

2023 Regular Session

HOUSE BILL NO. 434

BY REPRESENTATIVE MCFARLAND

1 AN ACT

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

6 Be it enacted by the Legislature of Louisiana:

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

8 §460.91. Claims processing data; reports to legislative committees

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

13 B. ~~The department shall conduct an independent review of claims submitted~~
14 ~~by healthcare providers to Medicaid managed care organizations. The review shall~~
15 ~~examine, in the aggregate and by claim type, the volume and value of claims~~
16 ~~submitted, including those adjudicated, adjusted, voided, duplicated, rejected, pending~~
17 ~~or denied in whole or in part for purposes of ensuring a Medicaid managed care~~
18 ~~organization's compliance with the terms of its contract with the department. The~~
19 ~~department shall actively engage provider representatives in the review, from design~~
20 ~~through completion. The initial quarterly report shall include detailed findings and~~
21 ~~defining measures to be reported on a quarterly basis, as well as all of the following~~
22 data on healthcare provider claims delineated by ~~an individual~~ a Medicaid managed
23 care organization including any dental Medicaid managed care organization

1 ~~contracted by the department and separated by claim provider type and shall be~~
 2 ~~separately reported for both acute care and behavioral health claims:~~

3 (1) ~~The following data on claims submitted by all healthcare providers~~
 4 ~~except behavioral health providers based on data of payment during calendar year~~
 5 ~~2017:~~

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

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

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

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

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

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

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

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

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

27 (j) ~~(9) For each managed care organization, a listing of the top of the five~~
 28 ~~network billing participating providers with the highest number of total denied~~
 29 ~~claims, that includes the number of total denied claims expressed as a ratio to all~~

1 claims adjudicated ~~and the total dollar value of the claims.~~ Provider information
2 shall be de-identified.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 ~~(i) The total number and dollar amount of pended claims:~~

2 ~~(j) For each of the five network billing providers with the highest number of~~
3 ~~total denied claims, the number of total denied claims expressed as a ratio to all~~
4 ~~claims adjudicated and the total dollar value of the claims. Provider information~~
5 ~~shall be de-identified.~~

6 C. ~~The report shall feature a narrative which includes, at minimum, the~~
7 ~~action steps which the department plans to take in order to address all of the~~
8 ~~following:~~

9 ~~(1) The five most common reasons for denial of claims submitted by~~
10 ~~healthcare providers other than behavioral health providers, including provider~~
11 ~~education to the five network billing providers with the highest number of total~~
12 ~~denied claims.~~

13 ~~(2) The five most common reasons for denial of claims submitted by~~
14 ~~behavioral health providers, including provider education to the five network billing~~
15 ~~providers with the highest number of total denied claims.~~

16 ~~(3) Means to ensure that provider education addresses root causes of denied~~
17 ~~claims and actions to address those causes.~~

18 ~~(4) Claims denied in error by managed care organizations:~~

19 ~~D.~~ The report shall include all of the following data relating to encounters:

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

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

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

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

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

1 **(b) The reason identified for case management.**

2 **(c) The Louisiana Department of Health region.**

3 **(2) The total number of ~~Medicaid enrollees eligible for case management~~**
4 **services: individuals who accepted and enrolled in case management services**
5 **delineated by all of the following:**

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

7 **(b) The reason identified for case management.**

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

10 **(d) The Louisiana Department of Health region.**

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

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

14 **(b) The reason identified for case management.**

15 **(c) The Louisiana Department of Health region.**

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

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

20 **(6) The total number of individuals enrolled in case management who**
21 **received specialized behavioral health services.**

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

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

26 **(2) The percentage of standard prior authorization requests that were**
27 **approved for all items and services subject to prior authorization categorized by type**
28 **of service.**

1 (3) The percentage of standard prior authorization requests that were denied
2 for all items and services subject to prior authorization categorized by type of
3 service.

4 (4) The percentage of standard prior authorization requests that were
5 approved after appeal for all items and services subject to prior authorization
6 categorized by type of service.

7 (5) The percentage of expedited prior authorization requests that were
8 approved for all items and services subject to prior authorization categorized by type
9 of service.

10 (6) The percentage of expedited prior authorization requests that were denied
11 for all items and services subject to prior authorization categorized by type of
12 service.

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

17 (8) The average and median time that elapsed between the submission of a
18 request and a decision by the managed care organization for expedited prior
19 authorizations for all items and services subject to prior authorization categorized by
20 type of service.

21 Section 2. This Act shall become effective October 1, 2023.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____