HOUSE COMMITTEE AMENDMENTS

2018 Regular Session

Substitute for Original House Bill No. 238 by Representative McFarland as proposed by the House Committee on Health and Welfare

This document reflects the content of a substitute bill but is not in a bill form; page numbers in this document DO NOT correspond to page numbers in the substitute bill itself.

To enact Subpart E of Part XIII of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 46:460.91, relative to the state medical assistance program known commonly as Medicaid; to require the Louisiana Department of Health to submit reports to certain legislative committees concerning the Medicaid managed care program; to provide for the content of the reports; to establish a reporting schedule; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Subpart E of Part XIII of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, comprised of R.S. 46:460.91, is hereby enacted to read as follows:

SUBPART E. CLAIMS PROCESSING DATA - REPORTING

§460.91. Claims processing data; reports to legislative committees

A. On a quarterly basis, the department shall produce and submit to the Joint Legislative Committee on the Budget and the House and Senate committees on health and welfare a report entitled the "Healthy Louisiana Quarterly Report" which conforms with the requirements of this Subpart.

B. The report shall include the following data on healthcare provider claims delineated by individual Medicaid managed care organization and separated by provider type:

(1) The following data on claims submitted by all healthcare providers except behavioral health providers:

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

(b) The total number and dollar amount of completely denied claims.

(c) The total number and dollar amount of claims adjudicated in the reporting period.

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

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

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

(g) The total number and dollar amount of duplicate claims.

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

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

(j) 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.

(2) The following data on claims submitted by behavioral health providers:

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

(b) The total number and dollar amount of completely denied claims.

(c) The total number and dollar amount of claims adjudicated in the reporting period.

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

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

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

(g) The total number and dollar amount of duplicate claims.

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

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

(j) 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.

C. The report shall feature a narrative which includes, at minimum, the action steps which the department 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.

D. The report shall include all of the following data relating to encounter claims:

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

(2) The total number of encounter claims submitted by each Medicaid managed care organization that are not accepted by the department or its designee.

E. The report shall 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 receiving case management services delineated by underlying reason for receiving those services.

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

Section 2. The secretary of the Louisiana Department of Health shall take such actions as are necessary to ensure that the first quarterly report required by R.S. 46:460.91, as enacted by Section 1 of this Act, is submitted to the Joint Legislative Committee on the

Budget and the House and Senate committees on health and welfare on or before October 1, 2018, and reflects April 1, 2018 through June 30, 2018 of the contract period. The department shall submit each successive quarterly report on or before the first day of each state fiscal year quarter following the date of the first report.

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 Draft 2018 Regular Session

Abstract: Requires the La. Dept. of Health to report data on healthcare provider claims submitted to Medicaid managed care organizations.

Proposed law requires the La. Dept. of Health (LDH), on or before Oct. 1, 2018, and on a quarterly basis thereafter, to produce and submit to the Joint Legislative Committee on the Budget and the House and Senate committees on health and welfare a report concerning the Medicaid managed care program, to be entitled the "Healthy Louisiana Quarterly Report".

Proposed law requires that the report include the following data on healthcare provider claims delineated by individual Medicaid managed care organization and separated by provider type:

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

(2) The total number and dollar amount of completely denied claims.

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

(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 duplicate claims.

(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 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 encounter claims:

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

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

Proposed law requires that the report 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 receiving case management services delineated by underlying reason for receiving those services.

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

(Adds R.S. 46:460.91)