HOUSE SUMMARY OF SENATE AMENDMENTS

HB 734 **2018 Regular Session** **McFarland**

MEDICAID: Requires reporting of data on healthcare provider claims submitted to Medicaid managed care organizations

Synopsis of Senate Amendments

1. Changes the name of the report required by proposed law from "Healthy Louisiana Quarterly Report" to "Healthy Louisiana Claims Report".

2. Requires the La. Department of Health (LDH) to conduct an independent review of claims submitted by healthcare providers to Medicaid managed care organizations. Requires that the review examine, in the aggregate and by claim type, the volume and value of claims submitted, including those adjudicated, adjusted, voided, duplicated, rejected, pended or denied in whole or in part for purposes of ensuring a Medicaid managed care organization's compliance with the terms of its contract. Requires further that LDH actively engage provider representatives in the review.

3. Provides that the initial report required by proposed law shall include detailed findings and defining measures to be reported on a quarterly basis, as well as data on healthcare provider claims as specified in proposed law, delineated by individual Medicaid managed care organization including any dental Medicaid managed care organization contracted by LDH, and separated by claim type.

4. Provides that data on claims to be included in the report required by proposed law shall be based on data of payment during calendar year 2017.

5. Revises references to denied claim lines and refers instead to claims denied at the service line level.

6. Revises references to completely denied claims to refer instead to claims denied at the service line level.

7. Revises references to claims adjudicated to refer instead to claims adjudicated at the service line level.

8. Revises references to encounter claims and refers instead to encounters.

9. Requires that certain provider information in the report required by proposed law be de-identified.

10. Deletes requirement that the segment of the report required by proposed law relating to case management include the total number of Medicaid enrollees receiving case management services delineated by underlying reason for receiving those services.

11. Changes the deadline by which proposed law requires LDH to submit the preliminary report from Oct. 1, 2018 to Sept. 30, 2018.

12. Requires LDH to submit the quarterly report on Jan. 1, 2019, reflecting the April - June 2018 quarter, and thereafter on or before the first day of each state fiscal year quarter following the date of the first report.

Digest of Bill as Finally Passed by Senate

Proposed law requires the La. Dept. of Health (LDH) to produce and submit to the Joint Legislative Committee on the Budget and the legislative committees on health and welfare a report concerning the Medicaid managed care program to be entitled the "Healthy Louisiana Claims Report".

Proposed law requires LDH to conduct an independent review of claims submitted by healthcare providers to Medicaid managed care organizations. Requires that the review examine, in the aggregate and by claim type, the volume and value of claims submitted, including those adjudicated, adjusted, voided, duplicated, rejected, pended or denied in whole or in part for purposes of ensuring a Medicaid managed care organization's compliance with the terms of its contract with LDH. Requires further that LDH actively engage provider representatives in the review.

Proposed law provides that the initial Healthy Louisiana Claims Report shall include detailed findings and defining measures to be reported on a quarterly basis. Stipulates that data on claims to be included in the report shall be based on data of payment during calendar year 2017.

Proposed law requires that the Healthy Louisiana Claims Report include the following data on healthcare provider claims delineated by individual Medicaid managed care organization, including any dental Medicaid managed care organization contracted by the department, and separated by claim type:

(1) The total number and dollar amount of claims for which there was at least one claim denied at the service line level.

(2) The total number and dollar amount of claims denied at the service line level.

(3) The total number and dollar amount of claims adjudicated in the reporting period at the service line level.

(4) The total number and dollar amount of denied claims divided by the total number and dollar amount of claims adjudicated.

(5) The total number and dollar amount of adjusted claims.

(6) The total number and dollar amount of voided claims.

(7) The total number and dollar amount of claims denied as a duplicate claim.

(8) The total number and dollar amount of rejected claims.

(9) The total number and dollar amount of pended claims.

(10) For each of the five network billing providers with the highest number of total denied claims, the number of total denied claims expressed as a ratio to all claims adjudicated and the total dollar value of the claims.

Proposed law requires that LDH report the data specified in proposed law separately for the following provider groups:

(1) Behavioral health providers.

(2) All other providers, collectively.

Proposed law requires that certain provider information included in the report be de-identified.

Proposed law requires that the report feature a narrative which includes, at minimum, the action steps which LDH plans to take in order to address all of the following:

(1) The five most common reasons for denial of claims submitted by healthcare providers other than behavioral health providers, including provider education to the five network billing providers with the highest number of total denied claims.

(2) The five most common reasons for denial of claims submitted by behavioral health providers, including provider education to the five network billing providers with the highest number of total denied claims.

(3) Means to ensure that provider education addresses root causes of denied claims and actions to address those causes.

(4) Claims denied in error by managed care organizations.

Proposed law requires that the report include all of the following data relating to encounters:

(1) The total number of encounters submitted by each Medicaid managed care organization to the state or its designee.

(2) The total number of encounters submitted by each Medicaid managed care organization that are not accepted by LDH or its designee.

Proposed law requires that the initial report and subsequent quarterly reports include the following information relating to case management delineated by Medicaid managed care organization:

(1) The total number of Medicaid enrollees receiving case management services.

(2) The total number of Medicaid enrollees eligible for case management services.

Proposed law requires LDH submit the initial report required by proposed law to the Joint Legislative Committee on the Budget and the House and Senate committees on health and welfare on or before Sept. 30, 2018. Requires LDH to submit the quarterly report on Jan. 1, 2019, reflecting the April - June 2018 quarter, and thereafter on or before the first day of each state fiscal year quarter following the date of the first report.

(Adds R.S. 46:460.91)