LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **HB 424** HLS 19RS 719
Bill Text Version: **ENGROSSED**
Opp. Chamb. Action:
Proposed Amd.:
Sub. Bill For.:

Date: May 1, 2019 12:50 PM
Author: STAGNI
Dept./Agy.: LDH/Medicaid
Subject: provider claims/prior authorizations
Analyst: Shawn Hotstream

MEDICAID EG SEE FISC NOTE GF EX See Note

Provides relative to denials of provider claims and prior authorization requests by Medicaid managed care organizations

Proposed law provides that if a claim is denied by a managed care organization (MCO) based upon an opinion or interpretation by the managed care organization of a law, regulation, policy, procedure, or medical criteria/guideline, then the MCO shall provide with the remittance advice either instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria/guideline in the public domain or an actual copy of the aforementioned.

Proposed law provides that prior authorization requirements LDH and MCO's shall be based on publicly available clinical criteria and posted in an easily searchable format on the respective websites of the MCO's and department.

EXPENDITURES	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**5 -YEAR TOTAL**
State Gen. Fd.	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

REVENUES	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**5 -YEAR TOTAL**
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
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	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

EXPENDITURE EXPLANATION

This measure requires Medicaid Managed Care Organizations (MCO's) to include certain information on both Prior Authorization (PA) denial notices and Medicaid claims denial notices that are sent to providers. Medicaid managed care organizations are anticipated to incur additional costs in the event the health plans would be required to hire staff to develop and maintain their own evidence based criteria. However, the extent of the administrative cost to the plans is indeterminable. Any administrative impact to the health plans as a result of this measure will be considered by the actuaries in the calculation of an actuarially sound capitation rate. The Louisiana Department of Health indicates these requirements are anticipated to result in a significant costs to MCO's of approximately $10 M annually, and such costs would be reimbursed from Medicaid to the health plans in the capitated payments. The fiscal impact is based on $2 M in additional costs to each Medicaid MCO to re create a clinical criteria model for determining medical necessity.

Prior Authorization denials:
If a prior authorization request is denied by an MCO or the department based upon medical criteria, this measure requires the medical criteria to be made accessible in the public domain. Requiring Medicaid Managed Care Organizations (MCO's) to make clinical criteria publicly available is anticipated to have a significant fiscal impact on MCO's. Louisiana MCO's utilize products from third party vendors that provide nationally utilized evidence based clinical criteria for prior authorization decisions. LDH reports this criteria is proprietary and confidential. MCO's could no longer utilize this criteria from its exiting contractors, and would be required to develop their own evidence based criteria, or seek other vendors. Note: To the extent the plans would no longer contract with third party vendors, the plans would realize some contractual savings.

Claim denials:
This measure also requires Medicaid MCO's to include certain claims denial information in their electronic remittance advice (ERA) transmissions or equivalent claim denial notices. LDH indicates in some cases some MCO's would be required to send notices on paper instead of electronically, resulting in some indeterminable but minimal impact to the health plans.

REVENUE EXPLANATION

There is no anticipated direct material effect on governmental revenues as a result of this measure.

Senate Dual Referral Rules

☐ 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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