2017 Regular Session

HOUSE BILL NO. 492

BY REPRESENTATIVES MAGEE, HOFFMANN, AND STOKES

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

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

AN ACT

To amend and reenact R.S. 40:1253.2(A)(introductory paragraph) and (3)(f) and (g), 1253.3(B), and 1253.4(A) and R.S. 46:460.31(introductory paragraph) and (4) and 460.51(5) and (8) and to enact R.S. 40:1253.2(A)(3)(h), R.S. 46:460.51(13), and Subpart D of Part XIII of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 46:460.81 through 460.88, relative to the Louisiana Medicaid program; to provide for duties of the Louisiana Department of Health in administering the Medicaid managed care program; to correct references to the name of such program; to establish a process for review of healthcare provider claims submitted to Medicaid managed care organizations; to provide for reviews of claim payment determinations which are adverse to healthcare providers; to provide for appeals of decisions rendered through such review process; to establish a panel for selection of independent reviewers; to provide reporting requirements; to provide for penalties; to provide for administrative rulemaking; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 40:1253.2(A)(introductory paragraph) and (3)(f) and (g), 1253.3(B), and 1253.4(A) are hereby amended and reenacted and R.S. 40:1253.2(A)(3)(h) is hereby enacted to read as follows:

§1253.2. ~~Bayou Health~~ Medicaid managed care program; reporting

A. The Louisiana Department of Health shall submit an annual report concerning the Louisiana Medicaid ~~Bayou Health~~ managed care program and, if not included within ~~the Bayou Health~~ that program, any managed care program providing dental benefits to Medicaid enrollees to the Senate and House committees on health and welfare. The department shall submit the report ~~shall be submitted~~ by June thirtieth every year, and the applicable reporting period shall be for the previous state fiscal year except for those measures that require reporting of health outcomes which shall be reported for the calendar year prior to the current state fiscal year. The report shall include:

* * *

(3) The following information related to healthcare services provided by healthcare providers to Medicaid enrollees enrolled in each of the managed care organizations:

* * *

(f)(i) The total number of independent reviews conducted pursuant to R.S. 46:460.81 et seq., delineated by provider type for each managed care organization.

(ii) The total number and percentage of adverse determinations overturned as a result of an independent review conducted pursuant to R.S. 46:460.81 et seq., delineated by provider type for each managed care organization.

(g) The following information concerning pharmacy benefits delineated by each managed care organization and by month:

(i) Total number of prescription claims.

(ii) Total number of prescription claims subject to prior authorization.

(iii) Total number of prescription claims denied.

(iv) Total number of prescription claims subject to step therapy or fail first protocols.

~~(g)~~ (h) The report shall include the following information concerning Medicaid drug rebates and manufacturer discounts delineated by each managed care

organization and the prescription benefit manager contracted or owned by the managed care organization and by month:

(i) Total dollar amount of the Medicaid drug rebates and manufacturer discounts collected and used.

(ii) Total dollar amount of Medicaid drug rebates and manufacturer discounts collected and remitted to the Louisiana Department of Health.

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§1253.3. Louisiana Behavioral Health Partnership; reporting

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B. Upon the integration of behavioral health services into the Louisiana Medicaid Bayou Health managed care program, or any successor, the final report produced pursuant to this Section for the period starting July 1, 2015, shall be issued by June 30, 2016, or six months following the integration date, whichever occurs later, and subsequent behavioral health reporting shall be included in the report produced pursuant to R.S. 40:1253.2.

§1253.4. Louisiana Department of Health information

A. The Louisiana Department of Health shall make available to the public all informational bulletins, health plan advisories, and guidance published by the department concerning the Louisiana Medicaid ~~Bayou Health~~ managed care program. ~~Such information shall be published and made~~ The department shall publish and make such information available to the public on ~~the department's~~ its website.

* * *

Section 2. R.S. 46:460.31(introductory paragraph) and (4) and 460.51(5) and (8) are hereby amended and reenacted and R.S. 46:460.51(13) and Subpart D of Part XIII of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, comprised of R.S. 46:460.81 through 460.88, are hereby enacted to read as follows:

§460.31. Definitions

As used in this Part, the following terms ~~shall~~ have the meaning ascribed to them in this Section unless the context clearly indicates otherwise:

* * *

(4) "Prepaid coordinated care network" means a private entity that contracts with the department to provide Medicaid benefits and services to enrollees of the Medicaid ~~coordinated~~ managed care program ~~known as "Bayou Health"~~ in exchange for a monthly prepaid capitated amount per member.

* * *

§460.51. Definitions

As used in this Part, the following terms have the meaning ascribed in this Section unless the context clearly indicates otherwise:

* * *

(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~~ person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution that provides health care or professional services to individuals enrolled in the Medicaid program.

* * *

(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~~ managed care program enrollees in exchange for a monthly prepaid capitated amount per member.

* * *

(13) "Adverse determination" means any of the following relative to a claim by a provider for payment for a health care service rendered by the provider to an enrollee of the Medicaid managed care organization:

(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.

(c) A decision by a managed care organization that results in recoupment of the payment of a claim.

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SUBPART D. MEDICAID MANAGED CARE

INDEPENDENT CLAIMS REVIEW PROCESS

§460.81. Right of providers to independent review; applicability

A. If a provider's claim is subject to an adverse determination evidenced in a remittance advice or other written or electronic notice from a managed care organization, then the provider shall have a right to an independent review of the adverse action taken by the managed care organization. Such independent review shall be governed by the provisions of this Subpart and any applicable rules and regulations promulgated by the department pursuant to the Administrative Procedure Act. The provisions of this Subpart shall not otherwise prohibit or limit any alternative legal or contractual remedy available to a provider to contest the partial or total denial of a claim for payment for healthcare services. Any contractual provision executed between a provider and a managed care organization which seeks to limit or otherwise impede the appeal process as set forth in this Subpart shall be null, void, and deemed to be contrary to the public policy of this state.

B. The provisions of this Subpart shall not apply to any adverse determination associated with a claim filed with a managed care organization prior to January 1, 2018, regardless of whether the claim is re-filed after that date. For all adverse determinations related to claims filed on or after January 1, 2018, the state shall not mandate that the provider and managed care organization resolve the claim payment dispute through arbitration.

C. An adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review under the provisions of this Subpart.

§460.82. Procedure for independent review

The following procedure shall govern the process for independent review of an adverse determination taken against a provider by a managed care organization:

(1) A provider shall submit a written request for reconsideration to the managed care organization that identifies the claim or claims in dispute, the reasons for the dispute, and any documentation supporting the provider's position or request by the managed care organization within one hundred eighty days from one of the following dates:

(a) The date on which the managed care organization transmits remittance advice or other notice electronically, or the date of postmark if the remittance advice or other notice is provided in a nonelectronic format.

(b) Sixty days from the date the claim was submitted to the managed care organization if the provider receives no remittance advice or other written or electronic notice from a managed care organization either partially or totally denying the claim.

(c) The date on which the managed care organization recoups monies remitted for a previous claim payment.

(2) The managed care organization shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with Paragraph (1) of this Subsection within five calendar days after receipt of the request. The managed care organization shall render a final decision and provide a response to the provider within forty-five calendar days from the date of receipt of the request for reconsideration, unless a longer time to completely respond is agreed upon in writing by the provider and the managed care organization.

(3)(a) Pursuant to the reconsideration request, if the managed care organization upholds the adverse determination or does not respond to the request

within the time frames allowed in this Section, then the provider may file a written notice with the department requesting the adverse action be submitted to an independent reviewer as provided for in this Subpart. The notice requesting an independent review shall be received by the department within sixty days from either the date the provider receives notice of the decision of the reconsideration request; or, if the managed care organization does not respond to the reconsideration request within the time frames allowed in this Section, the last date of the time period allowed for the managed care organization to respond.

(b) The department shall provide by rule for the appropriate address to be used by the provider for submission of the notice required by this Section. The provider shall include a copy of the written request for reconsideration with the request for an independent review.

(c) If the managed care organization reverses the adverse determination pursuant to a request for reconsideration, payment of the claim or claims in dispute shall be paid no later than twenty days from the date of the decision.

(4)(a) Upon receipt of a notice of request for independent review and all required supporting information and documentation, the department shall refer the adverse determination to an independent reviewer. The department shall use best efforts to refer an equal proportion of the total number of disputed claims to each independent reviewer.

(b) Subject to approval by the department, a provider may aggregate multiple adverse determinations involving the same managed care organization when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law. The sole fact that a claim is not paid does not create a common substantive question of fact or law unless the provider has received no remittance advice or other written or electronic notice from a managed care organization either partially or totally denying a claim within sixty calendar days of receipt of the claim by the managed care organization and the claims involve a common substantive question of fact or law.

(5)(a) Within fourteen calendar days of receipt of the request for independent review, the independent reviewer shall request in writing that both the provider and the managed care organization provide the reviewer all information and documentation regarding the disputed claim or claims. The independent reviewer shall request the provider and managed care organization to identify all information and documentation that has been submitted by the provider to the managed care organization regarding the disputed claim or claims. Further, the independent reviewer shall advise the managed care organization and the provider that he will not consider any information or documentation not received within thirty calendar days of receipt of his request or any information submitted by the provider that was not submitted to the managed care organization as part of the request for reconsideration.

(b) If a provider elected to aggregate its claims, the independent reviewer may, upon request, allow for up to an additional thirty days for both the provider and managed care organization to provide relevant information related to the independent review requests.

(6)(a) If the independent reviewer determines that guidance on a medical issue from the department is required to make a decision, then the reviewer shall refer this specific issue to the department for review and response unless the department designates a different contact for this function by rule. Medical issues requiring referral may include the matter of whether a medical benefit is a covered service under the Medicaid program.

(b) The department may respond to the request or refer it to an independent contractor. The response to a request to determine whether a service received was medically necessary must be provided by a physician who is licensed by the state of Louisiana and actively practices in the same medical specialty. The department shall provide a concise response to the request within ninety calendar days after receipt.

(7)(a) Upon receipt of the information requested from the provider and managed care organization or the lapse of the time period for the managed care organization and provider to submit information along with receipt of any applicable

responses from the department for guidance on medical issue, the independent reviewer shall examine all materials submitted and render a decision on the dispute within sixty calendar days. However, the independent reviewer may request in writing an extension of time from the department to resolve the dispute. If an extension of time is granted by the department, then the independent reviewer shall provide notice of the extension of time to both the provider and the managed care organization involved in the dispute.

(b) In reaching a decision, the independent reviewer shall not consider any information or documentation from the provider that the provider did not submit to the managed care organization during the managed care organization's review of the provider's request for reconsideration of the adverse determination.

(8) Upon rendering a decision, the independent reviewer shall send to the managed care organization, the provider, and the department a copy of the decision. Once the independent reviewer renders a decision requiring a managed care organization to pay any claims or portion of the claims, then the managed care organization shall send the payment in full along with interest back to the date the claim was originally denied or recouped to the provider within twenty calendar days of the date of the reviewer's decision.

§460.83. Independent review; judicial appeal

Within sixty calendar days of an independent reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the independent reviewer's decision and to recover any funds awarded by the independent reviewer to the other party. Any claim concerning an independent reviewer's decision not brought within sixty calendar days of the decision shall be barred indefinitely. Suits filed pursuant to this Section shall be conducted in accordance with applicable provisions of the Louisiana Code of Civil Procedure, and the review by the court will be de novo without regard to the independent reviewer's decision. The independent reviewer and any person who assisted the independent reviewer in reaching a decision shall be prohibited from testifying at the court proceeding considering the

independent reviewer's decision. Venue shall be proper in the district court for the parish where either the healthcare provider or the managed care organization is domiciled, and the district court for that parish has exclusive jurisdiction thereof. If the dispute between the parties is not fully resolved prior to the entry of a final decision by the court initially hearing the dispute, then the prevailing party shall be entitled to an award of reasonable attorney fees and expenses from the nonprevailing party. For purposes of this Section, "reasonable attorney fees" means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate, and shall not exceed ten percent of the total monetary amount in dispute or five hundred dollars, whichever amount is greater.

§460.84. Costs

A. The fee for conducting an independent review shall in all cases be paid to the independent reviewer by the managed care organization. A provider shall, within ten days of the date of the decision of the independent reviewer, reimburse a managed care organization for the fee associated with conducting an independent review when the decision of the managed care organization is upheld. If the provider fails to submit payment for the independent review within ten days from the date of the decision, the managed care organization may withhold future payments to the provider in an amount equal to the cost of the independent review; however, the managed care organization shall ensure that such a withholding is clearly delineated on the remittance advice. If a provider fails to properly reimburse the managed care organization, the department may prohibit that provider from future participation in the independent review process.

B. The managed care organization shall compensate the independent reviewer within thirty calendar days of receipt by the managed care organization of the reviewer's bill for services rendered. If the managed care organization fails to pay the bill for the independent reviewer's services, then the reviewer may request payment directly from the department from any funds held by the state that are payable to the managed care organization.

§460.85. Independent reviewer selection panel; procedure

A. The Independent Reviewer Selection Panel is hereby created within the department and shall consist of the secretary or his duly designated representative and the following members appointed by the secretary:

(1) Two provider representatives.

(2) Two managed care organization representatives.

B. All decisions of the panel shall be made by a majority vote. The panel shall meet at least twice per year. Panel members shall serve without compensation.

C. The panel shall:

(1) Select a chairperson.

(2) Select and identify an appropriate number of independent reviewers and determine a uniform rate of compensation per review to be paid to each reviewer.

(3) Continually review the number and outcome of requests for reconsideration and independent reviews on an aggregated basis. The panel shall not be provided any patient identifying information for any reason.

D. The secretary shall report to the panel the name of any provider who submits ten or more requests for independent review along with the percentage of adverse determinations that are overturned.

§460.86. Independent reviewers

Each managed care organization shall utilize only independent reviewers who are selected in accordance with R.S. 46:460.85, and shall comply with the provisions of this Subpart in the resolution of disputed adverse determinations.

§460.87. Penalties

A managed care organization found by the secretary to be in violation of any provision of this Subpart shall be subject to a penalty of up to twenty-five thousand dollars per violation. In addition, if a managed care organization is subject to more than fifty independent reviews and the percentage of adverse determinations overturned in favor of providers is greater than twenty-five percent, the managed

care organization may be subject to a penalty of up to twenty-five thousand dollars per occurrence over the twenty-five percent threshold.

§460.88. Rules and regulations

The department shall promulgate all rules and regulations in accordance with the Administrative Procedure Act as may be necessary to effectuate and implement the provisions of this Subpart.

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 492 Engrossed 2017 Regular Session Magee

Abstract: Establishes and provides for an independent claims review process within the Medicaid managed care program.

Present law provides for definitions, requirements, limitations, and exemptions relative to the Medicaid managed care program of this state. Provides for duties of the Louisiana Department of Health (LDH), and of managed care organizations (MCOs) contracted with the state to coordinate delivery of healthcare services to Medicaid enrollees, in operating the Medicaid managed care program. Proposed law retains present law.

Proposed law creates and provides for a process through which denial by MCOs of claims submitted by healthcare providers for payment for healthcare services rendered to Medicaid enrollees may be reviewed, and adverse determinations concerning those claims may be reconsidered.

Proposed law stipulates that it shall not:

(1) Otherwise prohibit or limit any alternative legal or contractual remedy available to a healthcare provider to contest the partial or total denial by an MCO of a claim for payment for healthcare services.

(2) Apply to any adverse determination associated with a claim filed with an MCO prior to January 1, 2018, regardless of whether the claim is re-filed after that date.

Proposed law provides that for all adverse determinations related to claims filed on or after January 1, 2018, the state shall not mandate that the provider and MCO resolve the claim payment dispute through arbitration.

Proposed law stipulates that an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review pursuant to proposed law.

Proposed law establishes the following procedure for independent review of adverse determinations by MCOs concerning healthcare provider claims:

(1) The provider shall submit a written request for reconsideration to the MCO that identifies the claim or claims in dispute, the reasons for the dispute, and any

documentation supporting the provider's position or request by the MCO within 180 days from one of the following dates:

(a) The date on which the MCO transmits remittance advice or other notice electronically, or the date of postmark if the remittance advice or other notice is provided in a non-electronic format.

(b) 60 days from the date the claim was submitted to the MCO if the provider receives no remittance advice or other written or electronic notice from an MCO either partially or totally denying the claim.

(c) The date on which the MCO recoups monies remitted for a previous claim payment.

(2) The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with proposed law within five calendar days after receipt of the request and shall render a final decision and provide a response to the provider within 45 calendar days from the date of receipt of the request for reconsideration, unless a longer time to completely respond is agreed upon in writing by the provider and the MCO.

(3) Pursuant to the reconsideration request, if the MCO upholds the adverse determination or does not respond to the request within the time frames allowed in proposed law, then the provider may file a written notice with LDH requesting the adverse action be submitted to an independent reviewer as authorized in proposed law.

(4) Upon receipt of a notice of request for independent review and all required supporting information and documentation, LDH shall refer the adverse determination to an independent reviewer.

(5) Within 14 calendar days of receipt of the request for independent review, the independent reviewer shall request in writing that both the provider and the MCO provide all information and documentation regarding the disputed claim or claims. The reviewer shall advise the MCO and the provider that he will not consider any information or documentation not received within 30 calendar days of receipt of his request or any information submitted by the provider that was not submitted to the MCO as part of the request for reconsideration.

(6) If the independent reviewer determines that guidance on a medical issue from LDH is required to make a decision, then the reviewer shall refer this specific issue to the department for review and response unless the department designates a different contact for this function by rule.

(7) Upon receipt of the information requested from the provider and MCO or the lapse of the time period for submission, the independent reviewer shall examine all materials submitted and render a decision on the dispute within 60 calendar days. However, the reviewer may request in writing an extension of time from LDH to resolve the dispute. If an extension of time is granted, then the reviewer shall provide notice of the extension to both the provider and the MCO.

(8) Upon rendering a decision, the independent reviewer shall send to the MCO, the provider, and LDH a copy of the decision. Once the reviewer renders a decision requiring an MCO to pay any claims or a portion thereof, then the MCO shall send the payment in full along with interest back to the date the claim was originally denied or recouped to the provider within 20 calendar days of the date of the reviewer's decision.

Proposed law provides that within 60 calendar days of an independent reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the independent reviewer's decision and to recover any funds awarded by the independent reviewer to the other party. Provides that any claim concerning an independent reviewer's decision not brought within 60 calendar days of the decision shall be barred indefinitely. Provides further that suits filed pursuant to proposed law shall be conducted in accordance with proposed law and applicable provisions of present law (La. Code of Civil Procedure).

Proposed law requires that the fee for conducting an independent review shall in all cases be paid by the MCO. Stipulates, however, that a provider shall, within 10 days of the date of the review decision, reimburse an MCO for the fee associated with the review if the decision of the MCO is upheld. Further stipulates that if the provider fails to submit this payment as required, the MCO may withhold future payments to the provider in an amount equal to the cost of the review. Requires in these cases that the MCO ensure that the withholding is clearly delineated on the remittance advice.

Proposed law creates the Independent Reviewer Selection Panel within LDH. Provides that the panel shall consist of the secretary of the department or the secretary's duly designated representative and the following members:

(1) Two healthcare provider representatives appointed by the secretary.

(2) Two MCO representatives appointed by the secretary.

Proposed law requires that all decisions of the panel be made by majority vote and that the panel shall meet at least twice per year. Stipulates that panel members shall serve without compensation.

Proposed law requires that the panel do all of the following:

(1) Select a chairperson.

(2) Select and identify an appropriate number of independent reviewers and determine a uniform rate of compensation per review to be paid to each reviewer.

(3) Continually review the number and outcome of requests for reconsideration and independent reviews on an aggregated basis.

Proposed law prohibits provision of any patient identifying information to the panel.

Proposed law requires MCOs to utilize only independent reviewers who are selected by the panel in accordance with proposed law.

Proposed law provides that any MCO found to be in violation of proposed law shall be subject to a penalty of up to $25,000 per violation. Additionally, provides that if an MCO is subject to more than 50 independent reviews and the percentage of adverse determinations overturned in favor of providers is greater than 25%, the MCO may be subject to a penalty of up to $25,000 per occurrence over the 25% threshold.

Present law relative to Medicaid transparency (R.S. 40:1253.1 et seq.) requires LDH to prepare and submit to the legislative committees on health and welfare an annual report concerning specific aspects of the Medicaid managed care program.

Proposed law retains present law and adds thereto a requirement that report include the following information:

(1) The total number of independent claim reviews conducted pursuant to proposed law, delineated by provider type, for each MCO.

(2) The total number and percentage of adverse determinations overturned as a result of an independent claim review conducted pursuant to proposed law, delineated by provider type, for each MCO.

Proposed law revises references to the name "Bayou Health" which had formerly been applied to the Medicaid managed care program.

(Amends R.S. 40:1253.2(A)(intro. para.) and (3)(f) and (g), 1253.3(B), and 1253.4(A) and R.S. 46:460.31(intro. para.) and (4) and 460.51(5) and (8); Adds R.S. 40:1253.2(A)(3)(h) and R.S. 46:460.51(13) and 460.81-460.88)

Summary of Amendments Adopted by House

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

1. Reduce the time period within which a healthcare provider is required to submit a written request for reconsideration of claim denial to a Medicaid managed care organization (MCO) from within 365 days from certain specified dates to within 180 days from one of those dates.

2. Change one of the specified dates commencing the time period within which a provider is required to submit a written request for reconsideration of claim denial to an MCO from the date on which the provider receives remittance advice or other written or electronic notice from the MCO denying the claim to the date on which the MCO transmits remittance advice or other notice electronically, or the date of postmark if the remittance advice or other notice is provided in a nonelectronic format.

3. Extend the time period within which the MCO must render a final decision and provide a response to the provider regarding a request for reconsideration of claim denial from 30 calendar days from the date of receipt of the request to 45 calendar days from that date.

4. Revise a provision requiring that an MCO, pursuant to a claim denial being overturned by an independent review, shall send payment in full along with interest back to the date the claim was denied or recouped to specify that this date is the date on which the claim was originally denied or recouped.

5. Require that a provider, within 10 days of the date of the independent review decision, shall reimburse an MCO for the fee associated with conducting the review if the decision of the MCO is upheld.

6. Stipulate that if the provider fails to submit payment for the independent review within 10 days from the date of the review decision, the MCO may withhold future payments to the provider in an amount equal to the cost of the review, and that the MCO shall ensure that such a withholding is clearly delineated on the remittance advice.

7. Revise a provision subjecting MCOs found to be in violation of proposed law to a penalty of exactly $25,000 per violation to provide that the amount of such penalty shall be up to $25,000.

8. Delete a provision authorizing an additional penalty of $25,000 to be imposed for each occurrence of an MCO exceeding 10% of adverse determinations over a 12-month period overturned as the result of an independent review.

9. Add a provision stipulating that if an MCO is subject to more than 50 independent reviews and the percentage of adverse determinations overturned in favor of providers is greater than 25%, then the MCO may be subject to an additional penalty of up to $25,000 per occurrence over the 25% threshold.

10. Make technical changes.