

**Louisiana Health Care Commission Meeting Minutes**  
**Poydras Building Hearing Room**  
**Baton Rouge, Louisiana**  
**May 31, 2019**

**Members present:** Lauren Bailey, Rick Born, Katie Brittain, Dr. William Ferguson, Dr. John Fraiche, Lisa Gardner, Arnold Goldberg, Dr. Faye Grimsley, Linda Hawkins, Dr. Marlon Henderson, Barbara Morvant, John Overton, Dr. Anthony Recasner, Debra Rushing, Dr. Butch Sonnier, and LaCosta Wix

**Members absent:** Jeff Albright, Diane Davidson, Dr. Rachel Durel, Rep. Mike Huval, Randal Johnson, Jennifer Katzman, Jesse Lambert, Dr. Eva Lamendola, Darrell Langlois, Jesse McCormick, Jennifer McMahon, Andrew Muhl, Ronnell Nolan, Frank Opelka, Ed Parker, Stephanie Phillips, Clay Pinson, Patrick Reed, Elizabeth Sumrall, Judy Wagner, Senator Rick Ward, Scott Webre and Dr. Shondra Williams

**Staff present:** Crystal M. Stutes and Julie Freeman

Chairperson Fraiche called the meeting to order at 9:00 a.m.

Roll call was conducted and a quorum was noted for the record. A motion was offered for the approval of the February 22, 2019 Meeting Minutes. Commission member Lauren Bailey, representing the Louisiana State Medical Society, stated she had stepped out of the last commission meeting while the roll was being conducted but was present at the meeting and would like to amend the Minutes to reflect her attendance. The change was noted and an amendment will be made to the February 22, 2019 minutes.

Chairperson Fraiche then announced that Ms. Rebecca DeLaSalle, Assistant Commissioner of the Office of Health, Life & Annuity, would provide a health legislative update. Ms. DeLaSalle covered the following legislation:

- HB 119 – Provides relative to the denial of a prescription based upon step therapy or fail first protocols or non-formulary status. *Status: House Order Awaiting Concurrence.*
- HB 237- Prohibits pre-existing condition exclusions or other discrimination based on health status. *Status: Involuntarily Deferred*
- HB 308- Prohibits lifetime and annual limits on health insurance benefits. If the ACA is struck down, this bill will be amended to protect the HIPAA guaranteed renewability provision. Initially, it was provided to prohibit the annual lifetime limits but it has since been amended to add the HIPAA

guaranteed renewability provision. *Status: House Orders awaiting concurrence.*

- HB 345-Provides for coverage for breast and ovarian cancer susceptibility screening. *Status: Passed Senate and sent to the Governor.*
- HB 347- Provides for the coverage of diagnostic imaging at the same level of coverage as screening mammograms. *Status: Set on Senate Orders.*
- HB 432 – Provides for the regulation of pharmacy services administrative organizations. *Status: Voluntarily Deferred in House Insurance.*
- SB 41- Provides relative to the regulation of pharmacy benefit managers/PBM Omnibus bill. *Status: Pending before the Senate.*
- SB 173- Provides for the Healthcare Coverage for Louisiana Families Protection Act. *Status: Passed House; Awaiting Enrollment.*
- SB 219 –Requires health insurance policies to adhere to certain standards. *Status: Failed to Pass the Senate.*

Chairperson Fraiche commented regarding HB 119. He questioned whether or not the payer is required to provide a list of covered medications to patients when they are denied for non-formulary status. Lauren Bailey, representing the Louisiana State Medical Society, stated that in working with Blue Cross an amendment was made for providers to make a request using the patient's Electronic Health Records for a list of covered medications to be provided to the patient.

Dr. Faye Grimsley, representing Xavier University, commented on HB 345 and inquired as to whether patients will have an opportunity to opt out of genetic screening or if it is on a voluntary basis. Chairperson Fraiche stated while he suspected patients could opt out of genetic testing, the question remains what this does from an insurability perspective -- not only from a health insurance perspective, but also for life and disability insurance.

Barbara Morvant, representing AARP as a volunteer representative, expressed her concerns about what recourse consumers had if they were not able to access the medications they needed. Chairperson Fraiche stated the only relief the consumer would have would be to contact his or her payer and negotiate with its medical directors and whomever is handling the authorizations in order to access medications.

Linda Hawkins, representing the League of Women Voters of Louisiana, questioned the status of SB 173. Crystal Stutes, Director of LHCC, stated the bill passed the Senate and is awaiting enrollment. She added that once the legislative session is over, in August there will be another review to explain all legislation but for now it's strictly a status update.

Next, Chairperson Fraiche stated he would present power point slides of health legislation in the absence of Department legal staff, who were away at legislative committee hearings. In addition to the bills already reviewed by Ms. DeLaSalle, Dr. Fraiche reviewed the following bills:

- HB 143-Provides for rights of qualified organ transplant candidates who have a disability. *Status: Enrolled.*

- HB 242- Prohibits certain claims and fees despite health insurance and pharmacy benefit managers. *Status: Enrolled.*
- HB 272- Provides for insurance companies coverage for acupuncture. *Status: Voluntarily Deferred in Appropriations.*
- HB 352- Authorizes health insurers to establish modern health care costs and quality programs. *Status: Set on Senate Orders.*
- HB 370- Provides relative to prescription drug benefits for persons with advanced metastatic Stage 4 Cancer. *Status: Set on Senate Orders.*
- HB 371- Establishes an independent dispute resolution process for out-of-network health benefit claims. *Status: Voluntarily deferred in House Insurance Committee.*
- HB 408- Provides relative to group health insurance renewals. *Status: Passed Senate.*
- HB 412- Provides relative to certain public assistance programs as relates to employment. *Status: Failed to Pass.*
- HB 433- Authorizes a pharmacist to decline to dispense a covered prescription drug if the coverage provider reimburses the pharmacy in an amount less than the drug's acquisition cost. *Status: Set on Senate Orders.*
- HB 538- Provides relative to pharmacy record audits. *Status: Set on Senate Orders.*
- HB 557-Provides relative to pharmacy reimbursement. *Status: Voluntarily deferred in House Insurance Committee.*
- SB 48- Provides relative to Medicaid pharmacy services. *Status: Substituted by SB 239.*
- SB 64- Authorizes group health insurance providers to consent on behalf of their employees for use of electronic documents. *Status: Enrolled.*
- SB 73- Provides for a dental service care provider choosing the method by which such provider shall be reimbursed by an insurer. *Status: Enrolled.*
- SB 75- Provides for a dental service care provider choosing the method by which such provider shall be reimbursed by an insurer. *Status: Enrolled.*
- SB 164- Provides relative to the administration of prescription drug health insurance benefits. *Status: Involuntarily Deferred in House Health & Welfare.*
- SB 239- Provides relative to the Medicaid prescription drug benefit program. *Status: Passed House; awaiting enrollment.*

Next, Lisa Gardner, speaking on behalf of CommCare Corporation, gave a presentation on *CMS Innovative Care Models as a Means for Improving Quality and Controlling Costs.*

### **Bundles/Bundled Payments**

- Incentives hospitals use bundles to reduce costs and improve quality.
- At the end of each year, hospitals either earn or lose money based on their performance.
- Device manufacturers, skilled nursing facilities and specialist groups are among those who may apply for bundles.
- Owners of bundles are looking for good home health SNF partners.
- The data is public, revealing how much cost is incurred per episode at a SNF, including length of stay.

### **Accountable Care Organizations**

- ACOs agree to be held accountable for the quality, cost and experience of the Medicare beneficiary based on fee-for-service and the shared savings that are tracked through a number of different formats.
- The arrangements range from shared risks to shared gains and moves CMS' payments away from volume towards value.
- CMS has a site on innovation models. It promotes accountability and coordinates items and services for Medicare beneficiaries and it encourages value.
- ACOs are much broader than a bundle.
- ACOs take every cost from Medicare beneficiaries for the whole cost of care known as population management, so providers like physicians and hospitals can create an ACO.

### **CMS Special Needs Plan Enrollment Requirements**

- Patients require or are expected to need the level of services provided in a long-term care (LTC) or skilled nursing facility (SNF) and are expected to reside there for 90 days or longer with no expected discharge.
- Patients may reside in a LTC facility (NF), a SNF/NF, an intermediate care facility (ICF) for the developmentally disabled, in an inpatient psychiatric facility, or an assisted living facility (ALF).
- Patients are enrolled in Medicare A&B or C.
- Patients must not have End Stage Renal Disease (ESRD).
- Patients must reside in plan's service area.

### **Shared Savings Accountable Care Organizations**

- ACOs are committed to achieving better health for individuals, better population health and lowering growth in expenditures.
- Providers and suppliers (e.g., physicians, hospitals and others involved in patient care) are offered an opportunity to create an ACO.
- An ACO agrees to be held accountable for the quality, cost and experience of care of an assigned Medicare fee-for-service beneficiary population.
- The Shared Savings Program has different tracks that allow ACOs to select an arrangement that makes the most sense for their organization.
- CMS' payment system are moved away from volume and towards value and outcomes.
- ACOs promote accountability for a patient population.
- ACOs coordinate items and services for Medicare Fee-for-Service beneficiaries.
- ACOs encourage investment in high quality and efficient services.

### **Institutional Special Needs Program (ISNP)**

- Special needs plans were created by Congress and implemented by the Center for Medicare and Medicaid Services (CMS) to improve care for Medicare's most vulnerable beneficiaries.
- ISNPs restrict enrollment to Medicare Advantage (MA) eligible individuals who are institutionalized or who meet state requirements for institutionalization.
- In 2018 Congress made ISNPs permanent.

- Currently, 97 plans in the United States serve 81,000 institutionalized individuals, a 20 percent growth since 2017.
- ISNPs are based on Fee-for-Service.
- They include chronic disease focused (CSNP); Medicare/Medicaid dual eligible focused (D-SNP); and institutionalized patients (ISNP).
- ISNPs allow for focused care for complex groups.
- Louisiana does not currently have any Medicare programs that focus on long-term care nursing home residents.
- Commcare has applied for an ISNP license.

Katie Brittain, representing the Louisiana Physical Therapy Association, asked how the total costs or outcomes are set since patients are not required to seek services from providers who are associated with the bundle mode. She stated there are two separate scenarios in an outpatient setting where people who have exhausted their benefits in the bundle still require services and use their regular Medicare benefits for the same services that are a part of surgery. Lisa Gardner stated that the targeted price is not attributed to the beneficiary but who owns the bundle.

Ms. Brittain further questioned how the absolute total true cost and outcomes is assessed in the event the patient is not required to see providers who were part of the bundle and could spend money with other providers associated with that care. Ms. Gardner stated that patients may be informed, told what to expect and be encouraged to visit these providers but ultimately it is their choice.

Lastly, Ms. Brittain questioned Ms. Gardner as to how Medicare assessed the actual outcomes. Ms. Gardner stated Medicare identifies the diagnosis and all of the claims the patient makes within the 90-day period of the bundle and then there is a reconciliation. If the aggregate is above the target, it's the responsibility of the hospital to pay and not the patient.

Finally, Chairman Fraiche stated that provider behavior can be changed when they are a part of a shared savings plan but it requires a lot of education to change provider behavior, especially with respect to ER visits for the Medicare population. He added educating patients is crucial to gain an understanding of where the dollars need to be spent.

With no further business, Chairperson Fraiche asked for a motion to adjourn the meeting. Dr. Grimsley moved to adjourn and Arnold Goldberg seconded the motion. Hearing no objections the meeting was adjourned at 11:00 a.m.