RÉSUMÉ DIGEST

ACT 233 (HB 434) **2023 Regular Session** **McFarland**

Prior law required 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 prior law.

New 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 prior law.

Prior law required LDH to conduct an independent review of claims submitted by healthcare providers to Medicaid managed care organizations and established provisions for such a review in accordance with the provisions of prior law. Prior law further provided 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 prior law. Prior law also included any dental Medicaid managed care organization contracted by LDH and separated by claim type in the provisions of prior law.

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

(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 existing 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 existing 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 were 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.

Prior law required the provision of certain data on claims submitted by behavioral health providers based on the date of payment during the 2017 calendar year. Prior law also required the provision of a narrative which prior law established requirements therefor.

New 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. New law also removes the narrative requirement.

Prior law required the report to include certain data relating to encounters, including an initial report and subsequent quarterly reports. New law removes the requirements of prior law.

New law requires the quarterly report to include the total number of individuals identified for case management categorized by all of the following:

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

(2) The reason identified for case management.

(3) The LDH region.

New law also requires the quarterly reports to include certain information relative to all of the following:

(1) The tier assignment required by the contract executed by the managed care organization.

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

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

(4) Total number of individuals enrolled in case management who received specialized behavioral health services.

New 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, categorized by type of service for all items and services subject to prior authorization.

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

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

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

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

Effective October 1, 2023.

(Amends R.S. 46:460.91)