Directs DHH, beginning Jan. 1, 2014, and annually thereafter, to submit a report concerning the Medicaid coordinated care network initiative known as "Bayou Health" to the legislative committees on health and welfare which includes but is not limited to the following information:

(1) The name and geographic service area of each coordinated care network which has contracted with DHH.

(2) The total number of health care providers in each coordinated care network broken down by provider type and specialty and by each geographic service area. The initial report shall also include the total number of providers enrolled in the fee-for-service Medicaid program broken down by provider type and specialty for each geographic service area for the period, either calendar or state fiscal year, prior to the date of services initially being provided under Bayou Health.

(3) The total and monthly average of the number of members enrolled in each network broken down by eligibility group.

(4) The percentage of primary care practices that provide verified continuous phone access with the ability to speak with a primary care provider clinician within 30 minutes of member contact for each coordinated care network.

(5) The percentage of regular and expedited service authorization requests processed within the time frames specified by the contract for each coordinated care network. The initial report shall also include comparable metrics or regular and expedited service authorizations and time frames when processed by the Medicaid fiscal intermediary for the period, either calendar or state fiscal year, prior to the date of services initially being provided under Bayou Health.

(6) The percentage of clean claims paid for each provider type within 30 calendar days and the average number of days to pay all claims for each coordinated care network. The initial report shall also include the percentage of clean claims paid within 30 days by the Medicaid fiscal intermediary broken down by provider type for the period, either calendar or state fiscal year, prior to the date of services initially being provided under Bayou Health.

(7)(a) The number of claims denied or reduced by each coordinated care network for each of the following reasons:

(i) Lack of documentation to support medical necessity.
(ii) Prior authorization was not on file.
(iii) Member has other insurance that must be billed first.
(iv) Claim was submitted after the filing deadline.
(v) Service was not covered by the coordinated care network.
(vi) Due to process, procedure, notification, referrals, or any other required administrative function of a coordinated care network.

(b) The initial report shall also include the number of claims denied or reduced for each of the reasons set forth by the Medicaid fiscal intermediary for the period, either calendar or state fiscal year, prior to the date of services initially being provided under Bayou Health.

(8) The number and dollar value of all claims paid to non-network providers by claim type categorized by emergency services and nonemergency services for each coordinated care network by geographic service area.

(9) The number of members who chose the coordinated care network and the number of members who were autoenrolled into each coordinated care network, broken down by coordinated care network.

(10) The amount of the total payments and average per member per month payment paid to each coordinated care network.

(11) The medical loss ratio of each coordinated care network and the amount of any refund to the state for failure to maintain the required medical loss ratio.

(12) A comparison of health outcomes, which includes but is not limited to the following outcomes among each coordinated care network:

(a) Adult asthma hospital admission rate.
(b) Congestive heart failure hospital admission rate.
(c) Uncontrolled diabetes hospital admission rate.
(d) Adult access to preventative or ambulatory health services.
(e) Breast cancer screening rate.
(f) Well child visits.
(g) Childhood immunization rates.

(13) The initial report shall also include a comparison of health outcomes for each of the aforementioned metrics for the Medicaid fee-for-service program for the period, either calendar or state fiscal year, prior to the date of services initially being provided under Bayou Health.

(14) A copy of the member and provider satisfaction survey report for each coordinated care network.

(15) A copy of the annual audited financial statements for each coordinated care network.

(16) The total amount of savings to the state for each shared savings coordinated care network.

(17) A brief factual narrative describing any sanctions levied by DHH against a coordinated care network.

(18) The number of members, broken down by each coordinated care network, who file a grievance or appeal and the number of members who accessed the state fair hearing process and the total number and percentage of grievances or appeals which reversed or otherwise resolved a decision in favor of the member.

(19) The number of members who received unduplicated Medicaid services from each coordinated care network, broken down by provider type, specialty, and place of service.

(20) The number of members who received unduplicated outpatient emergency services, broken down by coordinated care network and aggregated by the following hospital classifications:

(a) State.
(b) Nonstate nonrural.
(c) Rural.
(d) Private.

(21) The number of total inpatient Medicaid days broken down by coordinated care network and aggregated by the following hospital classifications:

(a) State.
(b) Public nonstate nonrural.
(c) Rural.
(d) Private.

(22) The number of claims for emergency services, broken out by coordinated care network, whether the claim was paid or denied and by provider type. The initial report shall also include comparable metrics for claims for emergency services that were processed by the Medicaid fiscal intermediary for the period, either calendar or state fiscal year, prior to the date of services initially being provided under Bayou Health.

(23) The following information concerning pharmacy benefits broken down by each coordinated care network and by month:

(a) Total number of prescription claims.
(b) Total number of prescription claims subject to prior authorization.
(c) Total number of prescription claims denied.
(d) Total number of prescription claims subject to step therapy or fail first protocols.

(24) Any other metric or measure which DHH deems appropriate for inclusion in the report.

Further, directs DHH, beginning Jan. 1, 2014, and annually thereafter, to submit reports concerning the Coordinated System of Care and the La. Behavioral Health Partnership to the legislative committees on health and welfare that include but are not limited to the following information:

(1) The name and geographic service area of each human services district or local government entity through which behavioral health services are being provided.

(2) The total number of health care providers in each human services district or local government entity, if applicable or by parish, broken down by provider type, applicable credentialing status, and specialty.

(3) The total number of Medicaid and non-Medicaid members enrolled in each human services district or local government entity, if applicable, or by parish.

(4) The total and monthly average number of adult Medicaid enrollees receiving services in each human services district or local government entity, if applicable, or by parish.

(5) The total and monthly average number of adult non-Medicaid patients receiving services in each human services district or local government entity, if applicable, or by parish.

(6) The total and monthly average number of children receiving services through the Coordinated System of Care by human services region or local government entity, if applicable, or by parish.

(7) The total and monthly average number of children not enrolled in the Coordinated System of Care receiving services as Medicaid enrollees in each human services district or local government entity, if applicable, or by parish.

(8) The total and monthly average number of children not enrolled in the Coordinated System of Care receiving services as non-Medicaid enrollees in each human services district or local government entity, if applicable, or by parish.

(9) The percentage of calls received by the statewide management organization that were referred for services in each human services district or local government entity, if applicable, or by parish.

(10) The average length of time for a member to receive confirmation and referral for services, using the initial call to the statewide management organization as the start date.

(11) The percentage of all referrals that were considered immediate, urgent, and routine in each human services district or local government entity, if applicable, or by parish.

(12) The percentage of clean claims paid for each provider type within 30 calendar days and average number of days to pay all claims for each human services district or local government entity.

(13) The total number of claims denied or reduced for each of the following reasons:

(a) Lack of documentation.

(b) Lack of prior authorization.
(c) Service was not covered.

(14) The percentage of members who provide consent for release of information to coordinate care with the member's primary care physician and other health care providers.

(15) The number of outpatient members who received services in hospital-based emergency rooms due to a behavioral health diagnosis.

(16) A copy of the statewide management organization's report to DHH on quality management, which shall include all of the following information:

(a) The number of qualified quality management personnel employed by the statewide management organization to review performance standards, measure treatment outcomes, and assure timely access to care.
(b) The mechanism utilized by the statewide management organization for generating input and participation of members, families, caretakers, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.
(c) Documentation verifying that all the federal requirements set forth in 42 CFR 438.240 have been met within the utilization management standards required by the Medicaid program as described in 42 CFR 456.
(d) Documentation verifying that the statewide management organization has implemented and maintained a formal outcomes assessment process that is standardized, relatable, and valid in accordance with industry standards.

(17) Any other metric or measure that DHH deems appropriate for inclusion in the report.

Further, directs DHH to make publicly available on its website all of the following items:

(1) All informational bulletins, health plan advisories, and published guidance concerning the Bayou Health coordinated care network program.

(2) All Medicaid state plan amendments and any correspondence related thereto, which shall be made publicly available within 24 hours of submission to the Centers for Medicare and Medicaid Services.

(3) All formal responses to DHH by the Centers for Medicare and Medicaid Services regarding any Medicaid state plan amendment, which shall be made publicly available within 24 hours of receipt by DHH.