties, civil monetary penalties, and additional recoveries or costs of investigations obtained by the attorney general shall be deposited into the Medical Assistance Programs Fraud Detection Fund, as established in R.S. 46:440.1. No Medicaid managed care organization or any officer, director, employee, representative, or agent thereof shall have any liability to the provider or any other person for reporting any suspected fraud to the department or to the attorney general as required by this Section.

D. Nothing in this Section shall be construed to prevent the department or the attorney general from enforcing and imposing penalties otherwise provided for in law or regulation.

E. The department shall promulgate rules and regulations necessary to implement the provisions of this Section in accordance with the Administrative Procedure Act.

F. Nothing in this Section shall be construed to supersede or conflict with the provisions of R.S. 46:460.62.

G. The provisions of this Section shall be subject to approval by the Centers for Medicare and Medicaid Services.

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PRESIDENT OF THE SENATE

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SPEAKER OF THE HOUSE OF REPRESENTATIVES

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GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____