2016 Regular Session

HOUSE BILL NO. 258

BY REPRESENTATIVES MIKE JOHNSON AND ROBBY CARTER

MEDICAID: Provides relative to grounds and procedures for denial or revocation of Medicaid provider enrollment and eligibility for health facility licensure

1 AN ACT

2 To amend and reenact R.S. 46:437.14(A)(introductory paragraph) and (12), and to enact
3 R.S. 46:437.3(31) and 437.14(A)(13), (C), and (D), relative to the Medical
4 Assistance Programs Integrity Law; to provide for the applicability of such law to
5 Medicaid provider agreements of certain healthcare providers with the Department
6 of Health and Hospitals; to provide grounds for denial or revocation of such provider
7 agreements; to provide grounds causing certain providers to become ineligible to
8 obtain a license to operate a healthcare facility; to provide for reinstatement of
9 eligibility for obtaining a Medicaid provider agreement or healthcare facility license;
10 and to provide for related matters.

11 Be it enacted by the Legislature of Louisiana:

12 Section 1. R.S. 46:437.14(A)(introductory paragraph) and (12) are hereby amended
13 and reenacted and R.S. 46:437.3(31) and 437.14(A)(13), (C), and (D) are hereby enacted to
14 read as follows:

15 §437.3. Definitions

16 As used in this Part the following terms shall have the following meanings:

17 * * *

18 (31) "Affiliate" means an entity that has with another entity a legal
19 relationship created or governed by at least one written instrument that demonstrates
20 any of the following:

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 (a) Common ownership, management, or control.

2 (b) A franchise agreement.

3 (c) The granting or extension of a license or other agreement that authorizes
4 an entity to use the other entity's brand name, trademark, service mark, or other
5 registered identification mark.

6 * * *

7 §437.14. Grounds for denial or revocation of enrollment

8 A. The department may deny or revoke enrollment in the medical assistance
9 programs to a ~~health care~~ healthcare provider if any of the following are found to be
10 applicable to the ~~health care~~ healthcare provider, his agent, a managing employee,
11 provider-in-fact, affiliate, or any person having an ownership interest equal to five
12 percent or greater in the ~~health care~~ healthcare provider:

13 * * *

14 (12)(a) Being found in violation of or entering into a settlement agreement
15 under the provisions of this Part, the Federal False Claims Act, the Federal Civil
16 Monetary Penalties Act, or any other similar civil statutes pertaining to fraud in this
17 state, in any other state, the United States, or a United States territory.

18 (b) If a False Claims Act action or other similar civil action is brought by a
19 qui tam plaintiff or relator, no violation of this Paragraph has occurred until the
20 defendant has been found liable in the action, either by final judgment or by entering
21 into a settlement agreement which requires the defendant to pay any sum as damages
22 to the relator in the qui tam action and to the federal government or any state
23 government who contends in the settlement agreement that the defendant submitted
24 false claims or made false statements in connection with claims submitted under any
25 of the following programs:

26 (i) The medical assistance program provided for in Title XIX of the Social
27 Security Act or any other publicly funded medical assistance program.

28 (ii) Any federal block grant program.

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

(c) No violation of this Paragraph has occurred if, at minimum, five years have passed from the time a person is found liable or entered a settlement agreement under the False Claims Act, or other similar civil statute, and the conditions of the judgment or settlement have been satisfactorily fulfilled.

(13) Failure to meet any condition of enrollment.

* * *

C. The secretary shall promulgate emergency rules requiring an immediate review of all active provider agreements to require all healthcare providers enrolled in a medical assistance program to disclose any and all documentation pertaining to the grounds provided in Subsection A of this Section, based on conduct by the healthcare provider, his agent, a managing employee, provider-in-fact, affiliate, or any person having an ownership interest equal to five percent or greater in the healthcare provider. The emergency rules required by this Subsection shall further require any and all documentation relevant to the grounds listed in Subsection A of this Section upon initial application for enrollment, as well as upon renewal, or at any time requested by the department.

D.(1) To protect the interests of this state relative to fiscal integrity and the prevention of fraud in its medical assistance programs, any healthcare provider that seeks a license to operate in a facility that is maintained, owned, or operated by its affiliate healthcare provider enrolled in a medical assistance program shall first disclose to the department whether the enrolled provider to which it is an affiliate is subject to being held in violation of the provisions of Paragraph (A) (6), (11), or (12) of this Section pertaining to fraud or false claims submitted by the enrolled provider under a state or federal medical assistance program.

(2) If an applicant provided for in Paragraph (1) of this Subsection discloses to the department that the applicant provider, his agent, a managing employee, provider-in-fact, affiliate, or any person having an ownership interest equal to five percent or greater in the healthcare provider is subject to being considered in violation of the provisions of Paragraph (A) (6), (11), or (12) of this Section

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 pertaining to fraud or false claims submitted by the enrolled provider under the
2 medical assistance program provided for in Title XIX of the Social Security Act, any
3 other publicly funded medical assistance program, or any federal block grant
4 program, then the applicant provider shall be considered ineligible to file an
5 application with the department to obtain a license to establish or operate a
6 healthcare facility in this state.
7 (3) The ineligibility of a healthcare provider to apply for a license pursuant
8 to this Section does not depend on imposition by the department of prior or future
9 sanctions on the healthcare provider, his agent, a managing employee,
10 provider-in-fact, affiliate, or any person having an ownership interest equal to five
11 percent or greater in the healthcare provider.
12 (4) If at least five years have passed from the time a provider initially
13 became subject to being considered in violation of the provisions of Paragraph (A)
14 (6), (11), or (12) of this Section the provider shall be eligible to apply for a license
15 under this Section.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 258 Original 2016 Regular Session Mike Johnson

Abstract: Adds grounds and procedures for denial or revocation of Medicaid provider agreements pursuant to the Medical Assistance Programs Integrity Law.

Present law known as the Medical Assistance Programs Integrity Law provides grounds for denial or revocation of agreements between healthcare providers and the Department of Health and Hospitals, referred to hereafter as the "department", for provision of services to Medicaid enrollees.

Proposed law retains present law, and adds thereto violating or entering into a settlement agreement under the provisions of present law and proposed law, the Federal False Claims Act, the Federal Civil Monetary Penalties Act, or any other similar statutes pertaining to fraud as grounds for denial or revocation of a Medicaid provider agreement.

Proposed law provides that if a False Claims Act action or other similar action is brought by a *qui tam* plaintiff or relator, no violation of proposed law has occurred until the defendant has been found liable in the action, either by final judgment or by entering into a settlement agreement which requires the defendant to pay any sum as damages to the relator in the *qui tam* action and to the federal government or any state government who contends in the

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

settlement agreement that the defendant submitted false claims or made false statements in connection with claims submitted under any of the following programs:

(1) The Medicaid program or any other publicly funded medical assistance program.

(2) Any federal block grant program.

Proposed law provides that no violation of proposed law has occurred if, at minimum, five years have passed from the time a person is found liable or entered a settlement agreement under the False Claims Act, or other similar civil statute, and the conditions of the judgment or settlement have been satisfactorily fulfilled.

Proposed law requires the department to promulgate emergency rules requiring an immediate review of all active Medicaid provider agreements. Requires further that all Medicaid providers disclose to the department any and all documentation pertaining to any grounds for provider agreement revocation provided in present law and proposed law relative to conduct by the healthcare provider, his agent, a managing employee, provider-in-fact, affiliate, or any person having an ownership interest equal to 5% or greater in the healthcare provider. Provides that the emergency rules required by proposed law shall require such documentation from providers upon initial application for enrollment, as well as upon renewal, or at any time requested by the department.

Proposed law requires that any healthcare provider seeking a license to operate in a facility that is maintained, owned, or operated by its affiliate healthcare provider enrolled as a Medicaid provider shall first disclose to the department whether the enrolled provider to which it is an affiliate is subject to being held in violation of present law or proposed law pertaining to fraud or false claims submitted by the enrolled provider under a state or federal medical assistance program.

Proposed law provides that if an applicant provider discloses to the department that the applicant provider, his agent, a managing employee, provider-in-fact, affiliate, or any person having an ownership interest equal to 5% or greater in the healthcare provider is subject to being considered in violation of present law or proposed law pertaining to fraud or false claims submitted to any publicly funded medical assistance program or any federal block grant program, then the applicant provider shall be considered ineligible to obtain a license to establish or operate a healthcare facility in this state.

Proposed law provides that the ineligibility of a provider for a license pursuant to proposed law does not depend on imposition by the department of prior or future sanctions on the provider, his agent, a managing employee, provider-in-fact, affiliate, or any person having an ownership interest equal to 5% or greater in the healthcare provider.

Proposed law provides that if at least five years have passed from the time a provider initially became subject to being considered in violation of present law or proposed law pertaining to fraud or false claims, then the provider shall be eligible to apply for a license.

(Amends R.S. 46:437.14(A)(intro. para.) and (12); Adds R.S. 46:437.3(31) and 437.14(A)(13), (C), and (D))

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.