

Regular Session, 2013

SENATE BILL NO. 55

BY SENATORS JOHNS, ALLAIN, BUFFINGTON, DORSEY-COLOMB, ERDEY,
GUILLORY, HEITMEIER, MILLS AND NEVERS

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

HEALTH/HOSPITALS DEPT. Provides for Medicaid transparency. (8/1/13)

1 AN ACT

2 To enact Part LXXIII of Chapter 5 of Title 40 of the Louisiana Revised Statutes of 1950, to

3 be comprised of R.S. 40:1300.361 through 1300.365, relative to Medicaid; to require

4 the Department of Health and Hospitals to submit an annual report to the legislature

5 on the Louisiana Medicaid Bayou Health and Louisiana Behavioral Health

6 Partnership and Coordinated System of Care programs; to provide for the

7 information to be included in the report; to provide for department information; to

8 provide for Medicaid state plan amendments; and to provide for related matters.

9 Be it enacted by the Legislature of Louisiana:

10 Section 1. Part LXXIII of Chapter 5 of Title 40 of the Louisiana Revised Statutes

11 of 1950, comprised of R.S. 40:1300.361 through 1300.365, is hereby enacted to read as

12 follows:

PART LXXIII. MEDICAID TRANSPARENCY

§1300.361. Legislative intent

15 **A. It is in the best interest of the citizens of the state that the Legislature**

16 **of Louisiana ensure that the Louisiana Medicaid program is operated in the**

17 **most efficient and sustainable method possible. With the transition of over two-**

1 thirds of the Medicaid eligible population from a fee-for-service based program
2 to a managed care organization based program, it is imperative that there is
3 adequate reporting from the Department of Health and Hospitals in order to
4 ensure the following outcomes are being achieved:

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

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

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

11 (4) Improved access to Medicaid services.

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

14 (6) A more financially sustainable Medicaid program.

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

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

29 (2) Improved access, quality, and efficiency of behavioral health services

1 for children not eligible for the Coordinated System of Care and for adults with
2 severe mental illness and addictive disorders, through management of these
3 services by the statewide management organization.

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

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

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

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

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

19 §1300.362. Bayou Health; reporting

20 Beginning January 1, 2014, and annually thereafter, the Department of
21 Health and Hospitals shall submit an annual report concerning the Louisiana
22 Medicaid Bayou Health program to the Senate and House committees on health
23 and welfare that shall include but not be limited to the following information:

24 (1) The name and geographic service area of each coordinated care
25 network that has contracted with the Department of Health and Hospitals.

26 (2) The total number of healthcare providers in each coordinated care
27 network broken down by provider type and specialty and by each geographic
28 service area. The initial report shall also include the total number of providers
29 enrolled in the fee-for-service Medicaid program broken down by provider type

1 and specialty for each geographic service area for the period, either calendar
2 or state fiscal year, prior to the date of services initially being provided under
3 Bayou Health.

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

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

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

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

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

25 (a) Lack of documentation to support medical necessity.

26 (b) Prior authorization was not on file.

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

28 (d) Claim was submitted after the filing deadline.

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

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

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

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

10 **(9) The number of members who chose the coordinated care network**
11 **and the number of members who were auto-enrolled into each coordinated care**
12 **network, broken down by coordinated care network.**

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

15 **(11) The Medical Loss Ratio of each coordinated care network and the**
16 **amount of any refund to the state for failure to maintain the required Medical**
17 **Loss Ratio.**

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

20 **(a) Adult asthma admission rate.**

21 **(b) Congestive heart failure admission rate.**

22 **(c) Uncontrolled diabetes admission rate.**

23 **(d) Adult access to preventative/ambulatory health services.**

24 **(e) Breast cancer screening rate.**

25 **(f) Well child visits.**

26 **(g) Childhood immunization rates.**

27 **(13) The initial report shall also include a comparison of health outcomes**
28 **for each of the aforementioned metrics in this Paragraph for the Medicaid**
29 **fee-for-service program for the period, either calendar or state fiscal year, prior**

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

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

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

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

8 (17) A brief factual narrative of any sanctions levied by the Department
9 of Health and Hospitals against a coordinated care network.

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

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

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

21 (a) State.

22 (b) Nonstate nonrural.

23 (c) Rural.

24 (d) Private.

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

28 (a) State.

29 (b) Public nonstate nonrural.

1 **(c) Rural.**

2 **(d) Private.**

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

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

11 **(a) Total number of prescription claims.**

12 **(b) Total number of prescription claims subject to prior authorization.**

13 **(c) Total number of prescription claims denied.**

14 **(d) Total number of prescription claims subject to step-therapy or fail**
15 **first protocols.**

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

18 **§1300.363. Louisiana Behavioral Health Partnership; reporting**

19 **Beginning January 1, 2014, and annually thereafter, the Department of**
20 **Health and Hospitals shall submit an annual report for the Coordinated System**
21 **of Care and an annual report for the Louisiana Behavioral Health Partnership**
22 **to the Senate and House committees on health and welfare that shall include but**
23 **not be limited to the following information:**

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

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

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

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

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

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

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

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

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

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

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

29 **(12) The percentage of clean claims paid for each provider type within**

1 thirty calendar days and the average number of days to pay all claims for each
2 human service district or local government entity.

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

5 (a) Lack of documentation.

6 (b) Lack of prior authorization.

7 (c) Service was not covered.

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

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

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

16 (a) The number of qualified quality management personnel employed by
17 the statewide management organization to review performance standards,
18 measure treatment outcomes, and assure timely access to care.

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

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

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

29 (17) Any other metric or measure that the Department of Health and

1 **Hospitals deems appropriate for inclusion in the report.**

2 **§1300.364. Department of Health and Hospitals information**

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

8 **§1300.365. Medicaid state plan amendments**

9 **The Department of Health and Hospitals shall make available to the**
10 **public on the department's website all Medicaid state plan amendments and any**
11 **related correspondence within twenty-four hours of submission to the Centers**
12 **for Medicare and Medicaid Services. All formal responses by the Centers for**
13 **Medicare and Medicaid Services regarding any state plan amendment shall be**
14 **made available to the public on the department's website within twenty-four**
15 **hours of receipt of the correspondence by the department.**

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

DIGEST

Johns (SB 55)

Proposed law requires that 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 and the Louisiana Behavioral Health Partnership and Coordinated System of Care programs to the Senate and House committees on health and welfare.

Proposed law requires the report to include but not be limited to the following items concerning the Louisiana 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 proposed law.
- (8) The number and dollar value of all claims paid nonnetwork 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 proposed 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 which 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.

Proposed law requires the report to include but not be limited to the following items concerning the Louisiana 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 the Department of Health and Hospital on quality management, which shall include specified data.
- (17) Any other metric or measure that the Department of Health and Hospitals deems

appropriate for inclusion in the report.

Proposed law provides the Department of Health and Hospitals shall make publicly available all informational bulletins, health plan advisories, and guidance published by the department concerning the Louisiana Bayou Health Medicaid program. Proposed law further provides such information shall be published and available to the public on the department's website.

Proposed law provides 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 24 hours of submission to the Centers for Medicare and Medicaid Services. Proposed law 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)