

2023 Regular Session

HOUSE BILL NO. 434

BY REPRESENTATIVE MCFARLAND

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

MEDICAID: Provides relative to the state medical assistance program

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~~~~

1 ~~defining measures to be reported on a quarterly basis, as well as~~ all of the following
2 data on healthcare provider claims delineated by ~~an individual~~ a Medicaid managed
3 care organization including any dental Medicaid managed care organization
4 ~~contracted by the department and separated by claim provider type and shall be~~
5 separately reported for both acute care and behavioral health claims:

6 (1) ~~The following data on claims submitted by all healthcare providers~~
7 ~~except behavioral health providers based on data of payment during calendar year~~
8 ~~2017:~~

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

13 (b) ~~The total number and dollar amount of claims denied at the service line~~
14 ~~level:~~

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

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

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

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

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

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

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

1 ~~(j)(9)~~ For each managed care organization, a listing of the top ~~of the five~~
2 ~~network billing participating~~ providers with the highest number of total denied
3 claims, that includes 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 (10) The total number 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.

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

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

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

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

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

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

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

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

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

- 1 ~~(e) The total number and dollar amount of adjusted claims.~~
- 2 ~~(f) The total number and dollar amount of voided claims.~~
- 3 ~~(g) The total number and dollar amount of duplicate claims.~~
- 4 ~~(h) The total number and dollar amount of rejected claims.~~
- 5 ~~(i) The total number and dollar amount of pending claims.~~
- 6 ~~(j) For each of the five network billing providers with the highest number of~~
7 ~~total denied claims, the number of total denied claims expressed as a ratio to all~~
8 ~~claims adjudicated and the total dollar value of the claims. Provider information~~
9 ~~shall be de-identified.~~

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

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

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

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

22 ~~(4) Claims denied in error by managed care organizations.~~

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

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

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

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

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

4 (1) The total number of ~~Medicaid enrollees receiving case management~~
5 ~~services.~~ individuals identified for case management delineated by all of the
6 following:

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

8 (b) The reason identified for case management.

9 (c) The Louisiana Department of Health region.

10 (2) The total number of ~~Medicaid enrollees eligible for case management~~
11 ~~services.~~ individuals who accepted and enrolled in case management services
12 delineated by all of the following:

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

14 (b) The reason identified for case management.

15 (c) The tier assignment as required by the contract executed by the managed
16 care organization and this state.

17 (d) The Louisiana Department of Health region.

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

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

21 (b) The reason identified for case management.

22 (c) The Louisiana Department of Health region.

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

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

27 E. The quarterly reports shall include all of the following information
28 relating to utilization management delineated by Medicaid managed care
29 organizations:

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

2 (2) The percentage of standard prior authorization requests that were
3 approved, delineated for all items and services subject to prior authorization.

4 (3) The percentage of standard prior authorization requests that were denied,
5 delineated for all items and services subject to prior authorization.

6 (4) The percentage of standard prior authorization requests that were
7 approved after appeal, delineated for all items and services subject to prior
8 authorization.

9 (5) The percentage of expedited prior authorization requests that were
10 approved, delineated for all items and services subject to prior authorization.

11 (6) The percentage of expedited prior authorization requests that were
12 denied, delineated for all items and services subject to prior authorization.

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, delineated for all items and services subject to prior authorization.

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

19 Section 2. This Act shall become effective upon signature by the governor or, if not
20 signed by the governor, upon expiration of the time for bills to become law without signature
21 by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If
22 vetoed by the governor and subsequently approved by the legislature, this Act shall become
23 effective on the day following such approval.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 434 Engrossed

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 further requires the quarterly report to include the total number of individuals identified for case management delineated 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 La. Dept. of Health region.

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)

Summary of Amendments Adopted by House

The Committee Amendments Proposed by House Committee on Health and Welfare to the original bill:

1. Delete the requirement for tier assignment information to be included in the quarterly report required by proposed law.
2. Specify that the total number of individuals who are accepted and enrolled in case management services shall be included in the quarterly report.
3. Make technical corrections.