Regular Session, 2013

HOUSE CONCURRENT RESOLUTION NO. 75

BY REPRESENTATIVE BARROW

HEALTH/DHH: Requires transparency in Medicaid managed care programs operated by DHH

A CONCURRENT RESOLUTION

To authorize and direct the Department of Health and Hospitals to ensure transparency in its Medicaid managed care programs through annual reports to the legislature on the coordinated care network initiative known as "Bayou Health", the Louisiana Behavioral Health Partnership, and the Coordinated System of Care.

WHEREAS, it is in the best interest of all citizens of this state that the Louisiana Medicaid program is operated in the most efficient and sustainable manner possible; and

WHEREAS, with the transition of over two-thirds of Louisiana's Medicaid enrollees since 2011 from a state-operated fee-for-service program to a program known as "Bayou Health" which relies on managed care coordinated by private insurance companies, it is imperative that the Department of Health and Hospitals, hereafter referred to as "department", report adequate information to the Legislature of Louisiana on financing and outcomes of such coordinated care; and

WHEREAS, as a policymaking body, the legislature requires reporting of this type in order to ensure that the department is achieving the following priority outcomes:

(1) Improved care coordination with patient-centered medical homes for Medicaid recipients.

(2) Improved health outcomes and quality of care as measured by a valid metric, such as the Healthcare Effectiveness Data and Information Set (HEDIS).

(3) Increased emphasis on disease prevention and early diagnosis and management of chronic conditions.

(4) Improved access to Medicaid services.

(5) Improved accountability with a decrease in fraud, abuse, and wasteful spending.

(6) A more financially sustainable Medicaid program; and

WHEREAS, it is in the best interest of all citizens of this state that services of the Louisiana Medicaid program for enrollees with mental health and behavioral health needs are delivered in the most efficient and sustainable manner possible; and

WHEREAS, with the transition of services of the department's office of behavioral health to a system in which a private contractor operates as a statewide management organization providing a single point-of-entry for behavioral health services, it is imperative that the department report adequate information to the Legislature of Louisiana on financing and outcomes of this managed care system; and

WHEREAS, as a policymaking body, the legislature requires reporting of this type in order to ensure that the department is achieving the following priority outcomes:

(1) Implementation of a Coordinated System of Care for youth and their families or caregivers that utilizes a family- and youth-driven practice model, provision of wraparound facilitation by child and family teams, family and youth supports, and overall management of these services by the statewide management organization.

(2) Improved access, quality, and efficiency of behavioral health services for children not eligible for the Coordinated System of Care, and for adults with severe mental illness and addictive disorders, through management of these services by the statewide management organization.

(3) Smooth and efficient transition of behavioral health service delivery and operations from a regional based approach coordinated through the office of behavioral health within the Department of Health and Hospitals to the use of human service districts or local government entities.

(4) Seamless coordination of behavioral health services with the comprehensive health care system without losing attention to the special skills of the behavioral health professionals.

(5) Advancement of a resiliency-, recovery-, and consumer-focused system of person-centered care.

(6) Implementation of evidence-based best practices that are effective, efficient, and supported by data collected from measuring outcomes, quality, and accountability.

(7) The efficient and effective use of state general funds in order to maximize federal funding of behavioral services provided by the Medicaid program.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby authorize and direct the department, beginning January 1, 2014, and annually thereafter, to submit a report concerning the Medicaid coordinated care network initiative known as "Bayou Health" to the House and Senate 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 the department.

(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 thirty 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 thirty 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 thirty 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 in this Paragraph 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 among each coordinated care network which shall include but shall not be limited to the following:

(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) 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 the department 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 the department deems appropriate for inclusion in the report.

BE IT FURTHER RESOLVED that the Legislature of Louisiana does hereby authorize and direct the department, beginning January 1, 2014, and annually thereafter, to submit reports concerning the Coordinated System of Care and the Louisiana Behavioral Health Partnership to the House and Senate committees on health and welfare that shall include but not be 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 thirty 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 the department 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 the department deems appropriate for inclusion in the report.

BE IT FURTHER RESOLVED that the Legislature of Louisiana does hereby authorize and direct the department to make publicly available on its Internet 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 twenty-four hours of submission to the Centers for Medicare and Medicaid Services.

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

BE IT FURTHER RESOLVED that a suitable copy of this Resolution be transmitted to the secretary of the Department of Health and Hospitals.

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)]

Barrow HCR No. 75

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 the department.

(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.

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(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.

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(3) All formal responses to the department 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 the department.