MCO Contract Changes Provider Webinar
Frequently Asked Questions
October 2022

General Questions

What is the contract term for the State's contracts with the MCOs?	This is a three year contract with the option to extend for two additional years.
What are the MCOs that will be in effect on 1/1/2023?	The MCOs effective 1/1/2023 are: • Aetna Better Health • AmeriHealth Caritas Louisiana • Healthy Blue* • Louisiana HealthCare Connections • United Healthcare Community • Humana Healthy Horizons in Louisiana (NEW) *Community Care Health Plan of Louisiana does business as Healthy Blue.
Will any of the current MCO contracts be fading out?	No, the five incumbent MCOs will remain in the Louisiana Medicaid Managed Care Program. The sixth MCO, Humana, is in addition to these.
Why was there a need for a sixth plan? We think five plans is too many.	It was determined this was best for the enrollees and the state of Louisiana.
Now that there will be six MCOs, are there plans to establish a centralized process so that we are not having to deal with six different sets of rules and regulations for authorizations, etc.?	LDH has made an effort to improve its guidance to the MCOs and require collaboration amongst MCOs and will continue to do so to promote consistency and transparency.
How many members can each provider have linked to them before their panel is closed? Will that ratio change with the addition of a sixth MCO?	LDH has established the following provider-to-enrollee linkage ratios under the new contract: • Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC) = 1:2,500 • Adult Physician Extenders = 1:1,000 • Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC) = 1:2,500 • Pediatric Physician Extenders = 1:1,000 Linkage ratios reflect the total number of Louisiana Medicaid managed care enrollees a provider may have *regardless of MCO*; therefore, adding a sixth MCO will not impact the ratio.
When was the last time members had a choice to change MCOs? When was the last open enrollment period?	The last open enrollment period was October 2021. An enrollee may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023.
Will you allow providers to recommend a certain MCO to their patients that has better benefits for the patients?	Providers should not recommend certain MCOs to patients. Enrollees have freedom of choice.
Who is the enrollment broker?	LDH is currently contracted with Maximus for enrollment broker services.

Will Humana offer adult dental services?	Humana has been approved to offer adult dental services as a value-added benefit.
Who is the vision provider for Humana?	Please reach out to Humana for this information. Contact information for all MCOs can be found on the LDH website.
Will the MCOs be making pharmacy access decisions or will this be done by the PBM?	LDH has defined the single Prescription Drug List. Additionally, LDH is moving toward a single PBM for all MCOs; however, the single PBM will not be effective January 1, 2023.
What BIN and PCN will Humana be using for pharmacies?	Humana will use the fee-for-service BIN and PCN.
How will the new MCO contract affect medical transportation?	The new contract will not affect medical transportation at this time. LDH is moving to a single transportation broker, so there will be some changes in the future. However, the single transportation broker may not be effective January 1, 2023.
Is it possible for one broker to manage transportation for the entire state of Louisiana, and who would manage the broker?	Many other states have one broker. A single broker would alleviate many issues. Each MCO is responsible for monitoring the broker, and LDH is responsible for monitoring the MCOs.
What is the withhold set for the MCOS? When is this calculated?	LDH withholds 2% of payments to the MCOs to incentivize quality, health outcomes, value-based payments, and health equity.
What is HEDIS?	HEDIS stands for "Healthcare Effectiveness Data and Information Set." This is a nationally-recognized performance method that sets quality standards.
Will the MCO rates increase?	Rates are reviewed twice per year and are determined by an actuary. Any rate increase will be actuarially sound.
Is the Medicaid fee schedule being updated or changed?	Medicaid fee schedules are not changing as a result of this process.
For those participants in waiver services, will the providers on the waiver freedom of choice need to enroll with the MCO?	Waiver providers who are not currently contracted with MCOs should not have to enroll with the MCO. All waiver services are delivered under fee-for-service Medicaid so there is no need for them to contract with an MCO. The only exception to this is CSoC waiver providers who enroll with Magellan.
Can LDH address the lack of Medicaid services for Home Health patients?	Home health services are provided in accordance with 42 CFR 440.70 and include nursing services, home health aide services, medical supplies, equipment and appliances, physical therapy, occupational therapy, speech pathology and audiology services. The services are provided to a beneficiary on his or her physician's orders as part of a written plan of care.
How much time are the MCOs allowed to update the eligibility information in their eligibility systems after receiving the file?	The eligibility information should be updated immediately as the process is automated.
When will this information be viewable in MEVS?	The process is not changing for MEVS.

Contracting

Will providers have to do anything?	Providers need to determine if they want to contract with the new entrant, Humana.
Will the MCOs be open to enrolling new providers?	If providers are interested in contracting with any MCO, they should reach out to the MCO directly. Contact information for all MCOs can be found on the LDH website.
Do providers need to sign a contract with, enroll with, or be credentialed by Humana?	Providers who are already serving Medicaid enrollees will not automatically be contracted with Humana. Providers who wish to be in Humana's network should reach out to Humana for all contracting and credentialing information. Contact information for all MCOs can be found on the LDH website.

What is the deadline for providers to contract with the new MCO?	The provider must determine whether and when they want to contract with Humana. However, the new MCO contract is effective 1/1/23.
Will the MCO be required to follow the same procedure with regards to credentialing?	Yes, all MCOs must follow credentialing requirements. This includes compliance with Act 143 of the 2022 Regular Session, which states that any provider who maintains hospital privileges or is a member of the medical staff of a hospital, FQHC, or RHC is exempt from having to satisfy any MCO credentialing requirements. Providers who are not credentialed with a hospital, FQHC, or RHC must follow the MCO credentialing process.
What if a provider is only contracted with three MCOs? Will the patient's MCO change automatically?	The automatic assignment algorithm seeks to preserve provider-beneficiary relationships; however, it is possible for enrollees to be assigned to an MCO that is not contracted with that provider.
Will CPST/PSR be opened with existing and new MCOs? Who do we contact if existing MCOs are not opening up for CPST/PSR contracts?	The MCOs, through the flexibility of their contracts with the State, have discretion about whether or not they credential and contract with providers expressing interest in joining their provider networks. In addition, 42 CFR 438.12 indicates MCOs are not required to contract with providers beyond the number necessary to meet the needs of their enrollees. If the MCO is contracted with an adequate number of qualified providers to provide sufficient access to mental health rehabilitation services to its enrollees, i.e. CPST and PSR services, the MCO may choose to cease credentialing new providers. Due to over-saturation of mental health rehabilitation providers in certain geographic areas of the state, MCOs have taken this measure as a means of safeguarding the fiscal sustainability of the MHR program as well as the integrity of its programming.
Will the MCOs have any interest in working with private behavioral health providers in the provision of case management services to targeted sub-populations of enrollees?	Please contact the MCOs to inquire about this. Contact information for all MCOs can be found on the LDH website.
Will each MCO have a different provider max per assigned patients?	LDH sets the linkage ratios (see General Questions section). Please contact the MCOs for additional contracting terms. Contact information for all MCOs can be found on the LDH website.
Our understanding of rates was that LDH controlled rates. Is this no longer true? Should we negotiate rates with each MCO?	LDH establishes the minimum reimbursement for in-network providers; however, reimbursement rates may vary if mutually agreed to by the MCO and the provider.
Will reimbursement remain the same for states that are within a 50 mile radius of Louisiana? For example, border counties in Mississippi.	There will be no changes to current reimbursement practices for border counties/trade areas.

Automatic Assignment

How will the automatic assignment affect PCP linkages?	The automatic assignment algorithm seeks to preserve provider-beneficiary relationships; however, it is possible for enrollees to be assigned to an MCO that is not contracted with that provider.
What if we have an agreement with only one MCO plan, will all current patients remain with our practice?	The automatic assignment algorithm seeks to preserve provider-beneficiary relationships; however, it is possible for enrollees to be assigned to an MCO that is not contracted with that provider.
Will members be auto-assigned to providers in the region where the member lives? Zip codes?	This process is regarding the automatic assignment of enrollees to MCOs—not to providers.

If a member requests a family member be reassigned to another MCO during the enrollment process will the family member or all family members be reassigned?	Households will be assigned at the same time to increase the likelihood of families being assigned to the same MCO; however, the automatic assignment algorithm prioritizes the provider-beneficiary relationship before the household relationship, so households are not guaranteed to stay together.
Are providers at risk of losing current patients if a member is auto-assigned to an MCO the current provider does not contract with?	The automatic assignment algorithm seeks to preserve provider-beneficiary relationships. This includes the enrollee's PCP, as well as the dominant provider within the last 12 months. However, it is possible that these relationships may be broken. It is also possible that the enrollee may be assigned to an MCO that is not contracted with all of the providers that are actively serving the enrollee.
How much of the twelve month history will be taken into account?	The automatic assignment algorithm seeks to preserve provider-beneficiary relationships. This includes the enrollee's PCP, as well as the dominant provider within the last 12 months.
Will members still be assigned a PCP?	Each MCO is responsible for developing a PCP Automatic Assignment methodology in accordance with contract section 2.9.11.2.
If the patient is receiving inpatient services, how would we be notified if the patient is assigned to a different MCO?	Per contract section 2.8.3.4, "If an Enrollee is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective on the date of Enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the Enrollee's hospitalization until the Enrollee is discharged. The receiving MCO is responsible for all other care."
How timely will eligibility roles be updated if enrollees have until March 31, 2023 to change plans?	Any transfer request processed on the last day of the business month will be effective on the second following month from the date of the request. Any transfer request processed on or before the 2nd to last business day of the month will be effective the following month.
Could you provide more explanation of retro transfer start dates?	CMS requires that if an enrollee loses and regains eligibility within 60 days, the enrollee must be assigned to the same MCO.
Is the member notified if their MCO move request is denied with the reason why?	After the initial assignment, enrollees may switch MCOs without cause from November 8, 2022, through March 31, 2023. There will be no reason to deny the request during this period.
If a provider does not take a specific MCO, will any of their members be moved to the MCO not taken?	The automatic assignment algorithm seeks to preserve provider-beneficiary relationships; however, it is possible for enrollees to be assigned to an MCO that is not contracted with that provider. Additionally, an enrollee may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023.
What if a member is in a high-risk category and the member is a plan that wasn't awarded? Will the patient still move to another plan?	All five of the current MCOs were awarded a contract.
How many members have actually chosen a specific health plan this year compared to those who were auto-assigned?	Generally, approximately 45% of individuals select a specific MCO when applying, and less than five percent switch to a new MCO.
How much time are the MCOs allowed to update the eligibility information in their systems after receiving the file?	This is up to the MCO.
If enrollees call in before December 27, 2022 requesting to stay with their current plan. Will that request be honored?	Yes, the request will be honored.
Will some members be enrolled in traditional Medicaid?	Enrollees who are in fee-for-service will remain in fee-for-service.

Will current subscribers be forced to change from their current MCO to another MCO, or will, for instance, current Aetna Better Health subscribers continue to be with Aetna Better Health, come next January?	If a current enrollee falls in one of the excluded populations, they will remain with their current MCO. If they have an active DCFS segment they will remain with their current MCO. An enrollee may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023. For more information, refer to the webinar presentation.
How do we verify who is keeping their current MCOs?	You can reach out to the MCO you are contracted with to get this information. Contact information for all MCOs can be found on the LDH website. The MCOs will be notified of enrollments beginning in November.
How will providers verify a patient's enrollment status and make sure they are not being reassigned incorrectly?	Providers may check the enrollment status in MEVS.
Will all of our Medicaid patients have a new policy assigned to them, particularly if they are Medicare/Medicaid eligible?	Most enrollees will go through automatic assignment; therefore, it is possible that enrollees may be reassigned to a different MCO.
When will members receive notification of assignment of new plan?	Current enrollees will receive a packet in the mail in November. LDH will be conducting an aggressive communication campaign to ensure enrollees are aware.
How is this information being communicated to patients?	Enrollees will receive letters with an explanation, regardless of whether they are assigned to a different MCO. LDH will also have commercial, and media ads. However, we will lean on our providers to share information as well.
Is it ethical to change someone's plan without their consent?	This process is not prohibited by CMS guidelines. An enrollee may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023.

Exclusions from Automatic Assignment

What are the high-risk groups which will be excluded from automatic assignment?	The following groups will be excluded from automatic assignment: • Case management • Cardiac Patients • Asthma • Behavioral Health • Chisholm Settlement • High Blood Pressure • Diabetes • Cancer • DCFS • High ED Utilizers If the enrollee does not fall in any of these groups, they will go through automatic assignment and may be assigned to a different MCO.
What criteria will be used to determine whether enrollees fall in these high-risk groups?	You may download this file for the relevant criteria. If the enrollee does not meet any of the criteria, they will go through automatic assignment and may be assigned to a different MCO.
Will LDH consider adding additional groups to be excluded from automatic assignment?	LDH has finalized the list of exclusions at this time. Enrollees who are reassigned may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023.
Will Humana not receive high-risk enrollees?	Humana will not receive those high-risk enrollees in the excluded groups; however, Humana may receive other high-risk enrollees.

If a client has behavioral health services and wants to keep their MCO, will they have to do anything?	If a current enrollee falls in the behavioral health excluded category, they will not need to do anything.
If behavioral health members will not be changing MCOs as they are high-risk, does that mean behavioral health providers should not expect to see Humana members for the beginning of this change?	You may download this file for the relevant criteria for behavioral health exclusions. Additionally, an enrollee may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023, so it is possible for an enrollee who was excluded from reassignment to be assigned, by choice, to Humana.
What is the rationale that diagnoses including asthma and high blood pressure are considered high-risk but pregnancy and obstetrics are not, considering that Louisiana has the highest rate of maternal mortality in the country?	LDH understands the importance of pregnancy and maternal health. The automatic assignment algorithm seeks to preserve provider-beneficiary relationships; however, it is possible for enrollees to be assigned to an MCO that is not contracted with that provider. Additionally, an enrollee may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023.
Should nursing home residents with Medicaid remain with their current Medicaid plan?	If the nursing home resident is part of the excluded population, they will remain with their current MCO.
How would the auto-assignment affect residents in a long-term care facility if the facility is only contracted with two of the MCOs; would they be considered high-risk if they are in a long-term setting?	The long term care setting is not considered high risk. The automatic assignment algorithm seeks to preserve provider-beneficiary relationships; however, it is possible for enrollees to be assigned to an MCO that is not contracted with that provider.

Disenrollment after Automatic Assignment

Since there is no current open enrollment process, if an individual wants to change their plan when can this be completed?	An enrollee may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023.. Enrollees should start receiving packets the first week in November.
Will enrollees who are excluded from automatic assignment have the opportunity to switch MCOs this year? Will they not have an open enrollment period?	An enrollee may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023. This includes the enrollees who are excluded from automatic assignment. After March 31, 2023, enrollees will be locked in until the next enrollment period which is October 2023.
What is an example of a reason that an enrollee is not approved to transfer to a new MCO? **Will you elaborate on "with cause" as it relates to changing MCOs? Members haven't had the opportunity to change providers in over a year. We had members that wanted to change MCOs but were denied.**	Per MCO Contract section 2.3.13.2, "An Enrollee may request Disenrollment from the Contractor as follows: **For cause,** at any time. The following circumstances are cause for Disenrollment: • The Contractor does not, because of moral or religious objections, cover the service the Enrollee seeks; • The Enrollee needs related services to be performed at the same time; not all related services are available within the Enrollee's MCO and the Enrollee's PCP or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; • The Contract between the Contractor and LDH is terminated; • Poor quality of care by the Contractor as determined by LDH; • Lack of access to MCO Covered Services as determined by LDH;

	• The Enrollee's active specialized behavioral health provider ceases to contract with the Contractor for reasons other than non-compliance with the Network Provider Agreement or this Contract; or • Any other reason deemed to be valid by LDH and/or its agent. **Without cause** at the following times: • During the Disenrollment period offered to Enrollees at the start of the Contract; • During the ninety (90) Calendar Days following the date of the Enrollee's initial Enrollment with the Contractor or during the ninety (90) Calendar Days following the date the Enrollment Broker sends the Enrollee notice of that Enrollment, whichever is later; • During the Enrollment Period; • Upon automatic reenrollment under 42 CFR §438.56(g), if a temporary (ninety (90) Calendar Day) loss of Louisiana Medicaid Program eligibility has caused the Enrollee to miss the Enrollment Period; • When LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3); or • After LDH notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722." If the member's circumstance does not meet one of the above-listed requirements, they will not be allowed to switch MCOs.

Continuity of Care

If the patient was admitted as an enrollee of MCO #1, and the patient was reassigned to MCO #2, is MCO #1 responsible for the entire stay?	If an enrollee is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective on the date of enrollment into MCO #2. However, MCO #1 will be responsible for the enrollee's hospitalization until the enrollee is discharged. MCO #2 is responsible for all other care.
How will this affect service authorizations already in place? **What if my patient has a procedure already approved by their MCO, or is in the middle of a residential substance abuse stay, and is later reassigned to another MCO?** **How would providers know about the change if the service is in progress or is scheduled before the reassignment process but their payer is changed on/before/during their date of service?**	The MCOs may not require service authorization for the continuation of medically necessary services for enrollees transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider; however, the MCO may require prior authorization of services beyond 30 calendar days. Providers can see the change in MEVS.
If a provider has long standing treatment relationship with a member and the member is assigned to an MCO the provider does not participate with, is the assumption the member	An enrollee may change MCOs with cause at any time, and without cause from November 8, 2022 through March 31, 2023.If the request is made prior to the December 27, 2022 deadline, there will be no break with the current MCO.

can stop treatment until the member returns to the participating MCO?	
If a client has an authorization with CPST/PSR services and is assigned to a new MCO, is their service authorization disrupted, and should a new OTR be requested with the MCO?	Per contract section 2.12.7, the MCO "shall not require service authorization for the continuation of medically necessary MCO covered services of a new enrollee transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider. However, the contractor may require prior authorization of services beyond thirty (30) calendar days."
What does preserve relationships actually mean? Please explain how this is being done.	The automatic assignment algorithm seeks to preserve provider-beneficiary relationships. This includes the enrollee's PCP, as well as the dominant provider within the last 12 months. However, it is possible that these relationships may be broken.
Will families be responsible for contacting every healthcare provider that they may visit, in order to determine how this may affect their ability to continue to receive services from them?	Enrollees may contact their newly assigned MCO to determine whether current providers are within network.

Webinar and Reference Materials

Will I receive confirmation for attending this webinar?	Attendance for this webinar is voluntary.
What is the website and where will the slides be available?	Please go to http://www.healthy.la.gov.
Where can we find the fee schedule?	Fee schedules may be found at lamedicaid.com.
Will there be a comparison chart available?	The comparison chart will be available at www.myplan.healthy.la.gov.
Who do we contact if we have concerns?	Please reach out to Ali Bagbey ali.bagbey@la.gov
Can you post or share the contract language we are reading?	Yes, the final executed contracts will be posted at www.healthy.la.gov once they are approved.
Are there flyers to post in our clinic to inform members of this upcoming change ASAP?	Yes, we will provide a toolkit and it will be posted on the LDH website at http://www.healthy.la.gov.