SLS 15RS-303 **REENGROSSED**

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)

AN ACT

To amend and reenact R.S. 40:1300.361(A)(2), 1300.362, 1300.363, and 1300.364, relative to Medicaid reporting; to provide for reporting measures regarding the Medicaid managed care program; to provide for reporting measures regarding the Louisiana Behavioral Health Partnership program; to provide for an integration report of the Louisiana Behavioral Health Partnership program; to provide for information to be reported by the Department of Health and Hospitals; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 40:1300.361(A)(2), 1300.362, 1300.363, and 1300.364 are hereby amended and reenacted to read as follows:

§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:

* * *

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

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§1300.362. Bayou Health; reporting

~~Beginning January 1, 2014, and annually thereafter, the~~ **A. 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:~~**. The report shall be submitted by June thirtieth every year, and the applicable reporting period shall be for the previous state fiscal year except for those measures that require reporting of health outcomes which shall be reported for the calendar year prior to the current state fiscal year. The report shall include:**

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

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

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

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

~~(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.~~

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

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

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

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

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

(i) Adult asthma admission rate.

(ii) Congestive heart failure admission rate.

(iii) Uncontrolled diabetes admission rate.

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

(v) Breast cancer screening rate.

(vi) Well child visits.

(vii) Childhood immunization rates.

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

(j) A copy of the annual audited financial statements for each managed

care organization. The financial statements shall be those of the managed care organization operating in Louisiana and shall not be those financial statements of any parent or umbrella organization.

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

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

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

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

~~(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.~~

~~(c) 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.~~

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

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

(d) The total number and percentage of enrollees of each managed care organization that had at least one visit with their primary care provider during

the reporting period.

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

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

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

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

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

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

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

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

(c) The total number of claims submitted by healthcare providers to each

managed care organization which meets the definition of a clean claim as it is defined in the contract executed between the state and the managed care organization, and the percentage of those clean claims that each of the managed care plans has paid for each provider type within fifteen calendar days and within thirty calendar days. In addition, the average number of days for each managed care organization to pay all claims of healthcare providers delineated by provider type.

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

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

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

(i) Total number of prescription claims.

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

(iii) Total number of prescription claims denied.

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

(g) The report shall also include the following information concerning Medicaid drug rebates and manufacturer discounts delineated by each managed care organization and the prescription benefit manager contracted or owned by the managed care organization and by month:

(i) Total dollar amount of the Medicaid drug rebates and manufacturer discounts collected and used.

(ii) Total dollar amount of Medicaid drug rebates and manufacturer discounts collected and remitted back to the Department of Health and Hospitals.

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

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

§1300.363. Louisiana Behavioral Health Partnership; reporting

~~Beginning January 1, 2014, and annually thereafter, the~~ **A. 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~~**. The report shall be submitted by June thirtieth of each year, and the applicable reporting period shall be for the previous state fiscal year. The report** 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~~ **contracting** status, and specialty.

~~(3)~~**(2)** 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)~~**(3)** 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)~~**(4)** The total and monthly average number of ~~adult non-Medicaid patients~~ **adults not enrolled in the Medicaid program** receiving services in each ~~human service district or local government entity, if applicable, or by~~ parish.

~~(6)~~**(5)** 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)~~**(6)** The total and monthly average number of children ~~not enrolled in~~ **receiving Louisiana Behavioral Health Partnership services outside** 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)~~**(7)** The total and monthly average number of children not enrolled in the **Medicaid program receiving Louisiana Behavioral Health Partnership services outside 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)~~**(8)** 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~~ **and the average length of time to authorize for services** by parish.

~~(12)~~**(9)** 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)~~**(10)** The **top five reasons for denial of claims and the** total number of claims denied ~~or reduced for each of the following reasons:~~ **according to the cause presented.**

~~(a) Lack of documentation.~~

~~(b) Lack of prior authorization.~~

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

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

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

~~(16)~~**(13)** 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)~~**(14)** 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)~~**(15)** 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)~~**(16)** Any other metric or measure that the Department of Health and Hospitals deems appropriate for inclusion in the report.

B. Upon the integration of behavioral health into the Louisiana Medicaid Bayou Health program, the final report produced pursuant to this Section for the period starting July 1, 2015, shall be issued by June 30, 2016, or six months following the integration date, whichever occurs later, and subsequent behavioral health reporting shall be included in the report produced pursuant to R.S. 40:1300.362.

§1300.364. Department of Health and Hospitals information

A. 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.

B. Prior to August 1, 2015, every managed care organization contracted with the state to provide Medicaid services to Medicaid enrollees shall report to the department the uniform resource locator of a webpage which contains a publicly accessible copy of all practice guidelines utilized by each managed care organization which are required to be made available to healthcare providers pursuant to 42 CFR 438.236(c). The department shall place and maintain publicly accessible web links to each of these respective webpages upon the website operated by the department.

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

The original instrument was prepared by Christopher D. Adams. The following digest, which does not constitute a part of the legislative instrument, was prepared by Michelle Broussard-Johnson.

DIGEST

SB 109 Reengrossed 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 adds that the report shall include information concerning Medicaid drug rebates and manufacturer discounts delineated by each managed care organization and the prescription benefit manager contracted or owned by the managed care organization.

Proposed law adds to the report a monthly total dollar amount of Medicaid drug rebates and discounts collected and used; also adds a monthly total dollar amount of Medicaid drug rebates and discounts collected and remitted back to the DHH.

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.

Proposed law provides prior to August 1, 2015, every managed care organization contracted

with the state to provide Medicaid services to Medicaid enrollees shall report to DHH the uniform resource locator of a webpage which contains a publicly accessible copy of all practice guidelines utilized by each managed care organization which are required to be made available to healthcare providers pursuant to 42 CFR 438.236(c). DHH shall place and maintain publicly accessible web links to each of these respective webpages upon the website operated by DHH.

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

(Amends R.S. 40:1300.361(A)(2), 1300.362,1300.363, and 1300.364)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Health and Welfare to the original bill

1. Provides for information to be reported by the Department of Health and Hospitals from Medicaid managed care organizations that will be placed and maintained on the department's publicly accessible website.

2. Technical changes.

Summary of Amendments Adopted by Senate

Senate Floor Amendments to engrossed bill

1. Makes Legislative Bureau technical changes.

2. Adds to the report the monthly total dollar amounts of Medicaid drug rebates and discounts collected and used, and those returned to DHH.