

2015 Regular Session

SENATE BILL NO. 109

BY SENATOR JOHNS

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

MEDICAID. Provides for reporting measures for the Medicaid managed care program and the Louisiana Behavioral Health Partnership program. (gov sig)

1 AN ACT
2 To amend and reenact R.S. 40:1300.361(A)(2), 1300.362, and 1300.363, relative to
3 Medicaid reporting; to provide for reporting measures regarding the Medicaid
4 managed care program; to provide for reporting measures regarding the Louisiana
5 Behavioral Health Partnership program; to provide for an integration report of the
6 Louisiana Behavioral Health Partnership program; to provide for an effective date;
7 and to provide for related matters.

8 Be it enacted by the Legislature of Louisiana:

9 Section 1. R.S. 40:1300.361(A)(2), 1300.362, and 1300.363 are hereby amended and
10 reenacted to read as follows:

11 §1300.361. Legislative intent

12 A. It is in the best interest of the citizens of the state that the Legislature of
13 Louisiana ensure that the Louisiana Medicaid program is operated in the most
14 efficient and sustainable method possible. With the transition of over two-thirds of
15 the Medicaid eligible population from a fee-for-service based program to a managed
16 care organization based program, it is imperative that there is adequate reporting
17 from the Department of Health and Hospitals in order to ensure the following

1 outcomes are being achieved:

2 * * *

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

5 * * *

6 §1300.362. Bayou Health; reporting

7 ~~Beginning January 1, 2014, and annually thereafter, the~~ **A. The** Department
8 of Health and Hospitals shall submit an annual report concerning the Louisiana
9 Medicaid Bayou Health program to the Senate and House committees on health and
10 welfare ~~that shall include but not be limited to the following information:~~ **The**
11 **report shall be submitted by June thirtieth every year, and the applicable**
12 **reporting period shall be for the previous state fiscal year except for those**
13 **measures that require reporting of health outcomes which shall be reported for**
14 **the calendar year prior to the current state fiscal year. The report shall include:**

15 **(1) The following information related to the managed care organizations**
16 **contracted with the state to provide Medicaid services to Medicaid enrollees:**

17 ~~(1)(a)~~ **(a)** The name and geographic service area of each coordinated care
18 network **managed care organization** that has contracted with the Department of
19 Health and Hospitals **to provide healthcare services to Medicaid enrollees.**

20 **(b) The total number of employees employed by each managed care**
21 **organization which is based in Louisiana and the average salary.**

22 **(c) The amount of the total payments and average per member per**
23 **month payment paid by the state to each managed care organization delineated**
24 **monthly.**

25 ~~(2)~~ **(2)** ~~The total number of healthcare providers in each coordinated care network~~
26 ~~broken down by provider type and specialty and by each geographic service area.~~
27 ~~The initial report shall also include the total number of providers enrolled in the~~
28 ~~fee-for-service Medicaid program broken down by provider type and specialty for~~
29 ~~each geographic service area for the period, either calendar or state fiscal year, prior~~

1 to the date of services initially being provided under Bayou Health.

2 (d) The total number of healthcare providers contracted to provide
3 healthcare services for each managed care organization delineated by provider
4 type, provider taxonomy code, and parish.

5 (e) The total number of providers contracted to provide healthcare
6 services for each managed care organization who provides primary care
7 services and submitted at least one claim for payment for services rendered to
8 an individual enrolled in the health plan delineated by provider type, provider
9 taxonomy code, and parish.

10 (f) The total number of providers contracted to provide healthcare
11 services for each managed care organization who has a closed panel for any
12 portion of the reporting period delineated by provider type, provider taxonomy
13 code, and parish.

14 (g) The Medical Loss Ratio of each managed care organization and the
15 amount of any refund to the state for failure to maintain the required Medical
16 Loss Ratio.

17 (h) A comparison of health outcomes, which includes but is not limited
18 to the following, among each managed care organization:

19 (i) Adult asthma admission rate.

20 (ii) Congestive heart failure admission rate.

21 (iii) Uncontrolled diabetes admission rate.

22 (iv) Adult access to preventative/ambulatory health services.

23 (v) Breast cancer screening rate.

24 (vi) Well child visits.

25 (vii) Childhood immunization rates.

26 (i) A copy of the member and provider satisfaction survey report for
27 each managed care organization.

28 (j) A copy of the annual audited financial statements for each managed
29 care organization. The financial statements shall be those of the managed care

1 organization operating in Louisiana and shall not be those financial statements
2 of any parent or umbrella organization.

3 (k) A brief factual narrative of any sanctions levied by the Department
4 of Health and Hospitals against a managed care organization.

5 (2) The following information regarding Medicaid enrollees receiving
6 healthcare services from a managed care organization:

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

9 (a) The total number of unduplicated enrollees enrolled during the
10 reporting period, and the monthly average of the number of members enrolled
11 in each managed care organization delineated by eligibility category of the
12 enrollees.

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

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

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

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

1 ~~(a) Lack of documentation to support medical necessity.~~

2 ~~(b) Prior authorization was not on file.~~

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

4 ~~(d) Claim was submitted after the filing deadline.~~

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

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

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

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

15 ~~(9) The number of members who chose the coordinated care network and the~~
16 ~~number of members who were auto-enrolled into each coordinated care network,~~
17 ~~broken down by coordinated care network.~~

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

20 ~~(11) The Medical Loss Ratio of each coordinated care network and the~~
21 ~~amount of any refund to the state for failure to maintain the required Medical Loss~~
22 ~~Ratio.~~

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

25 ~~(a) Adult asthma admission rate.~~

26 ~~(b) Congestive heart failure admission rate.~~

27 ~~(c) Uncontrolled diabetes admission rate.~~

28 ~~(d) Adult access to preventative/ambulatory health services.~~

29 ~~(e) Breast cancer screening rate.~~

- 1 ~~(f) Well child visits.~~
- 2 ~~(g) Childhood immunization rates.~~
- 3 ~~(13) The initial report shall also include a comparison of health outcomes for~~
4 ~~each of the aforementioned outcomes in Paragraph (12) of this Subsection for the~~
5 ~~Medicaid fee-for-service program for the period, either calendar or state fiscal year,~~
6 ~~prior to the date of services initially being provided under Bayou Health.~~
- 7 ~~(14) A copy of the member and provider satisfaction survey report for each~~
8 ~~coordinated care network.~~
- 9 ~~(15) A copy of the annual audited financial statements for each coordinated~~
10 ~~care network.~~
- 11 ~~(16) The total amount of savings to the state for each shared savings~~
12 ~~coordinated care network.~~
- 13 ~~(17) A brief factual narrative of any sanctions levied by the Department of~~
14 ~~Health and Hospitals against a coordinated care network.~~
- 15 ~~(18) The number of members, broken down by each coordinated care~~
16 ~~network, who file a grievance or appeal and the number of members who accessed~~
17 ~~the state fair hearing process and the total number and percentage of grievances or~~
18 ~~appeals that reversed or otherwise resolved a decision in favor of the member.~~
- 19 ~~(19) The number of members who receive unduplicated Medicaid services~~
20 ~~from each coordinated care network, broken down by provider type, specialty, and~~
21 ~~place of service.~~
- 22 ~~(20) The number of members who received unduplicated outpatient~~
23 ~~emergency services, broken down by coordinated care network and aggregated by~~
24 ~~the following hospital classifications:~~
 - 25 ~~(a) State.~~
 - 26 ~~(b) Nonstate nonrural.~~
 - 27 ~~(c) Rural.~~
 - 28 ~~(d) Private.~~
- 29 ~~(21) The number of total inpatient Medicaid days broken down by~~

1 coordinated care network and aggregated by the following hospital classifications:

2 (a) State.

3 (b) Public nonstate nonrural.

4 (c) Rural.

5 (d) Private.

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

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

14 (a) ~~Total number of prescription claims.~~

15 (b) ~~Total number of prescription claims subject to prior authorization.~~

16 (c) ~~Total number of prescription claims denied.~~

17 (d) ~~Total number of prescription claims subject to step-therapy or fail first~~
18 ~~protocols.~~

19 (24) ~~Any other metric or measure which the Department of Health and~~
20 ~~Hospitals deems appropriate for inclusion in the report.~~

21 **(b) The number of members who proactively chose the managed care**
22 **organization, and the number of members who were auto-enrolled into each**
23 **managed care organization, delineated by managed care organization.**

24 **(c) The total number of enrollees who receive unduplicated Medicaid**
25 **services from each managed care network, broken down by provider type,**
26 **provider taxonomy code, and place of service.**

27 **(d) The total number and percentage of enrollees of each managed care**
28 **organization that had at least one visit with their primary care provider during**
29 **the reporting period.**

1 (e) The following information concerning hospital services being
2 provided to Medicaid enrollees:

3 (i) The number of members who received unduplicated outpatient
4 emergency services, delineated by managed care organization.

5 (ii) The number of total inpatient Medicaid days delineated by managed
6 care organization.

7 (iii) The total number of unduplicated members who received outpatient
8 emergency services and had at least one visit to a primary care provider within
9 the past year of receiving the outpatient emergency services.

10 (f) The number of members, delineated by each managed care
11 organization, who filed an appeal, the number of members who accessed the
12 state fair hearing process, and the total number and percentage of appeals that
13 reversed or otherwise resolved a decision in favor of the member. An "appeal"
14 means a request for review of an action.

15 (3) The following information related to healthcare services provided by
16 healthcare providers to Medicaid enrollees enrolled in each of the managed care
17 organizations:

18 (a) The total number of claims submitted by healthcare providers to each
19 managed care organization. The total number of claims shall also be delineated
20 by whether the claims were for emergency or nonemergency services.

21 (b) The total number of claims submitted by healthcare providers to each
22 managed care organization which were adjudicated by the respective managed
23 care organization and payment for services was denied. This shall include a
24 delineation between emergency and nonemergency claim denials. Additionally,
25 this shall include the number of denied claims for each managed care
26 organization delineated by the standard set of Claim Adjustment Reason Codes
27 published by the Washington Publishing Company.

28 (c) The total number of claims submitted by healthcare providers to each
29 managed care organization which meets the definition of a clean claim as it is

1 defined in the contract executed between the state and the managed care
2 organization, and the percentage of those clean claims that each of the managed
3 care plans has paid for each provider type within fifteen calendar days and
4 within thirty calendar days. In addition, the average number of days for each
5 managed care organization to pay all claims of healthcare providers delineated
6 by provider type.

7 (d) The total number and percentage of regular and expedited service
8 authorization requests processed within the time frames specified by the
9 contract for each managed care organization. In addition, the report shall
10 contain the total number of regular and expedited service authorization
11 requests which resulted in a denial for services for each managed care
12 organization.

13 (e) The total number and dollar value of all claims paid to
14 out-of-network providers by claim type categorized by emergency services and
15 nonemergency services for each managed care organization by parish.

16 (f) The following information concerning pharmacy benefits delineated
17 by each managed care organization and by month:

18 (i) Total number of prescription claims.

19 (ii) Total number of prescription claims subject to prior authorization.

20 (iii) Total number of prescription claims denied.

21 (iv) Total number of prescription claims subject to step-therapy or fail
22 first protocols.

23 (4) Any other metric or measure which the Department of Health and
24 Hospitals deems appropriate for inclusion in the report.

25 B. To the greatest extent possible, the Department of Health and
26 Hospitals shall include in the report at least three years of historical data for
27 each of the measures set forth in Subsection A of this Section.

28 §1300.363. Louisiana Behavioral Health Partnership; reporting

29 ~~Beginning January 1, 2014, and annually thereafter, the~~ A. The Department

1 of Health and Hospitals shall submit an annual report for the Coordinated System of
 2 Care and an annual report for the Louisiana Behavioral Health Partnership to the
 3 Senate and House committees on health and welfare ~~that~~. **The report shall be**
 4 **submitted by June thirtieth of each year, and the applicable reporting period**
 5 **shall be for the previous state fiscal year. The report** shall include but not be
 6 limited to the following information:

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

9 (2) The total number of healthcare providers in each ~~human service district~~
 10 ~~or local government entity, if applicable, or by parish, broken down by provider type,~~
 11 applicable ~~credentialing~~ **contracting** status, and specialty.

12 ~~(3)~~**(2)** The total number of Medicaid and non-Medicaid members enrolled in
 13 each ~~human service district or local government entity, if applicable, or by parish.~~

14 ~~(4)~~**(3)** The total and monthly average number of adult Medicaid enrollees
 15 receiving services in each ~~human service district or local government entity, if~~
 16 ~~applicable, or by parish.~~

17 ~~(5)~~**(4)** The total and monthly average number of adult ~~non-Medicaid patients~~
 18 **adults not enrolled in the Medicaid program** receiving services in each ~~human~~
 19 ~~service district or local government entity, if applicable, or by parish.~~

20 ~~(6)~~**(5)** The total and monthly average number of children receiving services
 21 through the Coordinated System of Care ~~by human service district or local~~
 22 ~~government entity, if applicable, or by parish.~~

23 ~~(7)~~**(6)** The total and monthly average number of children ~~not enrolled in~~
 24 **receiving Louisiana Behavioral Health Partnership services outside** the
 25 Coordinated System of Care ~~receiving services as Medicaid enrollees in each human~~
 26 ~~service district or local government entity, if applicable, or by parish.~~

27 ~~(8)~~**(7)** The total and monthly average number of children not enrolled in the
 28 **Medicaid program receiving Louisiana Behavioral Health Partnership services**
 29 **outside the** Coordinated System of Care ~~receiving services as non-Medicaid~~

1 ~~enrollees in each human service district or local government entity, if applicable, or~~
2 ~~by parish.~~

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

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

9 ~~(11)~~**(8)** The percentage of all referrals that were considered immediate, urgent
10 and routine needs ~~in each human service district or local government entity, if~~
11 ~~applicable, or~~ **and the average length of time to authorize for services** by parish.

12 ~~(12)~~**(9)** The percentage of clean claims paid for each provider type within
13 thirty calendar days and the average number of days to pay all claims for each human
14 service district or local government entity.

15 ~~(13)~~**(10)** The **top five reasons for denial of claims and the** total number of
16 claims denied ~~or reduced~~ for each of the following reasons: **according to the cause**
17 **presented.**

18 (a) Lack of documentation.

19 (b) Lack of prior authorization.

20 ~~(c) Service was not covered.~~

21 ~~(14)~~**(11)** The percentage of members **asked to and** who provide consent for
22 the release of information to coordinate care with the member's primary care
23 physician and other healthcare providers.

24 ~~(15)~~**(12)** The number of outpatient members who received services **through**
25 **the Louisiana Behavioral Health Partnership** in hospital-based emergency rooms
26 due to a behavioral health diagnosis.

27 ~~(16)~~**(13)** A copy of the statewide management organization's report to the
28 Department of Health and Hospitals on quality management, which shall include:

29 (a) The number of qualified quality management personnel employed by the

1 statewide management organization to review performance standards, measure
2 treatment outcomes, and assure timely access to care.

3 (b) The mechanism utilized by the statewide management organization for
4 generating input and participation of members, families/caretakers, and other
5 stakeholders in the monitoring of service quality and determining strategies to
6 improve outcomes.

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

10 (d) Documentation that the statewide management organization has
11 implemented and maintained a formal outcomes assessment process that is
12 standardized, reliable, and valid in accordance with industry standards.

13 ~~(17)~~**(14)** The total amount of funding remitted by the state pursuant to its
14 contract with the statewide management organization during the period addressed by
15 the report, including an itemization of this amount which encompasses, at minimum,
16 the total costs to the state associated with the following cost items:

17 (a) Payment of claims to providers.

18 (b) Administrative costs of the statewide management organization.

19 (c) Profit for the statewide management organization.

20 ~~(18)~~**(15)** An explanation of all changes during the period addressed by the
21 report in any of the following program aspects:

22 (a) Standards or processes for submission of claims by behavioral health
23 service providers to the statewide management organization.

24 (b) Types of behavioral health services covered through the statewide
25 management organization.

26 (c) Changes in reimbursement rates for covered services.

27 ~~(19)~~**(16)** Any other metric or measure that the Department of Health and
28 Hospitals deems appropriate for inclusion in the report.

29 **B. Upon the integration of behavioral health into the Bayou Health**

1 **program, the final report produced pursuant to R.S. 40:1300.363 for the period**
 2 **starting July 1, 2015, shall be issued by June 30, 2016, or six months following**
 3 **the integration date, whichever occurs later, and subsequent behavioral health**
 4 **reporting shall be included in the report produced pursuant to R.S. 40:1300.362.**

5 Section 2. This Act shall become effective upon signature by the governor or, if not
 6 signed by the governor, upon expiration of the time for bills to become law without signature
 7 by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If
 8 vetoed by the governor and subsequently approved by the legislature, this Act shall become
 9 effective on the day following such approval.

The original instrument and the following digest, which constitutes no part
 of the legislative instrument, were prepared by Christopher D. Adams.

DIGEST

SB 109 Original

2015 Regular Session

Johns

Present law requires on an annual basis the Department of Health and Hospitals to submit an annual report concerning the Louisiana Medicaid Bayou Health program and the Louisiana Behavioral Health Partnership and Coordinated System of Care programs to the Senate and House committees on health and welfare.

Proposed law amends present law to require both reports be based on the fiscal year except for the report measures specifically measured on calendar year.

Proposed law amends present law by replacing the term "coordinated care network" with "managed care organization".

Proposed law amends present law by removing reported outcomes and comparisons to Legacy Medicaid.

Proposed law clarifies the reporting metrics for evaluation purposes.

Proposed law replaces the term "geographical service area" with "parish".

Proposed law replaces the term "human service district or local government entity" with "parish".

Proposed law amends present law by consolidating reporting metrics on referral calls to the Louisiana Behavioral Health Partnership into a single metric for all referrals.

Proposed law amends present law by replacing the requirement to report specified reasons for a claim denial with the requirement to report the top five reasons for claim denials.

Proposed law requires a final report on the Louisiana Behavioral Health Partnership's integration into Medicaid managed care to be issued no later than six months after integration.

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

(Amends R.S. 40:1300.361(A)(2), 1300.362, and 1300.363)