LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **HB 492** HLS 17RS 710
Bill Text Version: **ENROLLED**
Opp. Chamb. Action:
Proposed Amd.:
Sub. Bill For.:

Date: June 15, 2017 9:34 AM
Author: MAGEE
Dept./Agy.: DHH/Medicaid
Subject: independent claims review
Analyst: Shawn Hotstream

MEDICAID EN INCREASE GF EX See Note

Provides for an independent claims review process within the Medicaid managed care program

Current law provides that claims payment disputes between managed care organizations and providers be resolved through arbitration.
Proposed law provides for a right of providers to an independent review in the event a provider's claim is subject to an adverse determination beginning January 1, 2018. An adverse determination is defined in this measure as a) a decision by a managed care organization that denies a claim in whole or in part, b) a decision by a managed care organization that only partially pays a claim; or c) a decision by a managed care organization that results in recoupment of the payment of a claim.
Proposed law creates The Independent Reviewer Selection Panel with LDH, and provides for members of the panel.
Proposed law excludes any claim adjudication or adverse determination rendered by a Dental Coordinated Care Network.
See page 2

EXPENDITURES	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**5 -YEAR TOTAL**
State Gen. Fd.	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

REVENUES	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**5 -YEAR TOTAL**
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	$0	$0	$0	$0	$0	**$0**
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

EXPENDITURE EXPLANATION

Proposed law establishes a standardized provider appeals process for claims disputes between a managed care organization and a provider. Beginning January 1, 2018, providers appeals will be determined through an independent reviewer, requested by the provider. In the event a claim denial (adverse determination) is upheld, costs of the independent review will be paid by the provider. Likewise, if the adverse determination is overturned by the reviewer, the managed care organization is responsible for the review costs.

Information provided by the Louisiana Department of Health indicates this measure will require an additional 5 Medicaid program monitor positions to manage the program. The department based this projected level of additional staff on a similar program in the Tennessee Department of Insurance, which administers an independent review process for Tennessee Medicaid. However, the Independent Review process in Tennessee is supported with only 1.5 positions (1 Administrative staff position with oversight from a manager assigned on a half-time basis). The appropriate level of additional staff and associated personnel costs required to run this program will ultimately depend on the number of annual appeals associated with adverse determinations, and the additional activities required of LDH as a result of this measure. The department will be required to track incoming appeals and determinations, monitor provider and MCO compliance with timelines and payments, and provide trend analysis of determinations and appeals decisions for reporting purposes. Note: The LFO has requested historical data related to adverse determinations and appeals through the existing arbitration process.

In addition, any additional costs to the MCO's as a result of this measure is indeterminable. LDH has indicated this measure may result in higher managed care capitation payments to the health plans if a significant number of denied claims are overturned, however the impact to MCO rates is indeterminable, if at all.

REVENUE EXPLANATION

This measure establishes fines on MCO's under certain conditions. If an MCO is subject to more than 100 independent reviews and the percentage of adverse determinations overturned in favor of providers is greater than 25%, the MCO may be subject to an additional penalty of up to $25,000.

Senate Dual Referral Rules

[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S&H}

[ ] 13.5.2 >= $500,000 Annual Tax or Fee Change {S&H}

House

[ ] 6.8(F)(1) >= $100,000 SGF Fiscal Cost {H & S}

[ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

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Staff Director

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CONTINUED EXPLANATION from page one:

All decisions of the panel shall be made by majority vote.

Proposed law provides for the procedure for independent review, and provides for responsibilities of both the provider and managed care organization

Proposed law provides that if the managed care organization upholds the initial adverse determination or does not respond to the request for reconsideration from the provider within the time frames provided for in the bill, the provider may then file a written notice with the Louisiana Department of Health requesting the adverse action be submitted to an independent reviewer. Upon receipt of a notice of request for independent review of a claim or aggregated (multiple) claims, the department is required to refer the adverse determination to an independent reviewer.

Proposed law provides for a process in the event an adverse determination is reversed, which include requirements of the provider, managed care plans, and independent reviewer. The independent reviewer may seek guidance on a medical issue from LDH in certain circumstances.

Under proposed law, the independent review decision does not limit the ability of either the provider or managed care company to file suit in any court having jurisdiction to review the independent reviewer's decision.

The fee for conducting an independent review shall in all cases be paid to the independent reviewer by the managed care organization initially. A provider shall reimburse a managed care organization for the fee associated with conducting an independent review when the decision of the managed care organization is upheld.

Proposed legislation provides for a fine on MCO's under certain conditions.

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