DIGEST

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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)