RÉSUMÉ DIGEST

ACT 489 (SB 507) **2018 Regular Session** **Mills**

New law requires each Medicaid managed care organization (MCO) to comply with the following notice provisions regarding contracted provider status and ability to begin providing services and submitting claims for reimbursement:

(1) Requires each MCO that contracts with or enrolls a provider into its provider network to furnish written notice to the provider that informs the provider of the effective date of the contract and enrollment.

(2) Unless otherwise authorized, each provider is prohibited from submitting Medicaid reimbursement claims for any services provided prior to the effective date indicated in the written notice.

(3) The written notice is to be sent to the last mailing address and last email address submitted by the provider.

Requires MCOs to comply with the following notice provisions regarding contracted provider re-credentialing:

(1) Provide a minimum of three written notices to a contracted provider with information regarding the re-credentialing process, including requirements and deadlines for compliance. Requires the first notice to be issued no later than six months prior to the expiration of the provider's current credentialing and the notice is to include the effective termination date if the provider fails to meet the requirements and deadlines of the re-credentialing process.

(2) Notice to be sent to the last mailing address and last email address submitted by the provider.

(3) Provides that upon failure of a provider to timely submit all required documents and meet all re-credentialing requirements, the MCO is to send a termination notice to the provider with an effective date of termination to be 15 days after the date of the notice. Requires that the managed care organization is responsible for paying any claims for services delivered prior to the termination date.

Provides for termination and removal from a provider network for reasons other than failure to comply with re-credentialing process and for written notice to be sent by certified mail to the last known mailing address submitted by the provider. Provides for termination 15 days from date of the notice. Provides for immediate termination due to loss of the required license or other certain circumstances specified in new law.

Requires each MCO to 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. Provides that if the MCO fails to ensure proper compliance with Medicaid provider enrollment, credentialing, or accreditation requirements then it is liable for reimbursement to the provider for any services rendered to Medicaid recipients until such time as the deficiency is identified and notice sent to the provider. Provides that reimbursement for any services provided during the 15 day remedy period after notice of the deficiency was identified 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. Provides that if the deficiency is remedied, the organization shall remit payment to the provider and if the deficiency is not remedied, then the MCO may recoup funds from the provider.

Provides that if a provider cannot remedy the deficiency within 15 days and believes that the deficiency was caused by good faith reliance on misinformation by the MCO and the provider asserts that he acted without fault or fraudulent intent, the provider may seek departmental review if he believes there is no deficiency or that because of his reliance on misinformation from the MCO, he cannot remedy the deficiency within 15 days. Provides for exceptions to allow reasonable time to come into compliance so as to not disrupt patient care. Requires that the provider 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.

Requires the department to review all materials and information to render a written decision within 30 days of the date of receipt for a review. Authorizes the imposition of penalties on the MCO.

Provides for immediate termination of a provider's contract if the department's decision is not in favor of the provider. Provides that the written decision by the department is the final administrative decision and no appeal or judicial review shall lie from this final administrative decision.

Provides that each MCO is 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. Provides that failure of the MCO to execute the provisions of their responsibility to mitigate fraud, waste, and abuse shall not be considered a risk of the MCO for purposes of calculating per-member per-month rates and 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 MCO to seek an increase in rates or payments. Provides that the MCO is not precluded from recouping and retaining improper payments and overpayments to a provider.

Provides that in addition to its responsibility to void all claims and encounters associated with fraud, waste, and abuse of payments made to a provider, the department may impose penalties on the MCO. Provides for liability of the MCO 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.

Requires that each MCO report every instance of suspected fraud, waste, or abuse to the department and the attorney general and also authorizes the attorney general to investigate, enforce, impose sanctions upon, and seek recoveries from any MCO pursuant new law and the Medical Assistance Program Integrity Law. Requires that any recoupments be returned to the department and that 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. Provides that no MCO or any officer, director, employee, representative, or agent of the MCO shall have any liability to the provider or any other person for reporting any suspected fraud to the department or to the attorney general.

Does not prevent the department or the attorney general from enforcing and imposing penalties otherwise provided by law or regulation nor does it supersede or conflict with provisions regarding interim credentialing.

New law is subject to approval by the Centers for Medicare and Medicaid Services.

Effective August 1, 2018.

(Adds R.S. 46:460.72 and 460.73)