2025 Regular Session

HOUSE BILL NO. 565

BY REPRESENTATIVE SPELL

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

MEDICAID: Provides relative to third-party liability, claim adjudication, and timeliness of such within the state medical assistance program

AN ACT

To enact R.S. 46:460.71(E) and 460.76.3, relative to the state medical assistance program; to provide for claim payment information; to provide for third-party liability; to require notification; to provide penalties; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 46:460.71(E) and 460.76.3 are hereby enacted to read as follows:

§460.71. Claim payment information

* * *

E. A managed care organization shall be strictly prohibited from amending, modifying, or changing in any manner a claim submitted by a healthcare provider or from adjudicating payment of a claim submitted by a healthcare provider in any manner that is inconsistent with the manner in which the claim is billed by the healthcare provider. Any violation of the provisions of this Subsection shall result in the department withholding from payment to the managed care organization an amount to be determined by the department not less than twenty-five thousand dollars or greater for each violation of this Section.

* * *

§460.76.3. Claim information; third-party liability

A. The department shall provide all known information about the existence of any other health insurance that is obligated to pay all or part of the expenditures

of the medical assistance furnished under the Medicaid state plan for a Medicaid enrollee on the Medicaid Eligibility Verification System.

B.(1) A managed care organization shall provide notification to the department no later than five business days from the date the managed care organization identifies the existence of other health insurance providing health insurance coverage to a Medicaid enrollee when the other health insurance is not reflected on the Medicaid Eligibility Verification System. The notification shall include, at a minimum, the following information about the other health insurance:

(a) The name, address, and phone number of the liable third party or health insurance issuer.

(b) The policyholder information, including the policyholder name, policy number, and group number.

(c) The scope of coverage of the liable third party, if the scope of coverage is limited.

(2) The department may promulgate, by rule or inclusion, in the Medicaid managed care organization manual any additional information required in the notification and the manner in which the managed care organization shall submit the notification to the department.

C. A managed care organization shall not deny, pend, reject, or recoup a claim solely on the basis of the existence of a liable third party or primary coverage that is through other health insurance unless all of the following information related to the other health insurance is available on the Medicaid Eligibility Verification system that is maintained by the department:

(1) The name, address, and phone number of the liable third party or health insurance issuer.

(2) The policyholder information, including the policyholder name, policy number, and group number.

(3) The effective date of coverage by the liable third party or health insurance issuer and the scope of coverage of the liable third party or health insurance issuer, if the scope of coverage is limited.

D. A managed care organization shall provide written or electronic notification to a provider no later than five business days after the managed care organization receives payment from a liable third party for healthcare services rendered by the healthcare provider. Such notice shall include the following:

(1) A copy of the explanation of benefits provided to the managed care organization as result of payment being made to the managed care organization for the healthcare services rendered by the healthcare provider.

(2) The name, address and phone number of the liable third party or health insurance issuer.

(3) The policyholder information, including the policyholder name, policy number, and group number.

(4) The effective date of coverage by the liable third party of health insurance issuer and the scope of coverage of the liable third party or health insurance issuer, if the scope of coverage is limited.

E.(1) A managed care organization shall provide written notification to the department within two business days in any case where a Medicaid member of the managed care organization is enrolled in any other health insurance policy or provides coverage under Part C of the Medicare Program that is sold or administered by any entity that is a subsidiary of the managed care organization or is owned by a parent organization of the managed care organization.

(2) Notice required by this Section shall include the following:

(a) The name, address and phone number of the other health insurance issuer or issuer of the coverage under Part C of the Medicare program.

(b) The policyholder information, including the policyholder name, policy number, and group number.

(c) The effective dates of coverage by the liable third party or health insurance issuer and the scope of coverage of the liable third party or health insurance issuer, if the scope of coverage is limited.

(3) The department shall cause the information contained in the notification to be reflected in the Medicaid Eligibility Verification System no later than two business days from receiving a notice pursuant to this Paragraph.

F. The department shall withhold payment to the managed care organization in an amount to be determined by the department not less than twenty-five thousand dollars or greater for each violation of the provisions of this Section by a managed care organization. However, upon a finding by the department that the managed care organization has committed multiple violations of this Section or engages in a pattern of violations, the minimum amount shall be at least one hundred thousand dollars.

Section 2. This Act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If vetoed by the governor and subsequently approved by the legislature, this Act shall become effective on the day following such approval.

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 565 Original 2025 Regular Session Spell

Abstract: Provides relative to third-party liability and claim adjudication within the state medical assistance program.

Present law requires any claim payment to a provider by a managed care organization, a fiscal agent, or an intermediary of the managed care organization to be accompanied by an itemized accounting of the individual services represented on the claim that are included in the payment. Present law further provides what should be included in this itemization.

Proposed law retains present law.

Present law provides that if a managed care organization is a secondary payer, then the organization shall send, in addition to all information required by present law (R.S.

46:460.71(A)), acknowledgment of payment as a secondary payer, the primary payer's coordination of benefits information, and the third-party liability carrier code.

Proposed law retains present law.

Present law also provides the procedure for what happens when a claim for payment is denied in standard paper format or electronically. Proposed law retains present law.

Proposed law prohibits a managed care organization from amending, modifying, or changing in any manner a claim submitted by a healthcare provider or from adjudicating payment of a claim submitted by a healthcare provider in any manner that is inconsistent with the manner in which the claim is billed by the healthcare provider.

Proposed law provides that any violation of proposed law shall result in the La. Dept. of Health (LDH) withholding payment to the managed care organization. Proposed law further provides that the withheld amount, which shall be determined by LDH, shall not be less than $25,000 for each violation.

Proposed law requires LDH to provide all known information about the existence of any other health insurance that is obligated to pay all or part of medical assistance expenditures.

Proposed law requires a managed organization to provide notification to LDH no later than five business days from the date the managed care organization becomes aware of the existence of another health insurance providing health insurance coverage to a Medicaid enrollee, if the other health insurance is not reflected on the Medicaid Eligibility Verification System.

Proposed law requires the notification to include, at a minimum, the following information about the other health insurance:

(1) The name, address, and phone number of the liable third party or carrier.

(2) The policyholder information, including the policyholder name, policy number, and group number.

(3) The scope of coverage of the liable third party, if the scope of coverage is limited.

Proposed law allows LDH to promulgate, by rule or inclusion, any additional information required by the managed care organization and the method of how the managed care organization should submit this information.

Proposed law prohibits a managed care organization from denying, pending, rejecting, or recouping a claim solely on the basis of the existence of a liable third party or primary coverage that is through other health insurance, unless all of the following information related to the other health insurance is available on the Medicaid Eligibility Verification System maintained by LDH:

(1) The name, address, and phone number of the liable third party or carrier.

(2) The policyholder information, including the policyholder name, policy number, and group number.

(3) The effective date of coverage by the liable third party or health insurance issuer and the scope of coverage of the liable third party or health insurance issuer, if the scope of coverage is limited.

Proposed law requires a managed care organization to provide written or electronic notification to a provider no later than five business days after the managed care organization receives payment from a liable third party for healthcare services rendered by the healthcare provider. Proposed law provides that the notice shall include the following:

(1) A copy of the explanation of benefits provided to the managed care organization as result of payment being made to the managed care organization for the healthcare services rendered by the healthcare provider.

(2) The name, address, and phone number of the liable third party or health insurance issuer.

(3) The policyholder information, including the policyholder name, policy number, and group number.

(4) The effective date of coverage by the liable third party of health insurance issuer and the scope of coverage of the liable third party or health insurance issuer, if the scope of coverage is limited.

Proposed law requires a managed care organization to provide written notification to the department within two business days in any case where a Medicaid member of the managed care organization is enrolled in any other health insurance policy or provides coverage under applicable provisions of the Medicare program that is sold or administered by any entity that is a subsidiary of the managed care organization or is owned by a parent organization of the managed care organization.

Proposed law provides that notice required by proposed law shall include the following:

(1) The name, address, and phone number of the other health insurance issuer or issuer of the coverage under applicable providers of the Medicare program.

(2) The policyholder information, including the policyholder name, policy number, and group number.

(3) The effective dates of coverage by the liable third party or health insurance issuer and the scope of coverage of the liable third party or health insurance issuer, if the scope of coverage is limited.

(4) The department shall cause the information contained in the notification to be reflected in the Medicaid Eligibility Verification System no later than two business days from receiving a notice.

Proposed law requires LDH to withhold payment to the managed care organization in an amount to be determined by LDH.

Proposed law provides that the determined amount by LDH shall not be less than $25,000 for each violation of proposed law. Proposed law further provides that if LDH has determined that the managed care organization has committed multiple violations or engages in a pattern of violations, the minimum amount for each violation shall be at least $100,000.

Effective upon signature of governor or lapse of time for gubernatorial action.

(Adds R.S. 46:460.71(E) and 460.76.3)