New law requires that beginning January 1, 2014, and annually thereafter, the Department of Health and Hospitals (DHH) shall submit an annual report concerning the La. Medicaid Bayou Health program and the La. Behavioral Health Partnership and Coordinated System of Care programs to the Senate and House committees on health and welfare.

Requires the report to include but not be limited to the following items concerning the La. Medicaid Bayou Health program:

(1) The name and geographic service area of each network.
(2) The total number of healthcare providers in each network broken down by provider type and specialty and by each geographic service area.
(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.
(5) The percentage of regular and expedited service authorization requests processed within the time frames specified by the contract for network.
(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 network.
(7) The number of claims denied or reduced by each network for reasons enumerated in new law.
(8) The number and dollar value of all claims paid non-network providers by claim type categorized by emergency services and nonemergency services.
(9) The number of members who chose the network and the number of members who were auto-enrolled into each network.
(10) The amount of the total payments and average per member per month payment paid.
(11) The Medical Loss Ratio of each network and the amount of any refund to the state for failure to maintain required ratios.
(12) A comparison of health outcomes, which includes but is not limited to the following outcomes enumerated in new law.
(13) A copy of the member and provider satisfaction survey report for each network.
(14) A copy of the annual audited financial statements for each coordinated care network.
(15) The total amount of savings to the state for each shared savings coordinated care network.
(16) A brief factual narrative of any sanctions levied by DHH against a network.
(17) The number of members, broken down by 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 that reversed or otherwise resolved in favor of the member.
(18) The number of members who receive unduplicated Medicaid services from each network broken down by provider type, specialty, and place of service.
(19) The number of members who received unduplicated outpatient emergency services broken down by network and aggregated by certain enumerated hospital classifications.
(20) The number of total inpatient Medicaid days broken down by network and aggregated by certain enumerated hospital classifications.
(21) The number of claims for emergency services, broken out by network, whether the claim was paid or denied and by provider type.
(22) The number of claims for pharmacy benefits, broken out by network and by the month.
(23) Any other metric or measure which DHH deems appropriate for inclusion in the report.

Requires the report to include but not be limited to the following items concerning the La. Behavioral Health Partnership and Coordinated System of Care programs:

(1) The name and geographic service area of each human service district or local government entity through which behavioral health services are being provided.
(2) The total number of healthcare providers in each human service 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 service 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 service 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 service 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 service 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 service 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 service 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 service 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 needs in each human service 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 service district or local government entity.
(13) The total number of claims denied or reduced broken down by specified reasons.
(14) The percentage of members who provide consent for release of information to coordinate care with the member's primary care physician and other healthcare 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 specified data.
(17) The total amount of funding remitted by the state pursuant to its contract with the statewide management organization during the period addressed by the report, including an itemization of this amount which encompasses, at minimum, the total costs to the state associated with the following cost items:

    (a) Payment of claims to providers.
    (b) Administrative costs of the statewide management organization.
    (c) Profit for the statewide management organization.

(18) An explanation of all changes during the period addressed by the report in any of the following program aspects:

    (a) Standards or processes for submission of claims by behavioral health service providers to the statewide management organization.
    (b) Types of behavioral health services covered through the statewide management organization.
    (c) Changes in reimbursement rates for covered services.

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

Requires that DHH make publicly available all informational bulletins, health plan advisories, and guidance published by the department concerning the La. Bayou Health Medicaid program. Further provides such information shall be published and available to the public on the department's website.

Requires that DHH make available to the public on the department's website all Medicaid state plan amendments and any related correspondence within 24 hours of submission to the Centers for Medicare and Medicaid Services. Further provides all formal responses by the

Centers for Medicare and Medicaid Services regarding any state plan amendment shall be made available to the public on the department's website within 24 hours of receipt of the correspondence by the department.

Effective August 1, 2013.

(Adds R.S. 40:1300.361-1300.365)