RÉSUMÉ DIGEST

ACT 710 (HB 734) **2018 Regular Session** **McFarland**

New 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".

New 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.

New 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.

New 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 LDH, 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.

New law requires that LDH report the data specified in new law separately for the following provider groups:

(1) Behavioral health providers.

(2) All other providers, collectively.

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

New 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.

New 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.

New 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.

New law requires LDH to submit the initial report required by new 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.

Effective August 1, 2018.

(Adds R.S. 46:460.91)