SLS 13RS-487 **RE-REENGROSSED**

Regular Session, 2013

SENATE BILL NO. 185

BY SENATORS MURRAY AND THOMPSON

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

HEALTH CARE. Provides relative to Medicaid and certain managed health care organizations providing health care services to Medicaid beneficiaries. (gov sig)

AN ACT

To enact Part XI of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 46:460.31 through 460.32, 460.41 through 460.42, 460.51 through 460.53, and 460.71, relative to Medicaid; to provide for managed care organizations providing health care services to Medicaid beneficiaries; to provide for the standardized credentialing of providers; to provide for exemptions; to provide for prescription drugs; to provide for a standard form for the prior authorization of prescription drugs; to provide for procedures for utilizing step therapy and fail first protocols; to provide for standardized information to be provided with claim payments; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Part XI of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, comprised of R.S. 46:460.31 through 460.32, 460.41 through 460.42, 460.51 through 460.53, and 460.71, is hereby enacted to read as follows:

PART XI. MEDICAID MANAGED CARE

§460.31. Definitions

The following terms shall have the following meanings unless the context

clearly indicates otherwise:

(1) "Applicant" means a health care provider seeking to be approved or credentialed by a managed care organization to provide health care services to Medicaid enrollees.

(2) "Credentialing" or "recredentialing" means the process of assessing and validating the qualifications of health care providers applying to be approved by a managed care organization to provide health care services to Medicaid enrollees.

(3) "Department" means the Department of Health and Hospitals.

(4) "Enrollee" means an individual who is enrolled in the Medicaid program.

(5) "Health care provider" or "provider" means a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners or other individual health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law.

(6) "Health care services" or "services" means the services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(7) "Managed care organization" shall have the same definition as the term is defined by 42 C.F.R. 438.2 and shall include any entity providing primary care case management services to Medicaid recipients pursuant to a contract with the department.

(8) "Prepaid Coordinated Care Network" means a private entity that contracts with the department to provide Medicaid benefits and services to Louisiana Medicaid Bayou Health Program enrollees in exchange for a monthly prepaid capitated amount per member.

(9) "Primary care case management" means a system under which an entity contracts with the state to furnish case management services that include but are not limited to the location, coordination and monitoring of primary

health care services to Medicaid beneficiaries.

(10) "Secretary" means the secretary of the Department of Health and Hospitals.

(11) "Standardized information" means the customary universal data concerning an applicant's identity, education, and professional experience relative to a managed care organization's credentialing process including but not limited to name, address, telephone number, date of birth, social security number, educational background, state licensing board number, residency program, internship, specialty, subspecialty, fellowship, or certification by a regional or national health care or medical specialty college, association or society, prior and current place of employment, an adverse medical review panel opinion, a pending professional liability lawsuit, final disposition of a professional liability settlement or judgment, and information mandated by health insurance issuer accrediting organizations.

(12) "Verification" or "verification supporting statement" means the documentation confirming the information submitted by an applicant for a credentialing application from a specifically named entity or a regional, national, or general data depository providing primary source verification including but not limited to a college, university, medical school, teaching hospital, health care facility or institution, state licensing board, federal agency or department, professional liability insurer, or the National Practitioner Data Bank.

§460.32. Exemptions

The provisions of this Part shall not apply to any entity contracted with the Department of Health and Hospitals to provide fiscal intermediary services in processing claims of the health care providers.

SUBPART A. PROVIDER CREDENTIALING

§460.41. Provider credentialing

A. (1) Any managed care organization that requires a health care

provider to be credentialed, recredentialed, or approved prior to rendering health care services to a Medicaid recipient shall complete a credentialing process within ninety days from the date on which the managed care organization has received all the information needed for credentialing, including the health care provider's correctly completed application and attestations and all verifications or verification supporting statements required by the managed care organization to comply with accreditation requirements and generally accepted industry practices and provisions to obtain reasonable applicant-specific information relative to the particular or precise services proposed to be rendered by the applicant.

(2)(a) Within thirty days of the date of receipt of an application, a managed care organization shall inform the applicant of all defects and reasons known at the time by the managed care organization in the event a submitted application is deemed to be not correctly completed.

(b) A managed care organization shall inform the applicant in the event that any needed verification or a verification supporting statement has not been received within sixty days of the date of the managed care organization's request.

(3) In order to establish uniformity in the submission of an applicant's standardized information to each managed care organization for which he may seek to provide health care services until submission of an applicant's standardized information in a paper format shall be superseded by a provider's required submission and a managed care organization's required acceptance by electronic submission, an applicant shall utilize and a managed care organization shall accept either of the following at the sole discretion of the managed care organization:

(a) The current version of the Louisiana Standardized Credentialing Application Form, or its successor, as promulgated by the Department of Insurance.

(b) The current format used by the Council for Affordable Quality Healthcare (CAQH), or its successor.

B. Nothing in this Section shall be construed to require a managed care organization credentialing or approval in determining inclusion or participation in the managed care organization's contracted network.

§460.42. Interim credentialing requirements

A. Under certain circumstances and when the provisions of this Subsection are met, a managed care organization contracting with a group of physicians that bills a managed care organization utilizing a group identification number, such as the group federal tax identification number or the group National Provider Identifier as set forth in 45 CFR 162.402 et seq., shall pay the contracted reimbursement rate of the physician group for covered health care services rendered by a new physician to the group without health care provider credentialing as described in this Subpart. This provision shall apply in either of the following circumstances:

(1) When the new physician has already been credentialed by the managed care organization, and the physician's credentialing is still active with the managed care organization.

(2) When the managed care organization has received the required credentialing application and information, including proof of active hospital privileges from the new physician, and the managed care organization has not notified the physician group that credentialing of the new physician has been denied.

B. A managed care organization shall comply with the provisions of Subsection A of this Section no later than thirty days after receipt of a written request from the physician group.

C. Compliance by a managed care organization with the provisions of Subsection A of this Section shall not be construed to mean that a physician has been credentialed by the managed care organization, or the managed care

organization shall be required to list the physician in a directory of contracted physicians.

D. If, after compliance with Subsection A of this Section, a managed care organization completes the credentialing process on the new physician and determines the physician does not meet the managed care organization's credentialing requirements, the managed care organization may recover from the physician or the physician group an amount equal to the difference between appropriate payments for in-network benefits and out-of-network benefits, provided that the managed care organization has notified the applicant physician of the adverse determination and provided that the prepaid entity has initiated action regarding such recovery within thirty days of the adverse determination.

SUBPART B. PRESCRIPTION DRUG FORMULARY

§460.51. Prepaid coordinated care network pharmaceutical and therapeutic committees

Beginning January 1, 2014, every prepaid coordinated care network shall designate a pharmaceutical and therapeutics committee to develop a drug formulary and preferred drug list for the prepaid coordinated care network. Every prepaid coordinated care network pharmaceutical and therapeutics committee shall hold a meeting not less frequently than on a semi-annual basis in Baton Rouge, Louisiana, that is open to the public and permits public comment prior to voting on any changes in the preferred drug list or formulary.

§460.52. Prescription drug prior authorization

A. Beginning January 1, 2014, managed care organizations shall utilize a single-page prior authorization form promulgated by the department pursuant to the Administrative Procedure Act.

B. The department shall promulgate rules and regulations prior to January 1, 2014, that provide for the form that must be utilized by all managed care organizations. The department may consult with the managed care

organizations as necessary in development of the prior authorization form.

C. A managed care organization shall comply with the provisions of R.S. 46:153.3(C).

§460.53. Step therapy

A. Managed care organizations that utilize step therapy or fail first protocols shall comply with the provisions of this Section.

B. When medications for the treatment of any medical condition shall be restricted for use by a managed care organization by a step therapy or fail first protocol, the prescribing physician shall be provided with and have access to a clear and convenient process to request an override of such restriction from the managed care organization. An override of such restriction shall be granted by the managed care organization under any of the following circumstances:

(1) The prescribing physician demonstrates to the managed care organization, based on sound clinical evidence, the preferred treatment required under step therapy or fail first protocol has been ineffective in the treatment of the Medicaid enrollee's disease or medical condition.

(2) The prescribing physician demonstrates to the managed care organization, based on sound clinical evidence, the preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the Medicaid enrollee and known characteristics of the drug regimen.

(3) The prescribing physician demonstrates to the managed care organization, based on sound clinical evidence, the preferred treatment required under the step therapy or fail first protocol causes or likely causes an adverse reaction or other physical harm to the Medicaid enrollee.

C. The duration of any step therapy or fail first protocol shall not be longer than the customary period for the medication when such treatment is demonstrated by the prescribing physician to be clinically ineffective. When the

managed care organization demonstrates through sound clinical evidence the originally prescribed medication is likely to require more than the customary period for such medication to provide any relief or an amelioration to the Medicaid enrollee, the step therapy or fail first protocol may be extended for an additional period of time no longer than the original customary period for the medication.

SUBPART C. CLAIM PAYMENT

§460.71. Claim payment information

A. Any claim payment to a provider by a managed care organization or by a fiscal agent or intermediary of the managed care organization shall be accompanied by an itemized accounting of the individual services represented on the claim that are included in the payment. This itemization shall include but shall not be limited to all of the following items:

(1) The patient or enrollee's name.

(2) The Medicaid health insurance claim number.

(3) The date of each service.

(4) The patient account number assigned by the provider.

(5) The Current Procedural Terminology code for each procedure, hereinafter referred to as "CPT code", including the amount allowed and any modifiers and units.

(6) The amount due from the patient that includes but is not limited to copayments and coinsurance or deductibles.

(7) The payment amount of reimbursement.

(8) Identification of the plan on whose behalf the payment is made.

B. If a managed care organization is a secondary payer, then the organization shall send, in addition to all information required by Subsection A of this Section, acknowledgment of payment as a secondary payer, the primary payer's coordination of benefits information, and the third-party liability carrier code.

C.(1) If the claim for payment is denied in whole or in part by the managed care organization or by a fiscal agent or intermediary of the organization, and the denial is remitted in the standard paper format, then the organization shall, in addition to providing all information required by Subsection A of this Section, include a claim denial reason code specific to each CPT code listed that matches or is equivalent to a code used by the state or its fiscal intermediary in the fee-for-service Medicaid program.

(2) If the claim for payment is denied in whole or in part by the managed care organization or by a fiscal agent or intermediary of the plan, and the denial is remitted electronically, then the organization shall, in addition to providing all information required by Subsection A of this Section, include an American National Standards Institute compliant reason and remark code and shall make available to the provider of the service a complimentary standard paper format remittance advice that contains a claim denial reason code specific to each CPT code listed that matches or is equivalent to a code used by the state or its fiscal intermediary in the fee-for-service Medicaid program.

D. Each CPT code listed on the approved Medicaid fee-for-service fee schedule shall be considered payable by each Medicaid managed care organization or a fiscal agent or intermediary of the organization.

Section 2. The Department of Health and Hospitals shall be prohibited from amending or otherwise altering the existing Bayou Health plans per member per month contractual rates which are in effect on the effective date of this Act for any purpose which is related to the implementation of the provisions of this Act.

Section 3. 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.

The original instrument was prepared by Christopher D. Adams. The following digest, which does not constitute a part of the legislative instrument, was prepared by J. Ashley Mitchell.

DIGEST

Murray (SB 185)

Proposed law provides definitions.

Proposed law provides an exemption to the provisions of the proposed law for any entity contracted with the Department of Health and Hospitals to provide fiscal intermediary services in processing claims of the health care providers.

Proposed law provides for provider credentialing. Proposed law requires managed care organizations requiring a health care provider to be credentialed, recredentialed, or approved prior to rendering health care services to a Medicaid recipient within 90 days from the date receiving the information needed for credentialing.

Proposed law provides for a managed care organization informing an applicant within 30 days of the date of the receipt of the application of all defects and reasons known for the application being deemed incorrectly completed.

Proposed law provides for a managed care organization informing an applicant in the event verification or a verification supporting statement not received within 60 days of the date of the managed care organization's request.

Proposed law provides for interim credentialing requirements.

Proposed law provides for prepaid coordinated care network pharmaceutical and therapeutic committees. Such committees will be responsible for developing a drug formulary and preferred drug list for the prepaid coordinated network.

Proposed law provides for the committees to hold public meetings at least semi-annually in Baton Rouge. Such meetings must permit public comments.

Proposed law provides DHH will not implement the pharmacopoeia authorized by the proposed law until the initial pharmacopoeia is submitted to and approved by the Senate and House committees on health and welfare. Proposed law provides the Senate and House committees on health and welfare may only approve or reject the pharmacopoeia and may not add specific drugs to or delete specific drugs from the pharmacopoeia.

Proposed law provides beginning January 1, 2014, managed care organizations shall utilize a single page prior authorization form promulgated by the department, DHH, pursuant to the Administrative Procedure Act.

Proposed law provides a managed care provision shall comply with the exceptions to prior authorization pursuant to present law.

Proposed law provides managed care organizations utilizing step therapy or fail first protocols will comply with the proposed law. Proposed law provides when medications for the treatment of any medical condition will be restricted for use by a managed care organization by a step therapy or fail first protocol, the prescribing physician will be provided with and have access to a clear and convenient process to request an override. Proposed law provides an override will be granted under the following circumstances:

(1) The prescribing physician demonstrates to the managed care organization, based on sound clinical evidence, the preferred treatment required under step therapy or fail

first protocol has been ineffective in the treatment of the Medicaid enrollee's disease or medical condition.

(2) The prescribing physician demonstrates to the managed care organization, based on sound clinical evidence, the preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the Medicaid enrollee and known characteristics of the drug regimen.

(3) The prescribing physician demonstrates to the managed care organization, based on sound clinical evidence, the preferred treatment required under the step therapy or fail first protocol causes or likely causes an adverse reaction or other physical harm to the Medicaid enrollee.

Proposed law provides the duration of any step therapy or fail first protocol will not be longer than the customary period for the medication when such treatment is demonstrated by the prescribing physician to be clinically ineffective.

Prohibits the Department of Health and Hospitals from amending or altering the existing Bayou Health plans per member per month contractual rates in effect as of the effective date of the Act for any purpose which is related to the implementation of the provisions of the Act.

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

(Adds R.S. 46:460.31-460.32, 460.41-460.42, 460.51-460.53, and 460.71)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Health and Welfare to the original bill

1. Removes the Medicaid Managed Care Pharmaceutical and Therapeutics Committee.

2. Exempts from the provisions any entity contracted with the Department of Health and Hospitals to provide fiscal intermediary services in processing claims of the health care providers.

3. Provides for the prepaid coordinated care network pharmaceutical and therapeutic committees.

4. Provides that a managed care organization comply with the exceptions to prior authorization in present law.

5. Provide for claim payment information and claim payment for care rendered to newborns.

6. Technical changes.

Committee Amendments Proposed by Senate Committee on Finance to the engrossed bill

1. Deletes provisions for services rendered to newborns.

2. Prohibits the Department of Health and Hospitals from amending or altering the existing Bayou Health plans per member per month contractual rates in

effect as of the effective date of the Act for any purpose which is related to the implementation of the provisions of the Act.

Senate Floor Amendments to engrossed bill

1. Makes Legislative Bureau technical changes.