Regular Session, 2013

ACT No. 212

ENROLLED

SENATE BILL NO. 55

BY SENATORS JOHNS, ALARIO, ALLAIN, APPEL, BROOME, BROWN, BUFFINGTON, CORTEZ, CROWE, DORSEY-COLOMB, ERDEY, GUILLORY, HEITMEIER, KOSTELKA, LONG, MARTINY, MILLS, MORRISH, MURRAY, NEVERS, PERRY, GARY SMITH, THOMPSON, WALSWORTH AND WARD AND REPRESENTATIVES ADAMS, ARMES, BADON, BARROW, BILLIOT, BROADWATER, BROSSETT, BURRELL, COX, DANAHAY, DIXON, DOVE, GISCLAIR, GUINN, HARRISON, HAVARD, HENSGENS, HOFFMANN, HONORE, HOWARD, HUNTER, KATRINA JACKSON, JAMES, KLECKLEY, LEBAS, LORUSSO, MONTOUCET, MORENO, JAY MORRIS, NORTON, ORTEGO, POPE, PRICE, PYLANT, RICHARD, SMITH, THIBAUT AND WILLMOTT

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

AN ACT

To enact Part LXXIII of Chapter 5 of Title 40 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 40:1300.361 through 1300.365, relative to Medicaid; to require the Department of Health and Hospitals to submit an annual report to the legislature on the Louisiana Medicaid Bayou Health and Louisiana Behavioral Health Partnership and Coordinated System of Care programs; to provide for the information to be included in the report; to provide for department information; to provide for Medicaid state plan amendments; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Part LXXIII of Chapter 5 of Title 40 of the Louisiana Revised Statutes of 1950, comprised of R.S. 40:1300.361 through 1300.365, is hereby enacted to read as follows:

PART LXXIII. MEDICAID TRANSPARENCY

§1300.361. Legislative intent

A. It is in the best interest of the citizens of the state that the Legislature of Louisiana ensure that the Louisiana Medicaid program is operated in the most efficient and sustainable method possible. With the transition of over two-thirds of the Medicaid eligible population from a fee-for-service based program to a managed care organization based program, it is imperative that there is

adequate reporting from the Department of Health and Hospitals in order to ensure the following outcomes are being achieved:

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

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

(3) Increased emphasis on disease prevention and the 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.

B. It is in the best interest of the citizens of the state that the Legislature of Louisiana ensures that the Louisiana Medicaid program as it relates to the severely mentally ill recipients is operated in the most efficient and sustainable method possible. The transition of the services of the office of behavioral health within the Department of Health and Hospitals to a managed care system in which a single statewide management organization operates as a single point of entry to behavioral health services requires adequate reporting from the Department of Health and Hospitals in order to ensure the following outcomes are being achieved:

(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 healthcare 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 best practices and evidence-based practices that are effective and efficient and are supported by the 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.

§1300.362. Bayou Health; reporting

Beginning January 1, 2014, and annually thereafter, the Department of Health and Hospitals shall submit an annual report concerning the Louisiana Medicaid Bayou Health program to the Senate and House 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 coordinated care network that has contracted with the Department of Health and Hospitals.

(2) The total number of healthcare 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) The number of claims denied or reduced by each coordinated care network for each of the following reasons:

(a) Lack of documentation to support medical necessity.

(b) Prior authorization was not on file.

(c) Member has other insurance that must be billed first.

(d) Claim was submitted after the filing deadline.

(e) Service was not covered by the coordinated care network.

(f) Due to process, procedure, notification, referrals, or any other required administrative function of a coordinated care network.

(g) 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 nonnetwork 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 auto-enrolled 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 admission rate.

(b) Congestive heart failure admission rate.

(c) Uncontrolled diabetes admission rate.

(d) Adult access to preventative/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 outcomes in Paragraph (12) of this Subsection 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 of any sanctions levied by the Department of Health and Hospitals 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 that reversed or otherwise resolved a decision in favor of the member.

(19) The number of members who receive 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 of Health and Hospitals deems appropriate for inclusion in the report.

§1300.363. Louisiana Behavioral Health Partnership; reporting

Beginning January 1, 2014, and annually thereafter, the Department of Health and Hospitals shall submit an annual report for the Coordinated System of Care and an annual report for the Louisiana Behavioral Health Partnership to the Senate and House 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 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 district 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 thirty calendar days and the 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 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 the 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 the Department of Health and Hospitals on quality management, which shall include:

(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) Documented demonstration of meeting all the federal requirements of 42 CFR 438.240 and with the utilization management required by the Medicaid program as described in 42 CFR 456.

(d) Documentation 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) 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 the Department of Health and Hospitals deems appropriate for inclusion in the report.

§1300.364. Department of Health and Hospitals information

The Department of Health and Hospitals shall make available to the public all informational bulletins, health plan advisories, and guidance published by the department concerning the Louisiana Medicaid Bayou Health program. Such information shall be published and made available to the public on the department's website.

§1300.365. Medicaid state plan amendments

The Department of Health and Hospitals shall make available to the public on the department's website all Medicaid state plan amendments and any related correspondence within twenty-four hours of submission to the Centers for Medicare and Medicaid Services. 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 twenty-four hours of receipt of the correspondence by the department.

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PRESIDENT OF THE SENATE

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SPEAKER OF THE HOUSE OF REPRESENTATIVES

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GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____