

SENATE BILL NO. 207

BY SENATOR MOUNT AND REPRESENTATIVES
AUBERT, AUSTIN BADON, BALDONE,
BARROW, BROSSETT, BURRELL,
CARMODY, DANAHAY, DIXON, GISCLAIR, GUINN, HARDY,
HARRISON, HAZEL, HENSGENS, HINES, HUTTER, ROSALIND
JONES, LABRUZZO, LEBAS, LIGI, LORUSSO, NORTON,
RICHARD, SMILEY, ST. GERMAIN, STIAES AND WILLIAMS

VETOED
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Veto Message

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

1 AN ACT

2 To enact Part XLII of Chapter 5 of Title 40 of the Louisiana Revised Statutes of 1950, to be
3 comprised of R.S. 40:1300.21 through 1300.23, relative to Medicaid; to require the
4 Department of Health and Hospitals to submit an annual report to the legislature on
5 the Coordinated Care Network Medicaid initiative; to provide for termination of
6 legislative authority; and to provide for related matters.

7 Be it enacted by the Legislature of Louisiana:

8 Section 1. Part XLII of Chapter 5 of Title 40 of the Louisiana Revised Statutes of
9 1950, comprised of R.S. 40:1300.21 through 1300.23, is hereby enacted to read as follows:

10 **PART XLII. LOUISIANA MEDICAID COORDINATED CARE**

11 **PROGRAM TRANSPARENCY**

12 **§1300.21. Legislative intent**

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

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

22 **(2) Improved health outcomes and quality of care as measured by metric,**
23 **such as HEDIS.**

24 **(3) Increased emphasis on disease prevention and the early diagnosis and**

1 management of chronic conditions.

2 (4) Improved access to Medicaid services.

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

5 (6) A more financially sustainable Medicaid program.

6 §1300.22. Coordinated care program; reporting

7 A. Beginning January 1, 2013, and annually thereafter, the Department
8 of Health and Hospitals shall submit an annual report concerning the Louisiana
9 Medicaid Coordinated Care Program to the Senate and House committees on
10 health and welfare which shall include but not be limited to the following
11 information:

12 (1) The name and geographic service area of each coordinated care
13 network which has contracted with the Department of Health and Hospitals.

14 (2) The total number of health care providers in each coordinated care
15 network broken down by provider type and specialty and by each geographic
16 service area.

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

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

23 (5) The percentage of regular and expedited service authorization
24 requests processed within the timeframes specified by the contract for each
25 coordinated care network.

26 (6) The percentage of clean claims paid for each provider type within
27 thirty calendar days and the average number of days to pay all claims for each
28 coordinated care network.

29 (7) The number of claims denied or reduced by each coordinated care
30 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
7 required administrative function of a coordinated care network.

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

11 (9) The number of members who chose the coordinated care network
12 and the number of members who were autoenrolled into each coordinated care
13 network, broken down by coordinated care network.

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

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

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

21 (a) Adult asthma admission rate.

22 (b) Congestive heart failure admission rate.

23 (c) Uncontrolled diabetes admission rate.

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

25 (e) Breast cancer screening rate.

26 (f) Well child visits.

27 (g) Childhood immunization rates.

28 (13) A copy of the member and provider satisfaction survey report for
29 each coordinated care network.

30 (14) A copy of the annual audited financial statements for each

1 coordinated care network.

2 (15) The total amount of savings to the state for each shared savings
3 coordinated care network.

4 (16) A brief factual narrative of any sanctions levied by the Department
5 of Health and Hospitals against a coordinated care network.

6 (17) The number of members, broken down by each coordinated care
7 network, who file a grievance or appeal and the number of members who
8 accessed the state fair hearing process and the total number and percentage of
9 grievances or appeals which reversed or otherwise resolved in favor of the
10 member.

11 (18) The number of members who receive unduplicated medicaid
12 services from each coordinated care network broken down by provider type,
13 specialty, and place of service.

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

17 (a) State.

18 (b) Non-state non-rural.

19 (c) Rural.

20 (d) Private.

21 (20) The number of total inpatient medicaid days broken down by
22 Coordinated Care Network and aggregated by the following hospital
23 classifications:

24 (a) State.

25 (b) Public non-state non-rural.

26 (c) Rural.

27 (d) Private.

28 (21) Any other metric or measure in which the Department of Health
29 and Hospitals Coordinated Care Network Quality Committee deems
30 appropriate for inclusion into the report.

1 B. The Department of Health and Hospitals shall submit all quarterly
 2 reports required to be submitted by coordinated care networks to the Senate
 3 Committee on Health and Welfare, the House Committee on Health and
 4 Welfare, and the Senate Committee on Finance and House Committee on
 5 Appropriations.

6 §1300.23. Sunset

7 All authority for that portion of the Louisiana Medical Assistance
 8 Program which is administered by a coordinated care program, or meets the
 9 definition of managed care pursuant to federal law or regulation, excluding
 10 those portions which provide for behavioral health services, shall hereby
 11 terminate on December 31, 2014. After that date, the department shall
 12 administer the services encompassed by the portion terminated herein
 13 according to rules and regulations promulgated prior to the establishment of
 14 the coordinated care program within the Louisiana Medical Assistance
 15 Program.

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

 PRESIDENT OF THE SENATE

 SPEAKER OF THE HOUSE OF REPRESENTATIVES

 GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____

VETO MESSAGE

Senate Bill No. 207 by Senator Mount terminates Louisiana's Medicaid reform initiative, Coordinated Care Networks, as well as the Community Care Program on December 31, 2014. Coordinated Care Networks will provide a medical home for 800,000 Louisiana Medicaid recipients, providing better access to primary and preventative care, improved health outcomes, with an anticipated savings of \$24 million in the upcoming fiscal year and \$135.9 million in state fiscal year 2013.

Inserting a termination date for this important reform and preventing Louisiana from improving the performance and outcomes in our current Medicaid system sends the wrong message, that we are incapable of providing better care to our people, and we can do no better than our ranking of 49th in the nation for health outcomes. I am not content with the outcomes of our current Medicaid program and am committed to reforming our Louisiana health care system.

For this reason, I have vetoed Senate Bill No. 207 and hereby return it to the Senate.