2023 Regular Session

HOUSE BILL NO. 434

BY REPRESENTATIVE MCFARLAND

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

MEDICAID: Provides relative to the state medical assistance program

AN ACT

To amend and reenact R.S. 46:460.91, relative to the state medical assistance program; to provide for claims processing data; to provide for a quarterly report; to require the provision of certain information in the quarterly report; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 46:460.91 is hereby amended and reenacted to read as follows:

§460.91. Claims processing data; reports to legislative committees

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

B. ~~The department shall conduct an independent review of claims submitted by healthcare providers to Medicaid managed care organizations. The review shall 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 the department. The department shall actively engage provider representatives in the review, from design through completion.~~ The ~~initial~~ quarterly report shall include ~~detailed findings and~~

~~defining measures to be reported on a quarterly basis, as well as~~ all of the following data on healthcare provider claims delineated by ~~an individual~~ a Medicaid managed care organization including any dental Medicaid managed care organization ~~contracted by the department~~ and ~~separated~~ by ~~claim~~ provider type and shall be separately reported for both acute care and behavioral health claims:

(1) ~~The following data on claims submitted by all healthcare providers except behavioral health providers based on data of payment during calendar year 2017.~~

~~(a)~~ The total number ~~and dollar amount~~ of claims for which there was at least one ~~claim denied~~ denial at the service line level, except for hospital inpatient claims which shall be reported by the number of inpatient days paid and number of inpatient days denied.

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

~~(c)~~(2) The total number ~~and dollar amount~~ of claims adjudicated in the reporting period ~~at the service line level~~.

~~(d)~~(3) The total number ~~and dollar amount~~ of denied claims ~~divided by~~ expressed as a percentage of the total number ~~and dollar amount~~ of claims adjudicated, except for hospital inpatient claims which shall be expressed as a percentage of the hospital inpatient days denied out of the total hospital inpatient days.

~~(e)~~(4) The total number ~~and dollar amount~~ of adjusted claims.

~~(f)~~(5) The total number ~~and dollar amount~~ of voided claims.

~~(g)~~(6) The total number ~~and dollar amount~~ of claims denied as a duplicate claim.

~~(h)~~(7) The total number ~~and dollar amount~~ of rejected claims.

~~(i)~~(8) The ~~total number and dollar amount of pended claims~~ average number of days from receipt of the claim by the managed care organization to the date on which the provider is paid or is notified that no payment will be made.

~~(j)~~(9) For each managed care organization, a listing of the top ~~of the~~ five ~~network billing~~ participating providers with the highest number of total denied claims, that includes the number of total denied claims expressed as a ratio to all claims adjudicated ~~and the total dollar value of the claims~~. Provider information shall be de-identified.

(10) The total number of denied claims submitted to the managed care organization for reconsideration of the claim denial, excluding a reconsideration conducted pursuant to R.S. 46:460.81, et seq.

(11) The percentage of denied claims submitted to the managed care organization for reconsideration of the claim denial, excluding a reconsideration conducted pursuant to R.S. 46:460.81, et seq, that is overturned by the managed care organization.

(12) The number of denied claims submitted to the managed care organization for appeal of the claim denial.

(13) The percentage of denied claims submitted to the managed care organization for appeal of the claim denial that is overturned by the managed care organization.

(14) The total number of denied claims submitted to the managed care plan for arbitration of the claim denial.

~~(2) The following data on claims submitted by behavioral health providers based on date of payment during calendar year 2017:~~

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

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

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

~~(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. Provider information shall be de-identified.~~

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 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 the department or its designee.

~~E.~~D. ~~The initial report and subsequent quarterly~~ Quarterly reports shall include all of the following information relating to case management delineated by a Medicaid managed care organization:

(1) The total number of ~~Medicaid enrollees receiving case management services.~~ individuals identified for case management delineated by all of the following:

(a) The method of identification used by the managed care organization.

(b) The reason identified for case management.

(c) The tier assignment as required by the contract executed by the managed care organization and this state.

(d) The Louisiana Department of Health region.

(2) The total number of ~~Medicaid enrollees eligible for case management services.~~ individuals enrolled in case management services delineated by all of the following:

(a) The method of identification used by the managed care organization.

(b) The reason identified for case management.

(c) The tier assignment as required by the contract executed by the managed care organization and this state.

(d) The Louisiana Department of Health region.

(3) The total number of individuals identified but not enrolled in case management delineated by all of the following:

(a) Method of identification used by the managed care organization.

(b) The reason identified for case management.

(c) The tier assignment as required by the contract executed by the managed care organization and this state.

(d) The Louisiana Department of Health region.

(4) The total number of individuals enrolled in case management that are women whose pregnancy has been categorized as high-risk.

(5) The total number of individuals enrolled in case management that have been diagnosed with sickle cell disease.

E. The quarterly reports shall include all of the following information relating to utilization management delineated by Medicaid managed care organizations:

(1) A list of all items and services that require prior authorization.

(2) The percentage of standard prior authorization requests that were approved, delineated for all items and services subject to prior authorization.

(3) The percentage of standard prior authorization requests that were denied, delineated for all items and services subject to prior authorization.

(4) The percentage of standard prior authorization requests that were approved after appeal, delineated for all items and services subject to prior authorization.

(5) The percentage of expedited prior authorization requests that were approved, delineated for all items and services subject to prior authorization.

(6) The percentage of expedited prior authorization requests that were denied, delineated for all items and services subject to prior authorization.

(7) The average and median time that elapsed between the submission of a request and a determination by the managed care organization, for standard prior authorizations, delineated for all items and services subject to prior authorization.

(8) The average and median time that elapsed between the submission of a request and a decision by the managed care organization for expedited prior authorizations, delineated for all items and services subject to prior authorization.

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 434 Original 2023 Regular Session McFarland

Abstract: Provides for a quarterly report entitled the "Healthy Louisiana Claims Report" and establishes requirements for the report.

Present law requires the La. Dept. of Health (LDH) to 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 Claims Report", which conforms with the requirements of present law.

Proposed law requires the report to be submitted to the Joint Legislative Committee on the Budget and the House and Senate committees on health and welfare on a quarterly basis and otherwise retains the provisions of present law.

Present law requires LDH to conduct an independent review of claims submitted by healthcare providers to Medicaid managed care organizations and establishes provisions for such a review in accordance with the provisions of present law. Present law further provides that the initial report shall include detailed findings and the defined measures to be reported on a quarterly basis, as well as the data provided in present law. Present law includes any dental Medicaid managed care organization, contracted by LDH and separated by claim type.

Proposed law requires a quarterly report to include the data required in accordance with present law by provider type and separately reported for both acute care and behavioral health claims. Proposed law further removes dollar amount requirements from present law and adds the following data requirements to present law:

(1) The total number of denied claims submitted to the managed care organization for reconsideration of the claim denial, excluding a reconsideration conducted pursuant to present law.

(2) The percentage of denied claims submitted to the managed care organization for reconsideration of the claim denial, excluding a reconsideration conducted pursuant to present law, that is overturned by the managed care organization.

(3) The number of denied claims submitted to the managed care organization for appeal of the claim denial.

(4) The percentage of denied claims submitted to the managed care organization for appeal of the claim denial that are overturned by the managed care organization.

(5) The total number of denied claims submitted to the managed care plan for arbitration of the claim denial.

Present law requires the provision of certain data on claims submitted by behavioral health providers based on the date of payment during the 2017 calendar year. Present law also requires the provision of a narrative, which present law establishes requirements therefor.

Proposed law removes the requirement of certain data on claims submitted by behavioral health providers based on the date of payment during the 2017 calendar year. Proposed law also removes the narrative requirement.

Present law requires the report to include certain data relating to encounters, including an initial report and subsequent quarterly reports. Proposed law removes those requirements.

Proposed law requires only quarterly reports that include the provision of certain information relating to utilization management delineated by Medicaid managed care organizations.

Proposed law further requires the following data relating to utilization management delineated by Medicaid managed care organizations:

(1) A list of all items and services that require prior authorization.

(2) The percentage of standard prior authorization requests that were approved, delineated for all items and services subject to prior authorization.

(3) The percentage of standard prior authorization requests that were denied, delineated for all items and services subject to prior authorization.

(4) The percentage of standard prior authorization requests that were approved after appeal, delineated for all items and services subject to prior authorization.

(5) The percentage of expedited prior authorization requests that were approved, delineated for all items and services subject to prior authorization.

(6) The percentage of expedited prior authorization requests that were denied, delineated for all items and services subject to prior authorization.

(7) The average and median time that elapsed between the submission of a request and a determination by the managed care organization, for standard prior authorizations, delineated for all items and services subject to prior authorization.

(8) The average and median time that elapsed between the submission of a request and a decision by the managed care organization for expedited prior authorizations, delineated for all items and services subject to prior authorization.

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

(Amends R.S. 46:460.91)