Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

January 28, 2010

The Honorable Joel T. Chaisson II, President
Louisiana Senate
State Capitol
P.O. Box 94183
Baton Rouge, LA 70804

Dear President Chaisson:

In response to House Concurrent Resolution 3 (HCR 3) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. The resolution requests that state agencies maximize efficiency, minimize waste, and save taxpayer dollars. The resolution also requires DHH and other state agencies to submit a report to the legislature that allows legislators and citizens to ascertain whether success is being achieved in these areas and needs are being met.

DHH is available to discuss the enclosed report and recommendations with you at your convenience. Please contact Ms. Christine Arbo Peck, director of Legislative and Governmental Relations, at (225) 342-5274 with any questions or comments that you may have.

Sincerely,

Alan Levine
Secretary

Enclosures

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

January 28, 2010

The Honorable Jim Tucker, Speaker
Louisiana House of Representatives
State Capitol
P.O. Box 44486
Baton Rouge, LA 70804

Dear Speaker Tucker:

In response to House Concurrent Resolution 3 (HCR 3) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. The resolution requests that state agencies maximize efficiency, minimize waste, and save taxpayer dollars. The resolution also requires DHH and other state agencies to submit a report to the legislature that allows legislators and citizens to ascertain whether success is being achieved in these areas and needs are being met.

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January 28, 2010

The Honorable Richard "Rick" Gallot, Jr., Chair
House and Governmental Affairs
State Capitol
P.O. Box 44486
Baton Rouge, LA 70804

Dear Chairman Gallot:

In response to House Concurrent Resolution 3 (HCR 3) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. The resolution requests that state agencies maximize efficiency, minimize waste, and save taxpayer dollars. The resolution also requires DHH and other state agencies to submit a report to the legislature that allows legislators and citizens to ascertain whether success is being achieved in these areas and needs are being met.

DHH is available to discuss the enclosed report and recommendations with you and the members of the House and Governmental Affairs Committee. Please contact Ms. Christine Arbo Peck, director of Legislative and Governmental Relations, at (225) 342-5274 with any questions or comments that you may have.

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Alan Levine
Secretary

Enclosures

Bobby Jindal
GOVERNOR

Alan Levine
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State of Louisiana

Department of Health and Hospitals

Office of the Secretary

January 28, 2010

The Honorable Robert W. "Bob" Kostelka, Chair
Senate and Governmental Affairs
State Capitol
P.O. Box 94183
Baton Rouge, LA 70804

Dear Chairman Kostelka:

In response to House Concurrent Resolution 3 (HCR 3) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. The resolution requests that state agencies maximize efficiency, minimize waste, and save taxpayer dollars. The resolution also requires DHH and other state agencies to submit a report to the legislature that allows legislators and citizens to ascertain whether success is being achieved in these areas and needs are being met.

DHH is available to discuss the enclosed report and recommendations with you and the members of the Senate and Governmental Affairs Committee. Please contact Ms. Christine Arbo Peck, director of Legislative and Governmental Relations, at (225) 342-5274 with any questions or comments that you may have.

Sincerely,

Alan Levine
Secretary

Enclosures

The following current DHH Initiatives to maximize efficiency, minimize waste, and save taxpayer dollars were shared with and supported by the Governor's Commission on Streamlining Government:

Medicaid- Changing the Delivery of Public Funded Health Care

Transition Medicaid to Integrated Delivery System with Care Coordination. Louisiana's Medicaid program has significant challenges, led most importantly by the chronically poor outcomes produced despite the best efforts of our providers—providers who struggle to provide services in a fragmented system with little coordination of care. Our rates of hospitalization have been shown to be among the highest in the nation, and our quality metrics are poor by most measures. The financial challenges we face over the next several years will be profound and, without significant structural changes to our program, the state is not in a position to manage this challenge. To put it in perspective, the state has projected a deficit of over $300 million for the current fiscal year. Current estimates predict the state will face a shortfall in Medicaid with an annualized impact of $1.2 billion beginning in July 2011. In the year that begins July 2010, the shortfall could be as high as $700 million.

Current Medicaid services are primarily delivered by private providers reimbursed under a fee-for-service methodology, which virtually every national health policy expert across the political spectrum has decried as a failed system that incentivizes utilization, waste and overspending. Most recently, the Congressional Budget Office has said the fee-for-service system has contributed to the cost growth in health care nationally. This has been echoed by the Medicare Payment Advisory Commission, the Heritage Foundation, President Obama's health care advisors and even groups like the American Diabetes Association. We agree. Add to the fact that they cost more, fee-for-service programs have been shown in multiple states, from California to New York and throughout the nation, to have poor outcomes relative to systems of coordinated care, where consumers have the ability to choose their plan. A recent review of 24 different studies by the Lewin Group demonstrates with hard data that managed Medicaid programs have saved states anywhere from 2 to 19 percent of their Medicaid costs for medical services. We believe the heart of any reform should be consumer choice, transparency in results, and incentives for improved management of chronic disease. While the Administration has advanced this concept, some elements must be approved by the federal government. DHH recommends moving forward as rapidly as possible toward a Medicaid system of care that is more organized, less fragmented, and grants consumers, for the first time, the ability to make choices about which healthcare network from which they wish to receive their services.

With the discussion of national health care reform, all estimates are that a substantial expansion of eligibility for Medicaid could occur. Louisiana currently only covers adults up to With 12 percent of the Federal Policy Level. Given the expansion proposals by Congress to increase eligibility to as high as 150 percent FPL, coupled with the potential for a coverage mandate, the percentage of Louisiana residents covered by Medicaid could reasonably be estimated to reach almost 40 percent. With the potential for substantial expansion of an ailing system, DHH is focused on strategies to move toward a more coordinated delivery system.DHH plans to bring forward a state plan amendment for consideration in January to begin the process of transforming the current system to build an infrastructure that requires care coordination to promote efficiencies, primary and preventive care, and disease management, reduce unnecessary usage of emergency rooms and avoidable hospitalizations.

In this model, DHH would transform from its current role of simply paying for services to one which is more focused on setting benchmarks for performance, monitoring various systems of care to ensure the standards are met, and developing initiatives to improve overall health status while utilizing the coordinated systems of care to implement the care and prevention tools. DHH would measure each system of care based on metrics that correlate to improved quality, patient satisfaction and provider satisfaction, and ensure these metrics are reported publicly so consumers, the Legislature and regulators can monitor the performance of each care network. These standards of participation for providers in the program will be applied to both fee-for-service and prepaid models of reimbursement. Medicaid recipients will receive the right care at the right time in the right setting. Coordinated Care Networks will accept responsibility for the quality and cost of care provided to its patients by better managing treatment across care settings and by pursuing quality targets.

Preliminary projections by Mercer for the coordinated care system anticipate a savings of about 2.0 to 2.5 percent for the enhanced fee-for-service program and 3.0 to 4.0 percent for the capitation/prepaid model. Anticipated savings are $92 million in SFY 2012 upon completion of implementation in all regions of the state. All estimates are based upon the information available at this point in time. Therefore, any projection must be interpreted as having a likely range of variability, subject to unforeseen or random events.

It should be noted that the Medicaid budget is inclusive of an array services which are not impacted by this model - for instance, long-term care and services for the developmentally disabled. DHH has put forth cost saving concepts for consideration to the Commission addressing other services and programs within the department, such as integrated long-term care, privatization of mental health and developmental disability services and the downsizing of state operated institutional care.

Medicaid Pharmacy Program. Louisiana Medicaid has implemented several tools to achieve cost savings in the prescription drug program such as the multi-state buying pool, Preferred Drug List (PDL), negotiation of state supplemental rebates (in addition to federal rebates), and an established reimbursement methodology for generic drugs. With these efforts, Louisiana Medicaid was able to keep expenditures in this very costly program at just over $518 million in SFY 08. Recognizing that not all drug classes are included in the PDL and that the state utilization rate for generic drugs is 72%, the legislature passed Act 10 of the 2009 Regular Legislative Session which authorized DHH to redefine the reimbursement methodology for generic drugs and submit a State Plan Amendment to the Centers for Medicare and Medicaid for approval. Because of the state's aggressive supplemental rebate program, generic drugs are often more costly than name brand drugs. Revising the reimbursement methodology for generic drugs will lower their individual cost and make the manufacturers of both generics and name brand drugs more competitive with supplemental rebates. The Medicaid program has published a rule effective January 1, 2010 to redefine the reimbursement methodology for generic drugs authorize and has submitted a State Plan Amendment to the Centers for Medicare and Medicaid for approval.

Establish Medicaid Emergency Room (ER) Co-Pay. An analysis of Medicaid policies in other states found that 28 states impose a form of cost sharing for non-emergent services rendered in hospital emergency rooms. Twenty-three (23) of the 28 states have a co-pay ranging from $1 to $3. The maximum co-pay that can be assessed without an approved waiver is $3. Five (5) states have obtained waivers to impose a co-pay up to $6. Administrative rulemaking and a state plan amendment will be required before this can be implemented in Louisiana. Rates will need to be reduced and changes made to the claim processing system. Enrollees and providers will need to be informed of the change in policy through outreach and education. Since this is a "fee," it will require approval by 2/3 vote of the legislature and a statutory change will be needed.

In addition to children and emergency services, Section 1916 of the SSA and 42CFR 447.50 exclude certain populations (pregnant women and individuals residing in institutional settings) and services (e.g. family planning) from cost sharing. The ultimate decision as to whether an emergency room visit is emergent or non-emergent is dependent on the judgment of the attending physician. It is projected that a modest decrease of 2% in ER utilization will result with imposition of co-pays. Outreach and education for enrollees regarding the co-pay would be available by existing resources such as the 24/7 Nurse Advice Line provided to all Louisiana Medicaid enrollees, Chronic Care Management Program, and the Operation Redirect Emergency Room Diversion Project. This project is an initiative funded by a federal grant to identify high utilizers of emergency room services, and through intervention and education by RNs and care managers reduce the inappropriate utilization of ER services.

Maintain Low Administrative Costs. The vast majority (87%) of Medicaid administrative staff either handle the functions of determining eligibility for families who apply for coverage or providing oversight to assure compliance with Medicaid rules and regulations as well as mitigating fraudulent claims. Administrative costs in the Louisiana Medicaid Program have been among the lowest in the country for many years. The average administrative costs for other states are 68% higher than Louisiana. Louisiana has been recognized nationally as a model state for maintaining low administrative costs while continuing to cover more lives and providing increased services through the Medicaid program.

Efficient Service Delivery – Privatization, Outsourcing, and Ensuring Appropriate Care

Continue Downsizing Developmental Centers. The ARCs and other privately-operated services have proven to be cost effective and have shown improved outcomes for the individuals they serve and their families. The average annual cost for a person to receive services in a publicly operated facility is $170,000 while a privately operated facility receives an average of $70,000 to serve clients with similar needs. Outsourcing the operation of state-operated developmental disabilities institutions through a competitive process could prove to be a more cost-effective approach.

The Streamlining Commission has also recommended that the DHH reduce the number of publicly-operated institutions based on the assessed needs of the individuals served. The cost of services at the state-operated campuses is significantly higher than the cost of community-based services or alternative facilities. In 2003, the population at state-operated facilities was 1,615 people with a budget of $186 million. For FY 09/10, the census was 1,318 with a budget of $243 million. It is estimated that 20 percent of the people in state-operated facilities could have their needs met in communities at considerable cost savings. The state has continued to make significant investments in services for people with developmental disabilities and still has significant waiting lists for home- and community-based services.

These changes would facilitate cost-effective use of available resources. Taking these actions would be in keeping with national best practices to reduce reliance on institutions and serve people in their communities. Any action taken should provide allocation of services for people with developmental disabilities according to need, while gaining the ability to serve more people within the current allocation of resources.

Privatize DHH Community Homes. As part of the Fiscal Year 2010 budget, DHH moved twelve individuals out of two publicly operated community homes into existing private capacity or into waiver services. In addition, twenty-one supported independent living clients and six extended family living clients chose a private provider and have all transitioned to their new providers. Greater New Orleans Supports and Services Center no longer operates any residential services. DHH will continue pursuing this strategy statewide. OCDD currently operates 37 other

community homes (small ICF/DDs) serving approximately 220 clients. OCDD also provides services for 44 people in waiver and 41 people in Extended Family Living. These services are all currently managed by our state operated Supports and Services Centers. Private entities currently provide these same type services for less money. We are considering transferring all of these services to the private entities either by utilizing current vacancies and through Cooperative Endeavor Agreements for the community homes. For the wavier and Extended Family Living clients, they would simply choose a new non-state provider to provide the same supports. We have not issued any RFP or RFIs for these services at this time.

Privatize Inpatient Mental Health Institutions. All of the state's inpatient mental health institutions are aging and in need of significant capitalization. Already, the state is in the process of building a new facility to replace Central Louisiana State Hospital. This new building will be logistically more efficient; it is being designed to improve staff productivity and increase efficiency. While this initiative will improve efficiency at CLSH, the state would consider an innovative model, tested in other states, which reduces operating costs and improves consumer outcomes. The state could issue an RFP to analyze and evaluate the cost-benefit of private operation of the other state institutions, while also including a provision that permits the private entity to construct the new facilities. This model has been used successfully in other states, with the state saving millions of dollars in costs. In some cases, such as in privatization of forensic facilities, it was determined that the administration of inpatient mental health services was done in a more cost-effective manner, turnover improved, and the comparative metrics of performance were favorable. Clearly, the model would have to be designed based on what works for Louisiana, but DHH does not think it unreasonable to make the comparison to see if it can be done better and less expensively. A "roadmap" including a strategic plan and timeline for the financing and operation of inpatient facilities at the lowest possible cost for achieving optimal levels of care could be developed.

The projected savings at each state psychiatric facility would vary and is dependent upon the number of beds the facility has and the number of beds built in a newly constructed hospital. Using Southeast Louisiana Hospital (SELH) as an example, we estimate a potential for maximum savings in the amount of $56 million (capital outlay savings). This estimate is based on private operation of the institution and the private entity constructing a new facility. The estimate is based on the Department not incurring any new cost from replacing the existing hospital, but rather a new facility with the same service level SELH offers today being built by a private entity at no cost to the state. The estimate assumes the private entity is paid the current per diem rate, although, through a bid process, it may be determined there are operational savings beyond the capital savings. Capacity design and location of these facilities must be done within the context of the state's overall plan to create a Office of Behavioral Health, shift management responsibilities to local governing entities (Human Service Districts and Authorities), and decrease reliance on institutional care.

Redirect Public Health Unit Services. In many instances, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Human Service Districts, private physicians, community organizations and community clinics provide services that are often duplicative of services and programs provided by the state Office of Public Health (OPH) through local Public Health Units (PHUs). Many of these organizations receive cost-based reimbursement through Medicaid, or other DHH and federal funding and they provide a broad spectrum of services, such as comprehensive acute and chronic care, preventive health services, family planning, and immunizations among other services. Other testing or services traditionally offered in public health units, such as nutrition counseling, lead screening and STD testing, could be included in the service contract with the health care provider.

This transition would increase access to comprehensive coordinated care that is patient-centric, while reducing the cost to the state by maximizing the use of existing capacity and local service delivery systems. DHH has begun a parish by parish review of the health care needs of the population, what provider and community capacity exists, how population health needs are currently being met, what emergency preparedness surge capacity is required, and how OPH should best meet these needs. The primary focus is to determine how to best leverage DHH resources (not simply OPH, but all DHH program offices and Medicaid) to provide services that are not being met by local capacity - either by building new community capacity, contracting with current community capacity, or providing services directly through OPH programs and the PHUs.

Consolidate DHH Operated In-Patient Health Services in Greater New Orleans Area. In an effort to streamline inpatient mental health services and expand community-based, outpatient mental health services in the Greater New Orleans area, the Department consolidated the inpatient beds at the New Orleans Adolescent Hospital with those at Southeast Louisiana Hospital in Mandeville, La. The consolidation not only generated a savings of $9 million in the state budget, but also allowed for a city-wide expansion of community-based, outpatient services. Two clinics are now operating, one on the East Bank and the other West Bank of Orleans Parish. In addition to generating taxpayer savings, the new system will be better coordinated. Private capacity for these patients has been expanded at Children's Hospital, and we are now one step closer to having a complete continuum of mental health care in the city. These changes will allow the Department to serve significantly more individuals and families than last year.

Long-Term Care – Achieving Efficiencies while Serving our Aging Population

Reduce Unused Nursing Home Bed Supply. Louisiana has a high number of beds per capita, a low occupancy rate, and spends about $20 million per year on un-used capacity. The state has worked with the nursing home industry to develop current bed reduction programs including bed-buy back and private room conversion, which the Commission seeks to build upon. Many

states have implemented a variety of bed reduction strategies, including re-purchase of beds and conversion to other types of care which are more aggressive than what Louisiana currently has in place. These options will be pursued as part of implementation of this recommendation. Depending on the options used in Louisiana, full implementation could require legislation and/or CMS approval. The federal Centers for Medicare and Medicaid Services (CMS) and others have noted "right-sizing" bed supply is a key to developing balanced continuum of long-term care services.

Long-Term Care Managed Care Pilot Program. DHH will develop and implement pilot programs in selected areas of the state where long-term care (LTC) services will be integrated and coordinated. Pilot would have to be approved by federal Centers for Medicare and Medicaid Services (CMS), and would require promulgation of rules. Such pilot programs will allow for development of necessary infrastructure and systems, and for demonstration of effectiveness before a statewide expansion. Such managed LTC systems in other states have shown cost-effectiveness while providing a full spectrum of services based on individualized needs-based assessments. Ultimately, a coordinated, accountable system could slow spending growth in long-term care services, while ensuring choice and promoting care in the most appropriate setting.

Implementation of an integrated long term care system represents a major change in how the state currently provides and pays for long term care. In most states, integration of long-term care has occurred after the state has already accomplished significant integration of acute care services. DHH has recently made or is in the process of making changes in the community programs that will facilitate our efforts to move to an integrated model. An example is the small scale implementation of managed care for the elderly through the PACE (Program of All-inclusive for the Elderly). The PACE program is currently operated in two pilot locations; this program has successfully integrated social and medical care to assist fragile elderly adults to remain in their homes.

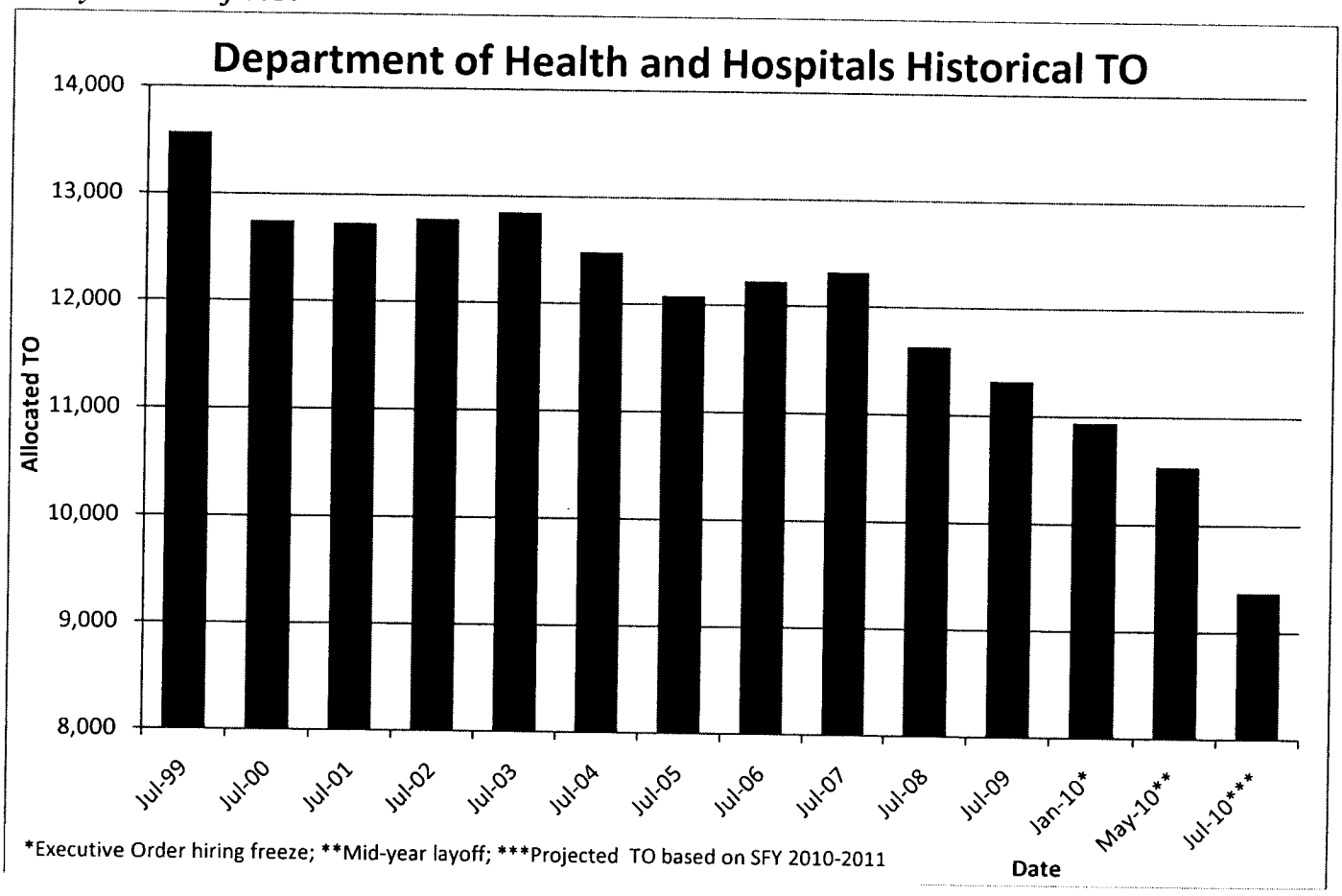
Continue Use of Resource Allocation. SR180/HR 190 of the 2008 Regular Session requested DHH to develop and implement cost control mechanisms for the Long-Term Personal Care Services program and the New Opportunities Waiver. The resolution noted that while it is in best interest of the state to operate a cost-effective and high-quality, home- and community-based services programs for citizens who are elderly or have developmental disabilities, the high cost of the Long-Term Personal Care Services program and the New Opportunities Waiver pose the greatest risk to the financial stability of the state's long-term care services. Without restructuring of these programs, the sustainability of long-term care and home and community-based services is threatened and the ability of the state to meet the growing needs of these citizens is impaired. OCDD and OASS have developed resource allocation methodology that utilizes a uniform needs-based assessment to determine the support needs of individuals and assures resources are

allocated fairly. OASS and OCDD began implementation of this process upon approval from the Centers for Medicaid and Medicare Services in 2009

Agency Efficiencies – Consolidation of Offices and Reduced Staffing

Create Office of Behavioral Health. The Legislature recently passed legislation (ACT 348 of 2009) authorizing the elimination of the Office of Mental Health and the Office for Addictive Disorders as standalone entities, and combining the administrative functions of both areas of care into the Office of Behavioral Health within DHH. The two current offices within DHH have separate administrators, policies and budgets and operate independently. This new authority ends the duplication and allows the operation of a single office that will continue to aggressively pursue best practices for programs that independently serve persons with mental illness and persons with addictive disorders. It will also increase access to the most complete and appropriate care for the significant number of persons with both mental illness and one or more addictive disorders, referred to as co-occurring disorder, which constitute about 50 percent of each of the current two offices' client populations. The advisory group established in the legislation is required to submit recommendations to the Secretary for his consideration; it further requires DHH to present its plan to the Joint Health and Welfare Committees prior to implementation of the merger.

Steady Decline of T.O.



ENROLLED

Regular Session, 2009

HOUSE CONCURRENT RESOLUTION NO. 3

BY REPRESENTATIVES PONTI, BALDONE, BARRAS, BURFORD, HENRY BURNS, CARMODY, CARTER, CHAMPAGNE, CHANEY, CONNICK, CORTEZ, DANAHAY, DOWNS, FOIL, GALLOT, GISCLAIR, GREENE, GUINN, HARRISON, HAZEL, HENRY, HINES, HOFFMANN, HOWARD, SAM JONES, KATZ, LANDRY, LEGER, LIGI, LITTLE, LOPINTO, MONICA, MORRIS, NOWLIN, PEARSON, PERRY, PETERSON, POPE, PUGH, RICHARDSON, SCHRODER, SIMON, SMILEY, GARY SMITH, JANE SMITH, TALBOT, TEMPLET, THIBAUT, TUCKER, WILLMOTT, AND WOOTON

A CONCURRENT RESOLUTION

To urge and request state agencies to maximize efficiency, minimize waste, and save taxpayer dollars, to be prepared to address their efforts in this regard at sunset review hearings and other legislative proceedings, and to deliver an annual report to the House and Senate governmental affairs committees and to direct state agency staff members responsible for monitoring legislation affecting their respective agencies to take immediate notice of this Resolution so that action can begin accordingly.

WHEREAS, revolutionary changes across the board are needed in the operations of state government, and state agencies must and will be held accountable by the legislature and citizenry for their actions; and

WHEREAS, state agencies should aggressively streamline their staffs and operations and deliver services to their targeted recipients in the most cost-effective way possible; and

WHEREAS, state agencies must closely scrutinize their operations and eliminate all obsolete programs, redundancies, and duplication of efforts which negatively affect the delivery of services to citizens or are an unnecessary drain on the state fisc; and

WHEREAS, state agency budgets must be constructed in a manner that will most efficiently deliver services and should be annually re-calibrated with the utmost care to ensure that resources are being appropriately applied and that not a single taxpayer dollar is being wasted; and

WHEREAS, through the existing annual performance planning and review process, state agencies must assess employee performance with absolute fairness and accuracy and

must break the cycle of awarding merit increases to employees who have not demonstrated truly outstanding and superior performance; and

WHEREAS, state agency employees must treat the state's citizens with courtesy and respect at all times and always strive for promptness and follow-through when providing services to them; and

WHEREAS, in order to consistently provide optimal service, state agencies should implement a method for citizens to provide feedback and evaluate services, the results of which should be made a part of agency employees' annual performance reviews; and

WHEREAS, state agencies should institute recognition programs that incentivize employees to be creative and innovative, and this recognition should only be bestowed upon employees who help their respective agencies save money, eliminate wastefulness, and increase productivity; and

WHEREAS, in order to meet the needs of the state's citizens and to address challenges and problems without further draining the state fisc, state agencies must cultivate partnerships with Louisiana's best and brightest minds at state colleges and universities, as well as collaborate with other state agencies and existing staff; and

WHEREAS, only after first tapping these resources should state agencies contract with private Louisiana consultants and companies, and state agencies should only consider contracting with more expensive out-of-state paid consultants or companies as a last resort; and

WHEREAS, taking into account these directives, the Louisiana Department of State Civil Service and state agencies must take all necessary and appropriate steps to modernize regulations and shape them in order to create a favorable environment for the timely implementation of these principles.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby urge and request state agencies to maximize efficiency, minimize waste, and save taxpayer dollars.

BE IT FURTHER RESOLVED that state agencies should expect and be prepared to address their progress in this regard at sunset review hearings and other legislative proceedings.

BE IT FURTHER RESOLVED that state agencies shall deliver an annual report to the House Committee on House and Governmental Affairs and the Senate Committee on Senate and Governmental Affairs with regards to the directives of this Resolution, which reports shall chart agencies' progress in a way that allows legislators and citizens to ascertain whether success is being achieved and needs are being met.

BE IT FURTHER RESOLVED that the annual report required to be delivered to the governmental affairs committees of the legislature pursuant to this Resolution shall be delivered each year no later than the sixtieth day prior to the beginning of the regular legislative session.

BE IT FURTHER RESOLVED that each state agency staff member responsible for monitoring legislation affecting his or her respective agency shall take immediate notice of this Resolution and ensure that it is brought to the attention of the agency head so that, if the Resolution is adopted, action can begin accordingly.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the office of the governor, the commissioner of administration, and the secretary or other official heading each of the following state departments: the Department of State Civil Service, the Department of Economic Development, the Department of Culture, Recreation and Tourism, the Department of Environmental Quality, the Department of Health and Hospitals, the Louisiana Workforce Commission, the Department of Natural Resources, the Department of Public Safety and Corrections, the Department of Revenue, the Department of Social Services, the Department of Transportation and Development, the Department of Wildlife and Fisheries, the Department of Agriculture and Forestry, the Department of Education, the Department of Insurance, the Department of Justice, the Department of State, the Department of the Treasury, and the Department of Veterans Affairs.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE