Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Louisiana** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program
Healthy LA	Healthy Louisiana and Coordinated System of Care 1915(b)(c) Concurrent Program	MCO;
CSoC	Healthy Louisiana and Coordinated System of Care 1915(b)(c) Concurrent Program	PIHP;

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):

Healthy Louisiana and CSoC Waiver

C. Type of Request. This is an:

☒ **Renewal request.**

☒ **The State has used this waiver format for its previous waiver period.**

The renewal modifies (Sect/Part):

Section A - Parts I, II, III and IV
Section B - Parts I and II
Section C
Section D

Requested Approval Period:*(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year**

○ **2 years**

○ **3 years**

○ **4 years**

◉ **5 years**

Draft ID:LA.028.02.00

D. Effective Dates: This renewal is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Proposed Effective Date: (mm/dd/yy)

07/01/22

Proposed End Date:06/30/27

Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name:

Brian Bennett

Phone: (225) 342-9846 **Ext:** ☐ **TTY**

Fax: (225) 342-9508

E-mail:

Brian.Bennett@la.gov

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **Healthy Louisiana and Coordinated System of Care 1915(b)(c) Concurrent Program**

☐ **Healthy Louisiana and Coordinated System of Care 1915(b)(c) Concurrent Program**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The Healthy Louisiana and Coordinated System of Care (CSoC) Waiver, LDH notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit this Medicaid waiver renewal request to CMS. This notice was made on November 19, 2021, and a copy of the applicable notice is available through the Office of Behavioral Health website. Comments are due by December 19, 2021.

Program History.
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Public Input Process -

The state published the public notice in the eight major daily newspapers of the state with the largest circulation. They were published in the following cities: Lafayette, Baton Rouge, New Orleans, Alexandria, Shreveport, Monroe, Lake Charles, and Houma.

The public notice appeared in the Legal Ad section of the hard copy newspapers and was published electronically on the Louisiana Press Association website. Within the public notice, we provided information on how to access the waiver application and provide comments and feedback in both hard copy and electronic forms.

The entire waiver renewal application was also made available on the OBH website for public review and comments for a period of 30 days prior to the submission to CMS for approval. The public comment period is from November 19, 2021 to December 19, 2021.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

   a. ☒ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
   -- *Specify Program Instance(s) applicable to this authority*

      ☒ **CSoC**

      ☒ **Healthy LA**

   b. ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
   -- *Specify Program Instance(s) applicable to this authority*

      ☐ **CSoC**

      ☐ **Healthy LA**

   c. ☒ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
   -- *Specify Program Instance(s) applicable to this authority*

      ☒ **CSoC**

      ☒ **Healthy LA**

   d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
   -- *Specify Program Instance(s) applicable to this authority*

      ☒ **CSoC**

      ☒ **Healthy LA**

      The 1915(b)(4) waiver applies to the following programs

      ☒ **MCO**

      ☒ **PIHP**

      ☐ **PAHP**

      ☐ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

      ☐ **FFS** Selective Contracting program
      Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

   a. ☐ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
   -- *Specify Program Instance(s) applicable to this statute*

   ☐ **CSoC**

   ☐ **Healthy LA**

   b. ☒ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
   -- *Specify Program Instance(s) applicable to this statute*

   ☒ **CSoC**

   ☒ **Healthy LA**

   c. ☒ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
   -- *Specify Program Instance(s) applicable to this statute*

   ☒ **CSoC**

   ☒ **Healthy LA**

   d. ☒ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

   CSoC Only

   -- *Specify Program Instance(s) applicable to this statute*

   ☒ **CSoC**

   ☐ **Healthy LA**

   e. ☐ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

   -- *Specify Program Instance(s) applicable to this statute*

   ☐ **CSoC**

   ☐ **Healthy LA**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. Delivery Systems. The State will be using the following systems to deliver services:

a. ☐ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. ☒ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

- ◉ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

c. ☐ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

- ○ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

d. ☐ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

f. ☒ **Other:** (Please provide a brief narrative description of the model.)

Louisiana will require the Healthy Louisiana managed care plans to comply with the federal requirements for Medicaid MCOs regardless of whether an individual receives comprehensive benefits (MCO) or less-than-comprehensive benefits (behavioral health only/PIHP). Therefore, the preprint sections for the Healthy Louisiana managed care plans are completed for MCO requirements, but Louisiana reserves the right to consider the plans under PIHP requirements in the future via amendment to this waiver for individuals who receive only behavioral health benefits through the plans. The preprint sections for the CSoC model are completed for PIHPs. To clarify the responses above in 1a and 1b, the Healthy Louisiana model operates as an MCO and the CSOC model operates under a single PIHP.
The PIHP is to be paid on a risk basis effective 11/01/2018.
The PIHP will be paid on a non risk basis through 10/31/2018.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. Procurement. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

☒ **Procurement for MCO**

- ◉ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☒ **Procurement for PIHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ◉ **Other** (please describe)

LDH intends to competitively procure the CSoC PIHP; however, services may continue under an emergency procurement consistent with 45 CFR Part 92 if needed.

☐ **Procurement for PAHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PCCM**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for FFS**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. Assurances.

☒ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

☒ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries ability to access services.

The State operates CSoC under a single state-wide PIHP for a subset of individuals ages 5 through age 20 who are in or at-risk of out-of-home placement for specialized behavioral health services.

Beneficiaries May Choose their Providers:
- Medicaid beneficiaries may choose to access services through any CSoC/PIHP network provider who provides the appropriate level of care.

The PIHP contractor is required to contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the state of Louisiana credentialing criteria, who agree to the standard contract provisions, and who wish to participate. The PIHP contractor is required to provide at least as much access to services that exists within Medicaid's fee for service program. Within the Plan's provider network, recipients have a choice of the providers which offer the appropriate level of care.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

Program: " **Healthy Louisiana and Coordinated System of Care 1915(b)(c) Concurrent Program.** *"*

- [x] **Two or more MCOs**
- [ ] **Two or more primary care providers within one PCCM system.**
- [ ] **A PCCM or one or more MCOs**
- [ ] **Two or more PIHPs.**
- [ ] **Two or more PAHPs.**
- [x] **Other:**
  please describe

OTHER: CSoC

A waiver of choice is requested for the single CSoC PIHP providing the specialized behavioral health services to Medicaid individuals eligible under the CSoC.

Enrollees will have free choice of providers within the CSoC PIHP and may change providers as often as desired. If an individual joins the CSoC PIHP and is already established with a provider who is not a member of the network, the CSoC PIHP will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network. In addition, if an enrollee needs a specialized service that is not available through the network, the CSoC PIHP will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, enrollees will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area.

In addition, consistent with requirements in 42 CFR 438 the CSoC PIHP must have credentialing and recredentialing policies consistent with federal and state regulations. The CSoC PIHP must evaluate every prospective subcontractor's ability to perform the activities to be delegated prior to contracting with any provider or subcontractor. The CSoC PIHP is not obligated to contract with any provider unable to meet contractual standards. In addition, the CSoC PIHP is not obligated to continue to contract with a provider who does not provide high quality services or who demonstrates utilization of services that are an outlier compared to peer providers with similarly acute populations and/or compared to the expectations of the CSoC PIHP and State. The CSoC PIHP's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. the CSoC PIHP must have a written contract that specifies the activities and report responsibilities delegated to the subcontractor, and provides for revoking delegation, terminating contracts, or imposing other sanctions if the subcontractor's performance is inadequate.

The CSoC PIHP must monitor all subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The CSoC PIHP must identify deficiencies or areas for improvement, and the subcontractor must take corrective action.

Program: " **Healthy Louisiana and Coordinated System of Care 1915(b)(c) Concurrent Program.** *"*

- ☐ **Two or more MCOs**
- ☐ **Two or more primary care providers within one PCCM system.**
- ☐ **A PCCM or one or more MCOs**
- ☐ **Two or more PIHPs.**
- ☐ **Two or more PAHPs.**
- ☒ **Other:**

please describe

For CSoC (PIHP):

A waiver of choice is requested for the single CSoC PIHP providing the specialized behavioral health services to Medicaid individuals eligible under the Coordinated System of Care.

Enrollees will have free choice of providers within the CSoC PIHP and may change providers as often as desired. If an individual joins the CSoC PIHP and is already established with a provider who is not a member of the network, the CSoC PIHP will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network. In addition, if an enrollee needs a specialized service that is not available through the network, the CSoC PIHP will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, enrollees will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area.

In addition, consistent with requirements in 42 CFR 438 the CSoC PIHP must have credentialing and recredentialing policies consistent with federal and state regulations. The CSoC PIHP must evaluate every prospective subcontractor's ability to perform the activities to be delegated prior to contracting with any provider or subcontractor. The CSoC PIHP is not obligated to contract with any provider unable to meet contractual standards. In addition, the CSoC PIHP is not obligated to continue to contract with a provider who does not provide high quality services or who demonstrates utilization of services that are an outlier compared to peer providers with similarly acute populations and/or compared to the expectations of the CSoC PIHP and State. The CSoC PIHP's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The CSoC PIHP must have a written contract that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation, terminating contracts, or imposing other sanctions if the subcontractor's performance is inadequate.

The CSoC PIHP must monitor all subcontractors' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The CSoC PIHP must identify deficiencies or areas for improvement, and the subcontractor must take corrective action.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. Rural Exception.

☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting.

○ **Beneficiaries will be limited to a single provider in their service area**
Please define service area.

◉ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Under 1915(b)(4) Selective Contracting:

Healthy Louisiana will provide a choice of at least two MCOs.

Individuals eligible for CSoC will have choice of providers within the CSoC PIHP for their specialized behavioral health services, except in certain situations when highly specialized services are usually available through only one agency in the geographic area, and may change providers as often as desired If an individual joins the CSoC PIHP and is already established with a provider who is not a member of the network, the CSoC PIHP will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network. In addition, if an enrollee needs a specialized service that is not available through the network, the CSoC PIHP will arrange for the service to be provided outside the network if a qualified provider is available.

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- Specify Program Instance(s) for Statewide

     ☒ **CSoC**

     ☒ **Healthy LA**
   - **Less than Statewide**
     -- Specify Program Instance(s) for Less than Statewide

     ☐ **CSoC**

     ☐ **Healthy LA**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	MCO	Aetna Better Health of Louisiana
Statewide	MCO	AmeriHealth Caritas Louisiana, Inc.
Statewide	MCO	Healthy Blue
Statewide	PIHP	Magellan Complete Care of Louisiana, Inc

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	MCO	UnitedHealthcare Community Plan
Statewide	MCO	Louisiana Healthcare Connections, Inc.

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

The statewide program name is officially the Healthy Louisiana and CSoC Waiver.

Louisiana will guarantee a choice of at least 2 MCOs and currently contracts with 5 Healthy Louisiana MCOs.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the States specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

☐ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

- ◉ **Mandatory enrollment**

○ **Voluntary enrollment**

☒ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

◉ **Mandatory enrollment**

○ **Voluntary enrollment**

☒ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Childrens Health Insurance Program (SCHIP) through the Medicaid program.

◉ **Mandatory enrollment**

○ **Voluntary enrollment**

☒ **Other** (Please define):

The Healthy Louisiana Waiver runs concurrently with Louisiana's Section 1932(a) state plan option for mandatory managed care under Healthy Louisiana. Populations exempt from mandatory managed care under the Section 1932(a) state plan are mandatorily enrolled under the 1915(b) waiver including:
-Children with special health care needs as defined in Section 1932(a) except those enrolled in the TEFRA/Katie Beckett program.
-Native Americans
-Full Dual Eligibles (for behavioral health services only)

Additionally, the following groups are mandatorily enrolled under this 1915(b) waiver:
-Children residing in an ICF (for behavioral health services only)
-All enrollees of waivers administered by OCDD or OAAS (mandatory for behavioral health services only)
-All Medicaid children functionally eligible for the CSoC program
-Adults residing in a Nursing Facility (for behavioral health services only)
-SSI/Transfer of Resources/LTC (adults and children for behavioral health services only)
-Transfer of Resources/LTC (adults and children for behavioral health services only)
-Adults identified as part of the DOJ target population (mandatory for all services including 1915(b)(3) services)

Note: Retroactive eligibles are enrolled in the waiver.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the Aged population may be required to enroll into the program, but Dual Eligibles within that population may not be allowed to participate. In addition, Section 1931 Children may be able to enroll voluntarily in a managed care program, but Foster Care Children within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☐ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

☐ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

☐ **Other Insurance** --Medicaid beneficiaries who have other health insurance.

☐ **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

☐ **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐ **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☐ **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

☐ **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

☐ **SCHIP Title XXI Children** Medicaid beneficiaries who receive services through the SCHIP program.

☐ **Retroactive Eligibility** Medicaid beneficiaries for the period of retroactive eligibility.

☒ **Other** (Please define):

For adults and children:
- Refugee Cash Assistance
- Refugee Medical Assistance
- Spend Down Medically Needy
- SLMB-only
- Aliens Emergency Services
- QI 1
- LTC Co-Insurance
- QDWI
- QMB-only
- Populations mandatorily enrolled under the Healthy Louisiana 1932a state plan, including former foster care children

Adult-only Populations excluded from 1915(b) Waiver
- Residents of an ICF/DD
- PACE
- Take Charge Plus

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

☒ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☒ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. Emergency Services. In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if

the emergency services provider does not have a contract with the entity.

☐ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

Emergency Services Category General Comments (optional):

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

☒ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.

☐ Other (please explain):

☐ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

☒ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

Healthy Louisiana MCO must offer a contract to all FQHCs and RHCs and enrollees will have a choice of available providers in the plan's network.

The Healthy Louisiana MCOs will permit any American Indian who is eligible to receive services from a participating I/T/U provider to choose to receive covered services from that I/T/U provider.

The CSoC PIHP will be required to reimburse or contract with at least one FQHC in each medical practice region of the State (according to the practice patterns within the State) if there is an FQHC appropriately licensed to provide substance use or specialty mental health under State law and to the extent that the FQHCs meet the provider qualifications outlined in the State Plan/waiver for those services.

Note: When a Medicaid member is enrolled in a Healthy Louisiana plan and the service is medically necessary, the CSoC PIHP will cover services provided in a FQHC that are not included in Healthy Louisiana.

Note: 638 Tribal clinics providing basic behavioral healthcare (e.g., physician, APRN, or PA) are reimbursed through the Healthy Louisiana or any eligible Indian Managed Care Entity (IMCE), using the prospective rate for any Healthy Louisiana member. If there are any 638 clinics providing specialized behavioral health, the PIHP will be required to contract with and reimburse that clinic consistent with the SMDL #10-001 and allow any American Indian to choose to receive covered services from an eligible and qualified behavioral health I/T/U provider, consistent with that guidance and any forthcoming regulations.

☐ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

5. EPSDT Requirements.

☒ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT Requirements Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

☒ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

Enrollees functionally eligible for CSoC, ages 5-20, are eligible for the following 1915(b)(3) covered services:
-Physician Consultation (Case Conferences): communication between LMHP, APRN or Psychiatrist for a patient consultation that is medically necessary for the medical management of psychiatric conditions. Provider types associated with this covered service include Licensed Mental Health Practitioners (LMHPs) who are not physicians, Advanced Practice Registered Nurses (APRNs), or Physicians. Services are available statewide.

Enrollees, ages 5-20, functionally eligible for CSoC, but not enrolled in the 1915(c) CSoC waiver are eligible through this 1915(b)(3) authority. The 1915(b)(3) services include:
-Parent Support and Training,
-Youth Support and Training
-Short-term Respite
- Habilitation (Independent Living Skills) as defined in the 1915(c) CSoC waiver.

These services will not exceed resources available in the waiver.

Adults, 21 years of age and older, who are diagnosed with a serious mental illness and are either transitioned or diverted from a nursing facility through the Preadmission Screening and Resident Review process, and who are identified as the DOJ target population, are eligible for the following 1915(b)(3) covered services:
- Personal care services (PCS): assistance and/or supervision necessary for members with mental illness to enable them to accomplish routine tasks and live independently in their own homes. PCS includes assistance with activities of daily living and instrumental activities of daily living and can be provided when medically necessary and recommended by a licensed mental health professional or physician within the scope of their practice up to a total of 20 hours per week. Agency providers must be licensed as a home and community based service provider/PCA agency per Revised Statute 40:2120.1 et seq. and LAC 48:I. Chapter 50 or a PT 24 Personal Care Attendant Agency, PS 8E CSoC/Behavioral Health and meet all other LDH agency staffing requirements.
-Individual Placement Support (IPS): mental health evidence-based practice of supported employment to help members living with mental health conditions regain the skills necessary to obtain and maintain employment of their choosing that exist in the open labor market and pay the same as others in a similar position, including part-time and full-time jobs. Components of IPS include intake, engagement, assessment, job placement, job coaching, and follow along supports before step down to less intensive employment support from another mental health practitioner. IPS must be provided only under the administrative oversight of licensed and accredited local governing entities and assertive community treatment agencies. Providers must meet State and federal requirements for providing IPS.

These services will be available and will not exceed resources available in the waiver.

7. Self-referrals.

☒ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

Healthy Louisiana MCOs allow for self-referral in accordance with federal requirements.

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. ☐ **Availability Standards.** The States PCCM Program includes established maximum distance and/or travel time requirements, given beneficiarys normal means of transportation, for waiver enrollees access to the following providers. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

b. ☐ **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The States PCCM Program includes established standards for appointment scheduling for waiver enrollees access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The States PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures timely access to the services covered under the selective contracting program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

b. ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the States standard:

c. ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

d. ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal	

Please note any limitations to the data in the chart above:

e. ☐ The State ensures adequate **geographic distribution** of PCCMs.

Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

f. ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) for facility programs, or vehicles (by type, per contractor) for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. **Assurances for MCO, PIHP, or PAHP programs**

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs.**

The following items are required.

a. ☒ The plan is a PIHP/PAHP, and the State has determined that based on the plans scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

The State has determined that all CSoC enrollees have specialized health care needs. For these enrollees, treatment planning may be performed by the PIHP in conjunction with the Wraparound Agency.

b. ☒ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

For the Healthy Louisiana MCOs, special health care needs population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. The MCO is responsible for identifying members with special health care needs within 90 days of receiving the member's historical Medicaid claims data (if available). In addition, providers must identify to the MCO those members who meet the MCO, LDH approved, guidelines for SHCN criteria and members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. LDH will also use claims data and/or other data to identify for the MCOs, members with special needs. Specific definitions and identifiers are described in the MCO contracts.

c. ☒ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

The MCO must assess members within ninety (90) days of identification. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for care management.

The PIHP must ensure a level of care assessment if conducted within 30 days of referral and every 6 months while the individual is enrolled in the Coordinated System of Care. The assessment must be conducted by appropriate healthcare professional.

d. ☒ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. ☒ Developed by enrollees primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee.
2. ☒ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☒ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

For CSoC enrollees, treatment planning may be performed by the PIHP in conjunction with the Wraparound Agency. For other special needs individuals receiving specialized BH services through the Healthy Louisiana program, the MCO or an independent community practitioner may develop the treatment plan. The treatment planner guides the treatment plan process and produces a community-based, individualized treatment plan in collaboration with the enrollee/family. The treatment planner is responsible for subsequent treatment plan review and revision as needed (minimum annually and more frequently when changes in the enrollee’s circumstances warrant changes in the plan).

Continued below under "Direct access to specialists"

e. ☒ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP

has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollees condition and identified needs.

Please describe:

Continued from Treatment Plans above:
The treatment planner will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources and promote flexibility to ensure that appropriate and effective service delivery to the enrollee and family/caregivers. An adequate number of case management staff necessary to support members in need of specialized behavioral health services shall be certified in treatment planning through the completion of specialized training in person-centered planning philosophy.

Direct Access to Specialists:
For enrollees determined to need a course of treatment or regular care monitoring, the Healthy Louisiana MCO and/or CSoC PIHP must ensure that the treatment plan in place to allows enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- **a.** ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.
- **b.** ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees overall health care.
- **c.** ☐ Each enrollee is receives **health education/promotion** information.

  Please explain:

- **d.** ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- **e.** ☐ There is appropriate and confidential **exchange of information** among providers.
- **f.** ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- **g.** ☐ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- **h.** ☐ **Additional case management** is provided.

  Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.

- **i.** ☐ **Referrals.**

  Please explain in detail the process for a patient referral. In the description, please include how the referred

services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☒ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

03/10/11 (mm/dd/yy)

☒ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. *Please provide the information below (modify chart as necessary):*

Program Type	**Name of Organization**	**Activities Conducted**		
		EQR study	**Mandatory Activities**	**Optional Activities**
MCO	Island Peer Review Organization (IPRO)	NO	- Validation of performance improvement projects - Validation of performance measures -Review to determine plan compliance with structure and operation standards and quality assessment and performance improvement - Validation of network adequacy: provider directory network and provider access survey	

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
				- Administration of provider satisfaction surveys - Calculation of performance measures -Conduct performance improvement projects -Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time - Development of a quality rating system - Behavioral health member survey - Evaluation of Louisiana's quality strategy -CAHPS dashboard and summary report - Technical assistance
PIHP				

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
	Island Peer Review Organization (IPRO)		- Validation of performance improvement projects - Validation of performance measures -Review to determine plan compliance with structure and operation standards and quality assessment and performance improvement - Validation of network adequacy: provider directory network and provider access survey	

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ☐ The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

b. ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
2. ☐ Initiate telephone and/or mail inquiries and follow-up
3. ☐ Request PCCMs response to identified problems
4. ☐ Refer to program staff for further investigation
5. ☐ Send warning letters to PCCMs
6. ☐ Refer to States medical staff for investigation
7. ☐ Institute corrective action plans and follow-up
8. ☐ Change an enrollees PCCM
9. ☐ Institute a restriction on the types of enrollees
10. ☐ Further limit the number of assignments
11. ☐ Ban new assignments
12. ☐ Transfer some or all assignments to different PCCMs
13. ☐ Suspend or terminate PCCM agreement
14. ☐ Suspend or terminate as Medicaid providers
15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ☐ Initial credentialing

B. ☐ Performance measures, including those obtained through the following (check all that apply):

- ☐ The utilization management system.
- ☐ The complaint and appeals system.
- ☐ Enrollee surveys.
- ☐ Other.

Please describe:

4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. ☐ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2. ☒ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

Please list types of indirect marketing permitted:

Healthy Louisiana MCOs - Indirect marketing generally includes, but is not limited to, the concepts of advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts and electronic messages designed to increase awareness and interest in the MCO. This includes any information that references the MCO, is intended for general distribution, and is produced in a variety of print, broadcast or alternative forms of media.

3. ☐ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the States procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ☒ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

Neither the MCO nor its subcontractors may distribute any MCO marketing or member materials without LDH consent. The MCO may not provide incentives or giveaways to providers to distribute to MCO members or potential MCO members. The State may impose sanctions for MCO violations.

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☒ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

The State requires that the MCO provide marketing materials in English and Spanish. In addition, the MCO must at no cost to members ensure that translation services are provided for all written marketing and member materials for any language that is spoken as a primary language by four percent (4%) or more of members or potential members of an MCO.

The State has chosen these languages because (check any that apply):

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b. ☒ The languages comprise all languages in the service area spoken by approximately 4 percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:

Under Item 1 - Marketing - Assurances

This waiver provides for mandatory enrollment of all CSoC-eligible individuals in the single, statewide CSoC PIHP for specialized behavioral health services. There is no enrollment process or choice of plan, thus marketing by the CSoC PIHP is not necessary. The remainder of Part IV, Section A has not been completed for the CSoC PIHP but has been completed for Healthy Louisiana MCOs.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

☒ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. ☒ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

Spanish

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines significant.:

b. ☒ The languages spoken by approximately 4.00 percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

2. ☒ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

The MCO and CSoC PIHP must make real-time oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages. The MCO and CSoC PIHP must notify its members that oral interpretation is available for any language and how to access those services.

Continued in the Additional Information section.

3. ☒ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

The MCOs are required to provide all covered services and provide info to enrollees. LDH contracts with an enrollment broker to also assist with info on Healthy Louisiana. All beneficiaries will receive information in a Welcome Packet about the covered services when first eligible for the program. This explanation is also available on the website 24/7 for all enrollees.

CSoC - see Add. Info.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☒ State
☒ Contractor

Please specify:

Contractor is Maximus.

For Healthy Louisiana MCOs, the State and/or its enrollment broker will provide information to potential enrollees. There are no potential enrollees in the CSoC PIHP. The state automatically enrolls beneficiaries in the single CSOC PIHP.

☒ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

☐ the State

☒ State contractor

Please specify:

For Healthy Louisiana, the enrollment broker will provide information to enrollees.

☒ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Complete response (due to space limitations)to the item "Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken."

The MCO and CSoC PIHP must make real-time oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages. The MCO and CSoC PIHP must notify its members that oral interpretation is available for any language and how to access those services.

The MCO and CSoC PIHP are required to make every reasonable effort to overcome any barrier that consumers may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the consumer in his/her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the consumer in his/her spoken language. The contract will require providers to have staff available to communicate with the consumer in his/her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the consumer in his/her spoken language.

Complete response (due to space limitations) to the item "The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program. Please describe."

The MCOs are required to provide all covered services and provide info to enrollees. LDH contracts with an enrollment broker to also assist with info on Healthy Louisiana. All beneficiaries will receive information in a Welcome Packet about the covered services when first eligible for the program. This explanation is also available on the website 24/7 for all enrollees.

All CSoC PIHP enrollees will receive information in a Welcome Packet about the CSoC PIHP when first eligible for the program. This explanation, which includes a description of the PIHP program, is also available on the website 24/7 for all enrollees.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

☒ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

☒ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

For the CSoC program, Louisiana requests a waiver of disenrollment 42 CFR 438.56.

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the States enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☒ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

For Healthy Louisiana MCOs, the LDH, Medicaid, enrollment broker, fiscal intermediary (FI) and contracted MCO websites provide basic information and updates including policy, program and eligibility changes and enrollment, performance and quality reporting. The FI offers direct provider communication through direct mailings, remittance advice notices, fee schedules and webinars. The state promotes the program through earned media, news releases and events, as needed. The enrollment broker communicates direct to individuals on issues related to MCO enrollment and program changes, including special outreach to voluntary members. Outreach to special populations includes utilizing all of these resources as well as engagement with organizations and associations, including provider groups that serve specific populations, to assist in the outreach efforts.

At the time of initial development of this 1915(b) waiver, LDH met with child welfare contractors, providers, juvenile justice staff, foster care advocacy groups and other stakeholders to develop policies and procedures to assure coordination by the CSoC PIHP with all related service systems.

New enrollees receive an enrollment packet from the CSoC PIHP explaining the program. The informational packet is mailed to all new enrollees upon determination of enrollment. The informational packet includes a handbook with information regarding client rights and responsibilities and a provider directory. All language will be written at the 5th grade reading level .

The handbook is available for distribution to any potential Louisiana behavioral health client, parents, guardians or other person upon request and includes the required CMS information from 42 CFR 438.l0.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☒ State staff conducts the enrollment process.

☒ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

☒ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Maximus

Please list the functions that the contractor will perform:

☒ choice counseling

☒ enrollment

☐ other

Please describe:

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☐ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

☒ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. ☒ Potential enrollees will have 0 ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☒ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

New members are given the opportunity to select an MCO at the time of application. If no MCO is selected, the member will be auto-assigned, using an LDH approved algorithm, to an MCO upon receipt by the enrollment broker after Medicaid eligibility has been determined. The effective date of Medicaid eligibility will be the effective date for coverage by the MCO. All members who are auto-assigned will be given a 90-day grace period during which they may change MCOs without cause.

For ii - There will be a single PIHP for the CSoC Program.

(Continued under "Additional Information")

☒ The State automatically enrolls beneficiaries.

☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).

☒ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).

☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☒ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☒ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- **i.** ☒ Enrollee submits request to State.
- **ii.** ☐ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- **iii.** ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☒ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☒ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollees health care needs):

In Healthy Louisiana, the Enrollment Broker is the single point of contact to the MCO member for disenrollment.

For the Healthy Louisiana MCOs, the State will evaluate requests for disenrollment for “cause” during the lock-in period. The following circumstances are cause for disenrollment:

- The MCO does not, because of moral or religious objections, cover the service the member seeks;
- The member requests to be assigned to the same MCO as family members;
- The member needs related services to be performed at the same time, not all related services are available within the MCO and the member’s PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;
- The contract between the MCO and LDH is terminated;
- Poor quality of care;
- Lack of access to MCO core benefits and services covered under the contract;
- Documented lack of access within the MCO to providers experienced in dealing with the member’s healthcare needs;
- Member moves out of the MCO’s service area, i.e. out of state; or
- Any other reason deemed to be valid by DHH and/or its agent.

☐ The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

☒ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

- **i.** ☒ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

  Please describe the reasons for which enrollees can request reassignment

  The member misuses or loans the member’s MCO-issued ID card to another person to obtain services. In such cases, the MCO shall report the event to the State.

- **ii.** ☒ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ☒ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCMs caseload.

iv. ☒ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Continued from c. Enrollment; auto-assigned; ii:

For individuals subject to mandatory enrollment for comprehensive (physical health and behavioral health) benefits and for individuals subject to mandatory enrollment in MCOs for physical health benefits and the CSoC PIHP for specialized behavioral health services:

- As part of the financial Medicaid and LaCHIP application process, applicants will be given the option to indicate their preferred choice of MCO and will have access to the LDH enrollment broker. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with a potential enrollee's current PCP, behavioral health provider, or other MCO network provider serving the member's particular needs.

- Enrollment Broker staff will be available by telephone to assist potential enrollees. Individuals will be offered multilingual enrollment materials or materials in alternative formats, large print, and/or Braille when needed. The enrollment broker will be able to assist the Medicaid enrollee with the selection of a MCO that meets the enrollee's needs by explaining in a non-biased manner the criteria that may be considered when selecting a MCO.

- If the choice of MCO is not indicated on the new enrollee file transmitted by LDH to the enrollment broker once an applicant has had been determined Medicaid eligible, the enrollment broker will utilize available information about relationships with existing PCPs in the assignment process. Individuals who fail to choose a MCO are automatically assigned to a MCO by the enrollment broker and the MCO is responsible to assign the member to a PCP.

For individuals subject to mandatory enrollment in Healthy Louisiana MCOs for behavioral health benefits only (i.e., those individuals eligible to enroll only for BH benefits or subject to mandatory enrollment for BH benefits/voluntary enrollment for comprehensive benefits):

- As part of the financial Medicaid and LaCHIP application process, applicants will be given the option to indicate their preferred choice of MCO. If the choice of MCO is not indicated on the new enrollee file transmitted by LDH to the enrollment broker once an applicant has had been determined Medicaid eligible, the enrollment broker will utilize available information about relationships with existing PCPs in the assignment process. Individuals who fail to choose an MCO are automatically assigned to an MCO by the enrollment broker and the MCO is responsible to assign the member to a PCP. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP/BH Provider who is in a MCO.

- Enrollment Broker staff will be available by telephone to assist program enrollees. Program enrollees will be offered multilingual enrollment materials or materials in alternative formats, large print, and/or Braille when needed. The enrollment broker shall assist the Medicaid enrollee with the selection of a MCO that meets the enrollee's needs by explaining in a non-biased manner the criteria that may be considered when selecting a MCO.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

☒ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

☒ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

   a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

   b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

   c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

   ☒ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

☒ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

☒ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

☐ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

☒ The States timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days (between 20 and 90).

☒ The States timeframe within which an enrollee must file a **grievance** is 365 days.

c. Special Needs

☒ The State has special processes in place for persons with special needs.

Please describe:

For the Healthy Louisiana MCOs and the CSoC PIHP, shall ensure that all members are informed of the State Fair Hearing process and the MCO's G&A procedures. These procedures must be described in the member handbook. Forms for filing G&A, concerns or recommendations to the MCO shall be available through the MCO, on their website, and upon request of the member.

Cont in "Additional Information"

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollees freedom to make a request for a fair hearing or a PCCM or PAHP enrollees direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☐ The State has a grievance procedure for its ☐ PCCM and/or ☐ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure): The grievance procedures are operated by:

- ☐ the State
- ☐ the States contractor.

  Please identify:
- ☐ the PCCM
- ☐ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

☐ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

☐ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

☐ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☐ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Continued from Item b - Timeframes

By federal regulation, there is no limit to when a grievance can be filed and Louisiana does not impose one either.

Continued from Item c - Special Needs

The MCOs and CSoC PIHP must also give members reasonable assistance in completing forms and taking other procedural steps including but not limited to providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCOs, PCCMs, PIHPs, or PAHPs equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCOs, PCCMs, PIHPs, or PAHPs obligations under its contract with the State.

☒ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
   - **a.** precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   - **b.** could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☒ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

☒ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the

areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:

- There must be at least one checkmark in each column under Evaluation of Program Impact.
- There must be at least one check mark in one of the three columns under Evaluation of Access.
- There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☒ MCO	☐ MCO	☐ MCO

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

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- **PCCM and FFS selective contracting** programs:
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  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
Healthy LA	MCO;
CSoC	PIHP;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Healthy Louisiana and Coordinated System of Care 1915(b)(c) Concurrent Program

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

b. ☒ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

Applicable programs: CSoC

Personnel responsible: CSoC PIHP and Office of Behavioral Health

Detailed description of activity: The State in collaboration with the EQRO determine the standards that may be deemed compliant based on accreditation results.

Frequency of use: Annually

How it yields information about the area(s) being monitored: Assists the State in determining the PIHP's compliance with state and federal standards.

☒ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

Applicable programs: CSoC

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): CSoC PIHP, Office of Behavioral Health and State Medicaid Agency

Detailed description of activity: Member satisfaction survey

Frequency of use: Annually.

How it yields information about the area(s) being monitored: Provides information on access to services, member satisfaction and quality of care.

☐ **CAHPS**
Please identify which one(s):

☒ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

Applicable programs: CSoC
Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor):CSoC PIHP, Office of Behavioral Health and State Medicaid Agency

Detailed description of activity: The CSOC PIHP is required to track and address grievances and appeals, which is reported to the State on a monthly basis.
Frequency of use: Monthly
How it yields information about the area(s) being monitored: Provides information on type of grievances and appeals filed, grievance resolutions, appeal decisions, and associated timelines to monitor member quality of care, access to care, and the PIHP's interaction with members and providers.

☐ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

- ☐ **From plan**
- ☐ **From PCP within plan**

☒ **Grievances and appeals data**

☐ **Other**
Please describe:

e. ☐ **Enrollee Hotlines**

Activity Details:

f. ☐ **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained

improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. ☒ **Geographic mapping**

Activity Details:

Applicable program: CSoC

Personnel responsible: CSoC PIHP, Office of Behavioral Health

Detailed description: The CSoC PIHP provides quarterly geographical access reports of the provider network and LDH reviews these reports to measure performance against established standards for reasonable geographic location of providers and number of providers. Specific deficiencies are addressed with a corrective action plan and follow-up activity is conducted to reassess compliance.

The CSOC PIHP provides a geographic mapping report to the State which includes distribution of provider types across the State as identified. The report also includes the number of providers and locations, percent of members residing within the required radius of the provider, and average distance in miles to the provider by parish. Examples of provider types shown through mapping include psychiatrists, psychologists, social workers, and prescribers.

Frequency of use: Quarterly.

How it yields information about the area(s) being monitored: The geographical mapping report, among other information, enables LDH to assess the CSOC PIHP"s network adequacy.

h. ☒ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

Applicable programs: CSoC

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): Contractor

Detailed description of activity: The Department contracts with an independent third party to perform an assessment of program impact, access, quality and cost-effectiveness.

Frequency of use: Once per waiver period.

How it yields information about the area(s) being monitored: Assists the State in evaluating access, quality, and cost-effectiveness of the program.

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☒ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

Applicable programs: CSoC

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): CSoC PIHP, Office of Behavioral Health and State Medicaid Agency

Detailed description of activity: The CSoC PIHP submits documentation to the State that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees.

Frequency of use: Documentation must be submitted at the time the CSoC PIHP enters into contract with the Department, annually, and any time there is a significant change in the PIHP's provider network that would affect adequate capacity and services.

How it yields information about the area(s) being monitored: LDH uses this information, along with other quality measures, to fully assess the CSoC PIHP's network adequacy.

k. ☐ **Ombudsman**

Activity Details:

l. ☒ **On-Site Review**

Activity Details:

Applicable program: CSoC

Personnel responsible: EQRO, Office of Behavioral Health, and State Medicaid Agency

Detailed description: The State Medicaid Agency contracts with an EQRO to conduct compliance reviews consistent with the CMS compliance monitoring protocol. The scope of the review includes state and federal regulations and contractual standards.

Frequency of use: At least ever three (3) years.

How it yields information about the area(s) being monitored: Assists the State with determining if program standards are met.

m. ☒ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

Applicable program: CSoC

Personnel responsible: CSoC PIHP, EQRO and Office of Behavioral Health

Detailed description: The CSoC PIHP is required to conduct an annual performance improvement project(s) that is designed to achieve, through on-going measurement and intervention, significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. The PIPs are validated by the SMA's EQRO consistent with the applicable CMS protocol.

Frequency of use: Annually.

How it yields information about the area(s) being monitored: Assists the State with determining if program goals are met.

☒ **Clinical**

☒ **Non-clinical**

n. ☒ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

Applicable program: CSoC

Personnel responsible: CSoC PIHP, Office of Behavioral Health and State Medicaid Agency

Detailed description: The Office for Behavioral Health has established a comprehensive list of performance measures, inclusive of waiver/ performance measures, HEDIS measures, and other measures geared toward assessing health outcomes/status, access/availability of care, service utilization, and cost of care. Performance measure reports are reviewed/monitored on an ongoing basis by LDH. The SMA's EQRO validates a select number of performance measures consistent with the applicable CMS protocol.

Frequency of use: Ranges from monthly to annually.

How it yields information about the area(s) being monitored: Assists the State with determining if program goals are met.

☒ **Process**

☒ **Health status/ outcomes**

☒ **Access/ availability of care**

☒ **Use of services/ utilization**

☒ **Health plan stability/ financial/ cost of care**

☒ **Health plan/ provider characteristics**

☒ **Beneficiary characteristics**

o. ☒ **Periodic Comparison of # of Providers**

Activity Details:

Applicable programs: CSoC

Personnel responsible: CSoC PIHP, Office of Behavioral Health and State Medicaid Agency

Detailed description of activity: The CSoC PIHP is required to report on the number and types of providers (by service type) relative to the number of providers at the beginning of the contract.

Frequency of use: Annually

How it yields information about the area(s) being monitored: Provides information relative to timely access and provider capacity.

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☐ **Provider Self-Report Data**

Activity Details:

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☒ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

Applicable programs: CSoC

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): CSoC PIHP, Office of Behavioral Health and State Medicaid Agency

Detailed description of activity: The CSoC PIHP is responsible for authorizing services consistent with State-approved medical necessity criteria, detecting and addressing over and under-utilization, and provider monitoring reviews. The CSoC PIHP submit utilization review reports and deliverables (e.g., service authorization timeframes, provider monitoring report, utilization management committee meeting minutes/agenda) to OBH for review.

Frequency of use: Quarterly.

How it yields information about the area(s) being monitored: This information is used to identify potential program integrity issues, assess access to care/quality of care, and to assess provider compliance with policies and procedures.

t. ☒ **Other**

Activity Details:

Review of Materials

Applicable programs: CSoC

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan,, EQR, other contractor): CSoC PIHP, Office of Behavioral Health, State Medicaid Agency, EQRO

Detailed description of activity: The CSoC PIHP is required to develop policies and procedures for a number of operational functions and submit to the LDH and the EQRO for review.

Frequency of use: Initially, upon revision, or more frequently according to LDH specified reporting periods.

How it yields information about the area(s) being monitored:
The information assist the State in determining if the PIHP's policies and procedures align with contractual requirements and any relevant best practices.

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Healthy Louisiana and Coordinated System of Care 1915(b)(c) Concurrent Program

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☒ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

Applicable programs: Healthy Louisiana

Personnel responsible: EQRO and the State Medicaid Agency

Detailed description of activity: The State in collaboration with the EQRO determine the standards that may be deemed compliant based on accreditation results.

Frequency of use: Annually

How it yields information about the area(s) being monitored: Assists the State determining the MCO's compliance with state and federal standards.

☒ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

b. ☒ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

Applicable programs: Healthy Louisiana

Personnel responsible: State Medicaid Agency, MCOs

Detailed description of activity: The State in collaboration with the EQRO determine the standards that may be deemed compliant based on accreditation results.

Frequency of use: Annually

How it yields information about the area(s) being monitored: Assists the State in determining the MCO's compliance with state and federal standards.

☒ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

Applicable programs: Healthy Louisiana

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): MCO, Office of Behavioral Health, EQRO and State Medicaid Agency

Detailed description of activity: Member satisfaction survey

Frequency of use: Annually.

How it yields information about the area(s) being monitored: Provides information on access to services, member satisfaction and quality of care.

☒ **CAHPS**

Please identify which one(s):

Healthy Louisiana:
Medicaid Adult Survey and supplement for People with Mobility Impairments

☒ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

Applicable programs: Healthy Louisiana

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): Enrollment Broker and State Medicaid Agency

Detailed description of activity: The enrollment broker provides a weekly report during the open enrollment period to be followed by a monthly report thereafter that includes all disenrollment requests by the MCOs to the state for ongoing monitoring and evaluation.

Frequency of use: Quarterly.

How it yields information about the area(s) being monitored: The disenrollment request report provides the state with information about consumer's overall satisfaction with their plan along with reasons for disenrollment request.

Healthy Louisiana uses Disenrollment requests by enrollee from the plan.

☐ **Denials of referral requests**

☒ **Disenrollment requests by enrollee**

☒ **From plan**

☐ **From PCP within plan**

☐ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☒ **Enrollee Hotlines**

Activity Details:

Applicable program: Healthy Louisiana

Personnel responsible: MCO and State Medicaid Agency

Detailed description: Toll-free numbers are established to directly assist enrollees or to refer enrollees to the appropriate LDH staff member for the purpose of understanding the MCO's policies and procedures, information on access to and availability of care, coordination of care, referrals to specialists, resolution of problem areas that will improve care provided, and member grievances.

Frequency of use: Weekly/Monthly.

How it yields information about the area(s) being monitored: All information received through the hotlines are compiled into an overall report to identify, analyze, and address trends.

f. ☐ **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. ☒ **Geographic mapping**

Activity Details:

Applicable program: Healthy Louisiana

Personnel responsible: MCO. Office of Behavioral Health and State Medicaid Agency

Detailed description: The MCO provides quarterly geographical access reports of the provider network and LDH reviews these reports to measure performance against established standards for reasonable geographic location of practitioners, number of practitioners, appointment availability, provision for emergency care, and after hours service. Specific deficiencies are addressed with a corrective action plan and follow-up activity is conducted to reassess compliance.

Frequency of use: Quarterly.

How it yields information about the area(s) being monitored: The geographical mapping report, among other network-related reports, enables LDH to assess the MCO's network adequacy.

h. ☒ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

Applicable programs: Healthy Louisiana

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): Contractor.

Detailed description of activity: The Department contracts with an independent third party to perform an assessment of program impact, access, quality and cost-effectiveness.

Frequency of use: Once per waiver period.

How it yields information about the area(s) being monitored: Assists the State in evaluating access, quality of care, and cost-effectiveness of the program.

i. ☒ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

Applicable programs: Healthy Louisiana

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): MCO, Office of Behavioral Health and State Medicaid Agency

Detailed description of activity : The State in partnership with the MCOs work to identify and address the factors that lead to health disparities among racial, ethnic, geographic, and socioeconomic groups so that barriers to health equity can be removed. The MCOs are required to report demographic data (including racial/ethnic data), outcome measures, utilization and special needs population (target population) data to the State through the required data submission process.

Frequency of use: Annually.

How it yields information about the area(s) being monitored: The measurement of any disparities by racial or ethnic groups will be used to monitor:
- timely access
- quality and appropriateness of care
- coverage and authorization of care

The disparity analysis provides information regarding trends and ongoing variations in health disparities and inequalities for selected performance measures. This information is important for encouraging action and facilitating accountability to reduce modifiable disparities by deployment of interventions that are effective and scalable.

j. ☒ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

Applicable programs: Healthy Louisiana

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): MCO, Office of Behavioral Health and State Medicaid Agency

Detailed description of activity: The MCO submits documentation to the State that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees.

Frequency of use: Documentation must be submitted at the time the MCO enters into contract with the Department and any time there is a significant change in the MCO's operations that would affect adequate capacity and services.

How it yields information about the area(s) being monitored: LDH uses this information, along with other quality measures, to fully assess the MCO's network adequacy. The MCO also integrates network adequacy information into their annual QAPI work plan and evaluation plan.

k. ☐ **Ombudsman**

Activity Details:

l. ☒ **On-Site Review**

Activity Details:

On-Site Review – EQR in conjunction with representative members of the LDH

Applicable program: Healthy Louisiana

Personnel responsible: EQRO and State Medicaid Agency

Detailed description: The Department contracts with an EQRO to conduct compliance reviews as outlined in 42 CFR 438.358 Subpart E. The compliance review monitoring process is consistent with the CMS compliance monitoring protocol. The scope of the review includes state and federal regulations and contractual standards. The MCO will be required to develop Department-approved corrective action plans for all areas of non-compliance. Corrective actions are monitored until the MCO is in compliance.

Frequency of use: Every three years..

How it yields information about the area(s) being monitored: Assists the State with determining if state and federal standards are satisfactorily met.

m. ☒ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

Applicable program: Healthy Louisiana

Personnel responsible: MCO, Office of Behavioral Health, EQRO

Detailed description: The MCO, PIHP is required to conduct annual performance improvement projects that are designed to achieve, through on-going measurement and intervention, significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. The PIPs are validated by the Department's EQRO consistent with the applicable CMS protocol.

Frequency of use: Annually.

How it yields information about the area(s) being monitored: Assists the State with determining if program goals are met.

☒ **Clinical**

☒ **Non-clinical**

n. ☒ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

Applicable program: Healthy Louisiana

Personnel responsible: MCO, Office of Behavioral Health, State Medicaid Agency, EQRO.

Detailed description: Louisiana requires MCOs to report annually on patient outcome performance measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®) quality metrics, CMS Adult and Children Core Set, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, and state-specified quality measures. In addition, Louisiana utilizes other data sources to assess network adequacy, utilization, cost of care, provider and beneficiary characteristics. These measures and assessments of data are geared toward evaluating health outcomes/status, access/availability of care, service utilization, and cost of care. Performance measure reports are reviewed/monitored on an ongoing basis by LDH. The Department's EQRO validates a select number of performance measures consistent with the applicable CMS protocol.

Frequency of use: Ranges from monthly to annually..

How it yields information about the area(s) being monitored: Assists the State with determining if program goals are met.

☒ **Process**

☒ **Health status/ outcomes**

☒ **Access/ availability of care**

☒ **Use of services/ utilization**

☒ **Health plan stability/ financial/ cost of care**

☒ **Health plan/ provider characteristics**

☒ **Beneficiary characteristics**

o. ☒ **Periodic Comparison of # of Providers**

Activity Details:

Applicable programs: Healthy Louisiana

Personnel responsible: State Medicaid Agency, MCOs, EQRO, and other state agency.

Detailed description of activity: The MCO is required to report on the number and types of practitioners (by service type) relative to the number of providers at the beginning of the contract.

Frequency of use: Annually

How it yields information about the area(s) being monitored: Provides information relative to timely access and specialist capacity.

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☐ **Provider Self-Report Data**

Activity Details:

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☒ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

Applicable programs: Healthy Louisiana

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): MCO, Office of Behavioral Health and State Medicaid Agency

Detailed description of activity: The MCO conducts member record reviews and performs ongoing monitoring of UM data via on-site review results and through review of claims data review. Results are reviewed by the MCO's Utilization Management Committee and reported to the Department.

Frequency of use: Quarterly and Annually.

How it yields information about the area(s) being monitored: This information is used to identify program integrity issues, monitor coverage/authorizations and to assess provider/contractor compliance with utilization policies and procedures.

t. ☒ **Other**

Activity Details:

Other: Review of Material

Applicable programs: Healthy Louisiana

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan,, EQR, other contractor): MCO, Office of Behavioral Health, State Medicaid Agency, EQRO

Detailed description of activity: The MCOs are required to develop policies and procedures for a number of operational functions and submit to the LDH and the EQRO for review.

Frequency of use: Annually or more frequently according to LDH specified reporting periods.

How it yields information about the area(s) being monitored:
The information is used to evaluate program impact for choice, marketing, enrollment/disenrollment, information to beneficiaries and grievances. The material review ensures compliance with approved policies and procedures and facilitates identification of improvement opportunities.

Other: Enrollment Broker Reports

Applicable programs: Healthy Louisiana

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan,, EQR, other contractor): State Medicaid Agency

Detailed description of activity: The Enrollment Broker provides monthly reports on new member health plan linkages, identifying which assignments were made by proactive choice versus auto assignment. There are also monthly reports on members who request disenrollment within their 90 day choice period (without cause) and for those who request disenrollment for cause beyond the 90 day period.

Frequency of use: Monthly

How it yields information about the area(s) being monitored: These monthly reports will be used to identify trends in member choice and proactive member movement between health plans, thereby alerting the department to possible areas of concern in the networks.

Section C: Monitoring Results

Renewal Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the States Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is a renewal request.

○ **This is the first time the State is using this waiver format to renew an existing waiver.**The State provides below the results of the monitoring activities conducted during the previous waiver period.

◉ **The State has used this format previously**The State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

MCO Monitoring Summary

LDH has contracted with Island Peer Review Organization (IPRO), a CMS-recognized External Quality Review organization (EQRO), to conduct full independent compliance reviews of Healthy Louisiana MCOs in accordance with CMS regulations. IPRO conducted EQR mandatory and optional monitoring activities and developed the annual technical report required by EQROs.

IPRO, on behalf of LDH, validated the Performance Improvement Projects (PIPs) and reported that the PIPs were progressing as scheduled with no major problems identified. IPRO also validated performance measures and reported that no major issues in calculating valid rates identified for HEDIS measures.

The MCOs monitor and assess the appropriateness of care furnished to Medicaid beneficiaries through various means including but not limited to evaluation of the quality assessment and performance improvement programs, comprehensive care management program reporting, care coordination, and CAHPS member satisfaction surveys annually.

The LDH provided ongoing performance monitoring through MCO generated reporting during the waiver period. Various reports are submitted to LDH monthly, quarterly, and annually such as a utilization and management of services report, network reports, grievance and appeals data, and treatment outcomes. These reports are reviewed by state staff as part of our ongoing monitoring efforts and LDH will work with the MCOs if any issues are found.

The primary area of concern observed statewide was in the area of network adequacy and member access to care. Despite ongoing outreach efforts by the MCOs some parishes in the state lack sufficient physicians in several specialty areas for MCOs to recruit and, therefore, network adequacy is suboptimal. LDH continues to closely monitor each MCO's network development plan and member access to primary and specialty providers. LDH is also currently validating MCO network adequacy data .

PIHP Monitoring Summary

The compliance review conducted by the EQRO in 2019 indicated the overall compliance score for the PIHP was 95%. The Office of Behavioral Health provided the PIHP with the EQRO's findings and required the PIHP to address any review elements that did not meet full compliance. In addition, the PIHP met the target rates for quality and waiver performance measures for the current reporting period (waiver year 4, quarter 4). OBH and the PIHP have targeted follow-up care after inpatient psychiatric hospitalization as an area for improvement, as current results indicate the follow-up rate is approximately 6 percentage points for the 7-day rate and 9 percentage points for the 30-day rate below the 90th percentile; OBH and the PIHP will continue to focus on this area through a performance improvement project.

Additional details of the state's monitoring efforts can be found in the EQRO and Independent Assessment reports. These reports will be submitted to CMS with the Healthy Louisiana 1915(b) waiver renewal application.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Non-Disabled Child - BH & Acute	
Non-Disabled Adult - BH & Acute	
MCHIP - BH Only	
Non-Disabled, Disabled, Foster Care - BH	
HCBS/Chisholm - BH & Acute	
Disabled Adult - BH & Acute	
CSoC SED 1915(c) Waiver - BH & Acute	
Foster Care & Disabled Child - BH & Acute	
MEGID440509	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	02/01/2016	06/30/2016		
Enrollment Projections for the Time Period*	04/01/2017	03/31/2018	04/01/2018	03/31/2019
**Include actual data and dates used in conversion - no estimates *Projections start on Quarter and include data for requested waiver period				

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Independent Living/Skills Building	☐	☒	☐	
Acute care services (see Appendix D2.s for additional detail)	☒	☐	☐	
Outpatient hospital (psych)	☒	☐	☐	
Inpatient Hospital (psych)	☒	☐	☐	
Physician Consultation (Case Conferences)	☐	☒	☐	
Parent Support and Training	☐	☒	☐	
Crisis Stabilization	☒	☐	☐	
Inpatient Hospital (Alcohol and Drug Abuse)	☒	☐	☐	
Inpatient Hospital (Psych) - Medicare crossover claims	☒	☐	☐	
Outpatient hospital (psych) - Medicare crossover claims	☒	☐	☐	
Physician services (psych) - Medicare crossover claims	☒	☐	☐	
ICF-DD for Children	☒	☐	☐	
Physician Services (psych)	☒	☐	☐	
Applied Behavioral Analysis for under age 21	☒	☐	☐	
Respite Care	☐	☒	☐	
Clinic Services	☒	☐	☐	
Rehabilitation Services (Psych)	☒	☐	☐	
Inpatient Psych for Under age 21	☒	☐	☐	
Youth Support and Training	☐	☒	☐	
Rehabilitation Services (Alcohol and Drug Abuse)	☒	☐	☐	
Prescribed Drugs (psych)	☒	☐	☐	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Other Practitioners (psych)	☒	☐	☐	
Personal Care Services	☐	☒	☐	
Individual Placement Support	☐	☒	☐	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the States waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the States submitted CMS-64 forms.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Cost-effectiveness spreadsheet is required for all 1915b waiver submissions.

b. Name of Medicaid Financial Officer making these assurances:

Daniel Cocran

c. Telephone Number:

(225) 219-3455

d. E-mail:

Daniel.Cocran@la.gov

e. The State is choosing to report waiver expenditures based on

◉ **date of payment.**

○ **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

b. ☒ The State provides additional services under 1915(b)(3) authority.

c. ☐ The State makes enhanced payments to contractors or providers.

d. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver.

e. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete ***Appendix D3***
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

Section D: Cost-Effectiveness

Part I: State Completion Section

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in A.I.b.

a. ☒ **MCO**

b. ☒ **PIHP**

c. ☐ **PAHP**

d. ☐ **PCCM**

e. ☐ **Other**

Please describe:

MCO - MCO contract from December 1, 2015, excluding behavioral health services covered by the CSoC PIHP for CSoC-eligible individuals.

PIHP - PIHP - mental health and substance abuse PIHP for individuals determined eligible for CSoC, effective December 1, 2015. PIHP transitions from non risk to capitated effective November 1, 2018.

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ☐ **Management fees are expected to be paid under this waiver.**
The management fees were calculated as follows.

1. ☐ **Year 1: $ [ ] per member per month fee.**
2. ☐ **Year 2: $ [ ] per member per month fee.**
3. ☐ **Year 3: $ [ ] per member per month fee.**
4. ☐ **Year 4: $ [ ] per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**
Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ☐ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. ☐ **Other reimbursement method/amount.**
$ [ ]
Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☒ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. ☒ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. ☒ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

There are two primary reasons for changes to the member months from the base year: (1) the integration of physical health and behavioral health in December 2015 under the 1915(b) waiver amendment (and corresponding shift of some member months out of the waiver) and (2)demographic changes over time.

Effective December 1, 2015 the State integrated behavioral health services for non-CSoC populations into the acute care MCOs and also enrolled the CSoC population into Healthy Louisiana MCOs for non-behavioral health services. Prior to December 1, 2015, the behavioral health carve-out mandated enrollment through 1915(b) waiver authority, while the acute care program operated under 1932a State Plan authority which provided both mandatory and voluntary enrollment for certain populations into managed care. The State maintains the 1932a authority for the populations that can be mandatorily enrolled in managed care under the State Plan and uses the 1915(b) waiver authority to mandate enrollment for behavioral health services for all waiver populations and acute care for a subset of the waiver population. CSoC-eligible individuals will continue to receive specialized behavioral health services from the CSoC PIHP and will be mandatorily enrolled in the MCOs for acute care services.

The new rate structure after integration where physical and behavioral health services are paid under the same capitation payment rather than through multiple capitation payments for the same individual was implemented February 1, 2016. Therefore, the experience between February 1, 2016 – June 30, 2016 was used as the base. Experience through June 30, 2016 was the latest that was available at the time the projections were completed. This base period is less than one year while prospective periods represent the projection for a full year.

Enrollment projection from the LDH was leveraged to determine the population growth trend applied in the waiver projection.

d. ☒ [Required] Explain any other variance in eligible member months from BY/R1 to P2:

The changes to the waiver populations effective December 1, 2015 described above amount to a significant change to the member months under the waiver with approximately 25% of the prior waiver population remaining under the waiver. Certain MEGs are expected to experience significant change in enrollment as certain prior waiver populations are now covered under the 1932a State Plan for acute care and behavioral health services.

e. ☒ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

R2 base period for the projection represents the experience from February 1, 2016 – June 30, 2016.

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost

For Conversion or Renewal Waivers:

a. ☒ **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**
Explain the differences here and how the adjustments were made on Appendix D5:

The following services were added and became effective during the previous waiver period:
-Coverage of Preventive Services under Section 4106 of the PPACA 7/1/2016. Authorized by Section 4106 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-152), states providing clinical preventive services recommended with a grade of A or B by the United States Preventive Services Task Force and adult immunizations recommended by the Advisory Committee on Immunization Practices are authorized to receive a one percentage point increase in their Federal medical assistance percentage rate for those services. Per this law, LDH decided to expand their State Plan to include the additional services necessary to meet this requirement. The impact of this adjustment was .1% or $0.254 PMPM.
-Contralateral Breast Reduction benefit added effective 2/1/2017. Per bulletin 16-19, Medicaid will cover breast reconstruction post mastectomy of the contralateral unaffected breast to achieve symmetry for patients diagnosed with breast cancer effective 2/1/2017. The impact of this adjustment is non-zero for the 1915(b) waiver population but is very small.*
-Reinstatement of LaHIPP program effective 2/1/2017. Effective February 1, 2017, the Louisiana Health Insurance Premium Payment (LaHIPP) program will be reinstated. Members that are enrolled in the LaHIPP program will receive PH services through FFS and will receive SBH and NEMT services through Healthy Louisiana. The LaHIPP members will be part of the SBH Dual Eligible rate cell. The impact of this adjustment is -$0.02 PMPM.
-Effective 2/1/2018, Applied Behavioral Analysis (ABA) services will now be covered by the Healthy Louisiana MCOs.
-Effective 11/01/2018, Louisiana will contract with a capitated vendor as the CSoC PIHP for the same set of services.
-Effective 2/01/2021, Louisiana Louisiana will use savings generated from the current waiver period to provide personal care and employment supports services through a 1915(b)(3) authority to individuals that are part of the DOJ target population. Services will be delivered through the MCOs.

b. ☐ **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**
For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Independent Living/Skills Building	☐	☐	☐	☒	☐	☐	☐
Acute care services (see Appendix D2.s for additional detail)	☒	☐	☐	☐	☐	☐	☐
Outpatient hospital (psych)	☒	☐	☐	☒	☐	☐	☐
Inpatient Hospital (psych)	☒	☐	☐	☒	☐	☐	☐
Physician Consultation (Case Conferences)	☒	☐	☐	☒	☐	☐	☐
Parent Support and Training	☐	☐	☐	☒	☐	☐	☐
Crisis Stabilization	☒	☐	☐	☐	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Inpatient Hospital (Alcohol and Drug Abuse)	☒	☐	☐	☒	☐	☐	☐
Inpatient Hospital (Psych) - Medicare crossover claims	☐	☐	☐	☒	☒	☐	☐
Outpatient hospital (psych) - Medicare crossover claims	☐	☐	☐	☒	☒	☐	☐
Physician services (psych) - Medicare crossover claims	☐	☐	☐	☒	☒	☐	☐
ICF-DD for Children	☐	☐	☐	☒	☐	☐	☐
Physician Services (psych)	☒	☐	☐	☒	☐	☐	☐
Applied Behavioral Analysis for under age 21	☒	☐	☐	☐	☐	☐	☐
Respite Care	☐	☐	☐	☒	☐	☐	☐
Clinic Services	☒	☐	☐	☒	☐	☐	☐
Rehabilitation Services (Psych)	☒	☐	☐	☒	☐	☐	☐
Inpatient Psych for Under age 21	☒	☐	☐	☒	☐	☐	☐
Youth Support and Training	☐	☐	☐	☒	☐	☐	☐
Rehabilitation Services (Alcohol and Drug Abuse)	☒	☐	☐	☒	☐	☐	☐
Prescribed Drugs (psych)	☒	☐	☐	☐	☒	☐	☐
Other Practitioners (psych)	☒	☐	☐	☒	☐	☐	☐
Personal Care Services	☒	☐	☐	☐	☐	☐	☐
Individual Placement Support	☒	☐	☐	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will*

enter all waiver and FFS administrative costs in the R1 and R2 or BY.
The allocation method for either initial or renewal waivers is explained below:

a. ☐ **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees***Note: this is appropriate for MCO/PCCM programs.*

b. ☐ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*

c. ☒ **Other**
Please explain:

Prior to 11/01/2018, LDH attributes the cost for Wrap Around Agencies (WAA) and the Merit Health ASO fee to the 1915b waiver as administrative cost. At the same time the waiver projections were being developed, the administrative expenses reported in the 64.10 reflects mostly the WAA and Magellan fee and only a small amount of other administrative expenses due to an allocation issue. Once the allocation issue is rectified, the administrative cost is expected to increase. An adjustment of $8.52 PMPM was added to the base administrative expenses. The $8.52 PMPM was determined by taking total administrative cost, deducting the WAA and Merit Health ASO fee and allocating the residual administrative expenses between the 1915(b) waiver and the non-waiver population using historical expenditure.

After 11/01/2018, the WAA fees and administrative service costs will be part of the capitation rate paid to the at-risk PIHP and will be reclassified as capitated managed care expenses. For this reason, a pro-rated portion of the WAA and Merit ASO fee was reallocated from Administrative Cost to State Plan Services (i.e., capitated covered service expenses) during Projection Year 1. The WAA and Merit ASO fees will be fully transitioned from Administrative costs to capitation costs during Projection Year 2.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

a. ☒ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the States Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the States Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5.**

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Independent Living/Skills Building	See paper application for details	See paper application for details	See paper application for details
Acute care services (see Appendix D2.s for additional detail)			
Total:			

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Outpatient hospital (psych)			
Inpatient Hospital (psych)			
Physician Consultation (Case Conferences)	See paper application for details	See paper application for details	See paper application for details
Parent Support and Training	See paper application for details	See paper application for details	See paper application for details
Crisis Stabilization			
Inpatient Hospital (Alcohol and Drug Abuse)			
Inpatient Hospital (Psych) - Medicare crossover claims			
Outpatient hospital (psych) - Medicare crossover claims			
Physician services (psych) - Medicare crossover claims			
ICF-DD for Children			
Physician Services (psych)			
Applied Behavioral Analysis for under age 21			
Respite Care	See paper application for details	See paper application for details	See paper application for details
Clinic Services			
Total:			

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Rehabilitation Services (Psych)			
Inpatient Psych for Under age 21			
Youth Support and Training	See paper application for details	See paper application for details	See paper application for details
Rehabilitation Services (Alcohol and Drug Abuse)			
Prescribed Drugs (psych)			
Other Practitioners (psych)			
Personal Care Services			
Individual Placement Support			
Total:			

b. ☐ **The State is including voluntary populations in the waiver.**
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. ☒ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.
Basis and Method:

1. ☒ **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. ☐ **The State provides stop/loss protection**
   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

d. ☐ **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. ☐ **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

   Document
   - **i. Document the criteria for awarding the incentive payments.**
   - **ii. Document the method for calculating incentives/bonuses, and**
   - **iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.**

2. ☐ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

   Document:
   - **i. Document the criteria for awarding the incentive payments.**
   - **ii. Document the method for calculating incentives/bonuses, and**
   - **iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.**

Appendix D3 Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

a. **State Plan Services Trend Adjustment** the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must

document the method used and how utilization and cost increases are not duplicative if they are calculated separately. . **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☒ **[Required, if the States BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).**

   The actual trend rate used is: 8.00

   Please document how that trend was calculated:

   The base period is February 1, 2016 – June 30, 2016. Rates during the first waiver year are expected to increase beyond those in the base due to trend. An adjustment of 8.0% was applied to reflect the new rates expected to be effective at the start of P1.

2. ☒ **[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations)** *(i.e., trending from present into the future).*

   i. ☒ **State historical cost increases.**

   Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

Base Years CY13 and CY14.
For the prospective time periods P1 – P5, Mercer leveraged the trend assumption used in the development of the Healthy Louisiana capitation rates formerly known as Bayou Health. The trend assumption applied was 8.0% at the aggregate level. Trend assumptions in the rate-setting process were developed by performing linear regression studies of historical experience, review of more recent experience, and actuarial judgment.

The state plan trend of 8.0% represents the high end trend across all categories of eligibility and all categories of service from the rate development process for February 1, 2017 – January 31, 2018 rates. To determine the assumptions used within the rate development process, Mercer reviewed historical experience by category of eligibility which includes:

SSI
Family and Children
Foster Care Children
Breast and Cervical Cancer
LaCHIP Affordable Plan
HCBS Waiver
Chisolm Class Members

Furthermore, within each category of eligibility, trend was also studied by major categories of service which included:

Inpatient
Outpatient
Physician
Transportation
Other
Rx

Where applicable, trends were studied separately for children versus adults. Trends were also examined separately for maternity kick payments.

The culmination of the application of the various trend assumptions by category of eligibility, by category of service and by age group is summarized in the table below. The aggregate high end trend assumption is 8.0% which corresponds to the state plan trend Mercer utilized in the 1915(b) waiver renewal projection.

Refer to Waiver Paper Document for an additional chart.

ii. ☐ **National or regional factors that are predictive of this waivers future costs.**
Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waivers future costs. Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ☒ **The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**
Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).
ii. Please document how the utilization did not duplicate separate cost increase trends.

For i above:
Utilization trends are not developed separately from unit cost trends.

For ii above:
Utilization trend is considered in Mercer's overall analysis of trend. Separate trends are not developed for utilization.

Appendix D4 Adjustments in Projection

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b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ☒ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i. ☐ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☐ Other:
Please describe

ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ☐ Changes brought about by legal action:
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

iv. ☒ Changes in legislation.
Please list the changes.

A number of program/fee schedule changes became effective after the end of the base period that required adjustments to the waiver projection. They include in addition to those added to the renewal, the following: Eff. 2/1/18 ABA Services Added; Eff. 11/1/18, LDH will contract with a CSoC full risk PIHP vendor; Eff. 11/1/18, WAA costs & ASO activities will migrate to the procured CSoC vendor

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☒ Determine adjustment based on currently approved SPA
PMPM size of adjustment
19.72

D. ☐ Other
Please describe

v. ☐ Other
Please describe:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

Section D: Cost-Effectiveness

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c. Administrative Cost Adjustment: This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.

2. ☒ An administrative adjustment was made.

i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2.
Please describe:

ii. ☒ Cost increases were accounted for.

A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ☒ State Historical State Administrative Inflation. THe actual trend rate used is PMPM size of adjustment

2.00

Please describe:

Inflation rate for admin cost was determined based on a study of admin cost changes. Most MEGs were adj at 2.0% per annum with the exception of the CSoC pop.WAA and Merit admin fee make up a significant portion of the CSoC MEGs admin cost in P1/P2. WAA and Merit admin fee is not expected to incr. by same level as other MEGs. An adj of .25% was used for the CSoC MEG in P1-2.

D. ☒ Other
Please describe:

Continuation from above response ii.C:
All MEGs are trended at 2.0% starting with Projection Year 3 when all WAA and the Merit administrative fee have transitioned to State Plan services via the capitation rate.

iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
Please indicate the State Plan Service trend rate from Section D.I.J.a. above

Section D: Cost-Effectiveness

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☐ [Required, if the States BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:

Please provide documentation.

2. ☒ [Required, when the States BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. A. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years

2. Please provide documentation.

For item d.2 1915(b)(3) Trend Adjustment please review to paper application for additional explanation and documentation.

B. State Plan Service trend

Please indicate the State Plan Service trend rate from Section D.I.J.a. above

8.00

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

3. Explain any differences:

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

p. ***Other adjustments*** including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)** *: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ☒ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5.**
2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
3. ☐ Other

Please describe:

For Item 1 above:
LDH collects federal rebates of approximately 45.8% on both behavioral health Rx expenses paid on a FFS basis and Rx expenses included in the capitated managed care program (allowable under the Affordable Care Act). An adjustment of 8.1% was applied to the capitation rates to account for the managed care rebates.

1. ☐ No adjustment was made.

2. ☐ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

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K. Appendix D5 Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

Please refer to Excel Spreadsheet Appendix D5 - Waiver Cost Projections (paper copy format).

Appendix D5 Waiver Cost Projection

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L. Appendix D6 RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

Please refer to Excel Spreadsheet Appendix D6 - RO Targets (paper copy format).

Appendix D6 RO Targets

Section D: Cost-Effectiveness

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M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

There are two primary reasons for changes to the member months from the base year: (1) the integration of physical health and behavioral health in December 2015 under the 1915(b) waiver amendment (and corresponding shift of some member months out of the waiver) and (2)demographic changes over time.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

There are two primary reasons for changes to the member months from the base year: (1) the integration of physical health and behavioral health in December 2015 under the 1915(b) waiver amendment (and corresponding shift of some member months out of the waiver) and (2)demographic changes over time.

Effective December 1, 2015 the State integrated behavioral health services for non-CSoC populations into the acute care MCOs and also enrolled the CSoC population into Healthy Louisiana MCOs for non-behavioral health services. Prior to December 1, 2015, the behavioral health carve-out mandated enrollment through 1915(b) waiver authority, while the acute care program operated under 1932a State Plan authority which provided both mandatory and voluntary enrollment for certain populations into managed care. The State maintains the 1932a authority for the populations that can be mandatorily enrolled in managed care under the State Plan and uses the 1915(b) waiver authority to mandate enrollment for behavioral health services for all waiver populations and acute care for a subset of the waiver population. CSoC-eligible individuals will continue to receive specialized behavioral health services from the CSoC PIHP and will be mandatorily enrolled in the MCOs for acute care services.

Enrollment projection from the LDH was leveraged to determine the population growth trend applied in the waiver projection.

2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of cost increase given in Section D.I.I and D.I.J:

Mercer did not estimate cost changes separate from the utilization changes. While adjustments for programmatic, policy, or pricing changes known today through P1 were applied, future programmatic, policy, or pricing changes not known today are not included in the trend assumption; therefore, trend estimates do not duplicate the effect of any changes.

Note the Health Insurer Provider Fee (HIPF) under the ACA is paid separately from the capitation rates. The HIPF is also suspended in 2017 and is expected to be reinstated in 2018.

3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of utilization given in Section D.I.I and D.I.J:

In developing trend for the time periods from BY to P1 and from P1 to P2, P2 to P3, P3 to P4, and P4 to P5 estimates were based primarily on historical experience, with consideration for other data sources such as CPI and DRI. Changes in utilization and unit cost were considered together in developing trend where appropriate.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

No other factors for App D7 Col I.

Appendix D7 - Summary