DIGEST

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HB 565 Engrossed 2025 Regular Session Spell

Abstract: Provides relative to third-party liability and claim adjudication within the state medical assistance program.

Present law requires any claim payment to a provider by a managed care organization, a fiscal agent, or an intermediary of the managed care organization to be accompanied by an itemized accounting of the individual services represented on the claim that are included in the payment. Present law further provides what should be included in this itemization.

Proposed law retains present law.

Present law provides that if a managed care organization is a secondary payer, then the organization shall send, in addition to all information required by present law (R.S. 46:460.71(A)), acknowledgment of payment as a secondary payer, the primary payer's coordination of benefits information, and the third-party liability carrier code.

Proposed law retains present law.

Present law also provides the procedure for what happens when a claim for payment is denied in standard paper format or electronically. Proposed law retains present law.

Proposed law prohibits a managed care organization from amending, modifying, or changing in any manner a claim submitted by a healthcare provider or from adjusting, down-coding, or paying a claim at a lower level of service than what was submitted by the healthcare provider, unless the secretary of the department promulgates a rule in accordance with proposed law.

Proposed law provides that proposed law shall not prohibit a managed care organization from conducting required post-payment reviews and audits, and taking action as a result of such reviews and audits.

Proposed law provides that any violation of proposed law shall result in the La. Dept. of Health (LDH) withholding payment to the managed care organization. Proposed law further provides that the withheld amount, which shall be determined by LDH, shall not be less than $25,000 for each violation.

Proposed law provides that the department may promulgate rules in accordance with the Administrative Procedure Act that authorize a statewide policy for managed care organizations to

adjudicate payment of claims in a manner that would otherwise violate proposed law. Such rule shall become effective only upon the approval of the Senate health and welfare committee and the House health and welfare committee, meeting separately or jointly.

Proposed law requires LDH to provide all known information about any health insurer or other third party that is legally liable for payment of all or part of a claim for healthcare services furnished under the Medicaid state plan for a Medicaid enrollee on the Medicaid Eligibility Verification System.

Proposed law requires a managed organization to provide notification to LDH no later than two business days from the date the managed care organization verifies or has knowledge of the existence of any health insurer or other third party that is legally liable for payment of all or part of a claim for healthcare services furnish under the Medicaid state plan to an enrollee when the health insurer or other liable third party is not reflected on the Medicaid Eligibility Verification System.

Proposed law requires the notification to include, at a minimum, the following information about the other health insurance:

(1) The name, address, and phone number of the health insurer or other liable third party.

(2) The policyholder information, including the policyholder name, policy number, and group number.

(3) The scope of coverage of the liable third party, if the scope of coverage is limited.

(4) The effective date of coverage.

(5) Any other information required by the department.

Proposed law allows LDH to promulgate, by rule or inclusion, any additional requirements in the managed care organization manual as are necessary for the implementation of proposed law.

Proposed law requires the department to cause the information contained in the notification to be reflected in the Medicaid Eligibility Verification System no later than three business days from receiving notice.

Proposed law prohibits a managed care organization from denying, pending, rejecting, or recouping a claim solely on the basis of the existence of a liable third party or primary coverage that is through other health insurance, unless all of the following information related to the other health insurance is available on the Medicaid Eligibility Verification System maintained by LDH:

(1) The name, address, and phone number of the health insurer or other liable third party.

(2) The policyholder information, including the policyholder name, policy number, and group number.

(3) The effective date of coverage by the liable third party or health insurance issuer and the scope of coverage of the liable third party or health insurance issuer, if the scope of coverage is limited.

Proposed law requires a managed care organization to provide written or electronic notification to a provider no later than five business days after the managed care organization receives payment from a liable third party for healthcare services rendered by the healthcare provider. Proposed law provides that the notice shall include the following:

(1) A copy of the explanation of benefits provided to the managed care organization as result of payment being made to the managed care organization for the healthcare services rendered by the healthcare provider.

(2) The name, address, and phone number of the health insurer or other liable third party.

(3) The policyholder information, including the policyholder name, policy number, and group number.

(4) The effective date of coverage

(5) The scope of coverage, if the scope of coverage is limited.

Proposed law requires LDH to withhold payment to the managed care organization in an amount to be determined by LDH.

Proposed law provides that the determined amount by LDH shall not be less than $25,000 for each violation of proposed law. Proposed law further provides that if LDH has determined that the managed care organization has committed multiple violations or engages in a pattern of violations, the minimum amount for each violation shall be at least $100,000.

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

(Adds R.S. 46:460.71(E) and 460.76.3)

Summary of Amendments Adopted by House

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

1. Require that in order for a managed care organization to amend, modify or change a claim submitted by a healthcare provider, the secretary of the department must promulgate a rule in accordance with proposed law.

2. Clarify the language from "adjudicating a payment of a claim" to "adjusting, down-coding, or paying a claim at a lower level of service than what was submitted."

3. State the department may promulgate rules in accordance with the APA for managed care organizations to adjudicate payment of claims and such rule shall only be effective upon approval of the Senate health and welfare committee and House health and welfare committee.

4. Require that the department shall provide all known information about any health insurer or other third party that is liable for payment of all or part of a claim for healthcare services furnished under the Medicaid state plan.

5. Change notification to the department from five business days to two business days from the date the managed care organization verifies or has knowledge of the existence of any health insurer or other third party that is liable for payment of all or part of a claim for healthcare services furnished under the Medicaid state plan to enrollee when the health insurer or other liable third party is not reflected on the Medicaid Eligibility Verification System.

6. Change the notification to include the "the name, address and phone number of the liable third party or health insurance issuer" to "the name, address, and phone number of the health insurer or other liable third party."

7. Require the inclusion of the effective date of coverage and the scope of coverage, if the scope of coverage is limited in the managed care organization's notice.

8. Delete the requirement that the department shall cause the information contained in the notification to be reflected in the Medicaid Eligibility Verification System no later than two business days from receiving a notice.