RÉSUMÉ DIGEST

ACT 349 (HB 492) **2017 Regular Session** **Magee**

Existing law provides for definitions, requirements, limitations, and exemptions relative to the Medicaid managed care program of this state. Provides for duties of the Louisiana Department of Health (LDH), and of managed care organizations (MCOs) contracted with the state to coordinate delivery of healthcare services to Medicaid enrollees, in operating the Medicaid managed care program. New law retains present law.

New law creates and provides for a process through which denial by MCOs of claims submitted by healthcare providers for payment for services rendered to Medicaid enrollees may be reviewed, and adverse determinations concerning those claims may be reconsidered.

New law stipulates that it shall not:

(1) Otherwise prohibit or limit any alternative legal or contractual remedy available to a healthcare provider to contest the partial or total denial by an MCO of a claim for payment for healthcare services.

(2) Apply to any adverse determination associated with a claim filed with an MCO prior to January 1, 2018, regardless of whether the claim is re-filed after that date.

(3) Apply to any claim adjudication or adverse determination rendered by a Dental Coordinated Care Network, defined as an MCO that solely provides dental benefits to Medicaid recipients.

New law provides that for all adverse determinations related to claims filed on or after January 1, 2018, the state shall not mandate that the provider and MCO resolve the claim payment dispute through arbitration.

New law stipulates that an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review pursuant to new law.

New law establishes the following procedure for independent review of adverse determinations by MCOs concerning healthcare provider claims:

(1) The provider shall submit a written request for reconsideration to the MCO that identifies the claim or claims in dispute, the reasons for the dispute, and any documentation supporting the provider's position or request by the MCO within 180 days from one of the following dates:

    (a) The date on which the MCO transmits remittance advice or other notice electronically, or the date of postmark if the remittance advice or other notice is provided in a non-electronic format.

    (b) 60 days from the date the claim was submitted to the MCO if the provider receives no remittance advice or other written or electronic notice from an MCO either partially or totally denying the claim.

    (c) The date on which the MCO recoups monies remitted for a previous claim payment.

(2) The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with new law within five calendar days after receipt of the request and shall render a final decision and provide a response to the provider within 45 calendar days from the date of receipt of the request for reconsideration, unless a longer time to completely respond is agreed upon in writing by the provider and the MCO.

(3) Pursuant to the reconsideration request, if the MCO upholds the adverse determination or does not respond to the request within the time frames allowed in

new law, then the provider may file a written notice with LDH requesting the adverse action be submitted to an independent reviewer as authorized in new law.

(4) Upon receipt of a notice of request for independent review and all required supporting information and documentation, LDH shall refer the adverse determination to an independent reviewer.

(5) Within 14 calendar days of receipt of the request for independent review, the independent reviewer shall request in writing that both the provider and the MCO provide all information and documentation regarding the disputed claim or claims. The reviewer shall advise the MCO and the provider that he will not consider any information or documentation not received within 30 calendar days of receipt of his request or any information submitted by the provider that was not submitted to the MCO as part of the request for reconsideration.

(6) If the independent reviewer determines that guidance on a medical issue from LDH is required to make a decision, then the reviewer shall refer this specific issue to the department for review and response unless the department designates a different contact for this function by rule.

(7) Upon receipt of the information requested from the provider and MCO or the lapse of the time period for submission, the independent reviewer shall examine all materials submitted and render a decision on the dispute within 60 calendar days. However, the reviewer may request in writing an extension of time from LDH to resolve the dispute. If an extension of time is granted, then the reviewer shall provide notice of the extension to both the provider and the MCO.

(8) Upon rendering a decision, the independent reviewer shall send to the MCO, the provider, and LDH a copy of the decision. Once the reviewer renders a decision requiring an MCO to pay any claims or a portion thereof, then the MCO shall send the payment in full along with interest back to the date the claim was originally denied or recouped to the provider within 20 calendar days of the date of the reviewer's decision.

New law provides that within 60 calendar days of an independent reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the independent reviewer's decision and to recover any funds awarded by the independent reviewer to the other party. Provides that any claim concerning an independent reviewer's decision not brought within 60 calendar days of the decision shall be barred indefinitely. Provides further that suits filed pursuant to new law shall be conducted in accordance with new law and applicable provisions of existing law (La. Code of Civil Procedure).

New law requires that the fee for conducting an independent review shall in all cases be paid by the MCO. Stipulates, however, that a provider shall, within 10 days of the date of the review decision, reimburse an MCO for the fee associated with the review if the decision of the MCO is upheld. Further stipulates that if the provider fails to submit this payment as required, the MCO may withhold future payments to the provider in an amount equal to the cost of the review. Requires in these cases that the MCO ensure that the withholding is clearly delineated on the remittance advice.

New law creates the Independent Reviewer Selection Panel within LDH. Provides that the panel shall consist of the secretary of the department or the secretary's duly designated representative and the following members:

(1) Two healthcare provider representatives appointed by the secretary.

(2) Two MCO representatives appointed by the secretary.

New law requires that all decisions of the panel be made by majority vote and that the panel shall meet at least twice per year. Stipulates that panel members shall serve without compensation.

New law requires that the panel do all of the following:

(1) Select a chairperson.

(2) Select and identify an appropriate number of independent reviewers and determine a uniform rate of compensation per review to be paid to each reviewer.

(3) Continually review the number and outcome of requests for reconsideration and independent reviews on an aggregated basis.

New law prohibits provision of any patient-identifying information to the panel.

New law requires MCOs to utilize only independent reviewers who are selected by the panel in accordance with new law.

New law provides that any MCO found to be in violation of new law may be subject to a penalty of up to $25,000 per violation. Additionally, provides that if an MCO is subject to more than 100 independent reviews annually and the percentage of adverse determinations overturned in favor of healthcare providers is greater than 25%, the MCO may be subject to a penalty of up to $25,000.

Existing law relative to Medicaid transparency (R.S. 40:1253.1 et seq.) requires LDH to prepare and submit to the legislative committees on health and welfare an annual report concerning specific aspects of the Medicaid managed care program.

New law retains existing law and adds thereto a requirement that report include the following information:

(1) The total number of independent claim reviews conducted pursuant to new law, delineated by claim type, for each MCO.

(2) The total number and percentage of adverse determinations overturned as a result of independent claim reviews conducted pursuant to new law, delineated by claim type, for each MCO.

New law revises references to the name "Bayou Health" which had formerly been applied to the Medicaid managed care program.

Effective August 1, 2017.

(Amends R.S. 40:1253.2(A)(intro. para.) and (3)(f) and (g), 1253.3(B), and 1253.4(A) and R.S. 46:460.31(intro. para.) and (4) and 460.51(5) and (8); Adds R.S. 40:1253.2(A)(3)(h), R.S. 46:460.51(13), and 460.81-460.89)