MEDICAID MANAGED CARE ORGANIZATION CONTRACTS EXTENSION REQUEST

FACT SHEET

	Current Contracts		Contract Extension	Current Enrollment
Start Date:	*February 1, 2015*		*January 31, 2018*	
End Date:	*January 31, 2018*		*December 31, 2019*	
Contract Term:	*Original 3-year term with up to a 24-month extension (with legislative approval)*		*23 months*	
Contract Amounts:	*Aetna Better Health*	*$1,964,731,789*	*+$1,342,091,604*	*115,681*
	AmeriHealth Caritas Louisiana	*$2,652,436,746*	*+$2,215,771,363*	*215,708*
	Community Care Health Plan of Louisiana (dba Healthy Blue Louisiana)	*$2,818,893,534*	*+$2,522,526,662*	*242,198*
	Louisiana Healthcare Connections	*$5,899,819,639*	*+$4,748,537,099*	*486,135*
	United Healthcare of Louisiana	*$5,033,878,483*	*+$4,599,983,548*	*439,232*
	Total:	***$18,369,760,191***	***+$15,428,910,276****	***1,498,954****

*MCO contracts are financed using a blend of the regular federal match rate and the enhanced expansion match rate. The estimated value of the extension is based on a continuation of the current program with some applied enrollment and rate trends and adjustments for pending program changes.

**Enrollment figures are current as of August 2017

PURPOSE AND BACKGROUND

Louisiana Medicaid serves nearly 1.6 million Louisianans, approximately 35 percent of the state's population. In 2012, Louisiana Medicaid transitioned its legacy fee-for-service program to a managed care delivery model. Today, managed care organizations (MCOs) deliver healthcare services to more than 90 percent of the nearly 1.6 million members, including more than 440,000 new adults since Medicaid expansion took effect in July 2016.

The MCO contracts provide specified Medicaid core benefits and services, included in the Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals, to children and adults enrolled in Louisiana Medicaid.

The Louisiana Department of Health (LDH) is committed to transforming its Medicaid managed care program to advance high-value, quality care; improve population health; engage and support providers; improve member experience; and reduce the per capita cost of health care.

This extension request supports LDH's goals for a multi-year payment and systems transformation. The 23-month extension term provides LDH time to both implement and measure early results from the incremental improvements included in the contract extension.

MCO CONTRACT EXTENSION HIGHLIGHTS

- Provides meaningful financial incentives for quality and health outcomes and value-based payments.
- Increases expectations for care management, evidence-based care, and provider network development and adequacy to meet member needs.
- Increases standardization of administrative practices across MCOs to reduce provider burden.
- Increases transparency and accountability for MCO performance against contract requirements.

MCO CONTRACT EXTENSION MAJOR CHANGES

REQUIREMENT	SECTION	HOW/WHY

Withhold of Capitation Payment for Quality Performance and Increased Value-Based Payments	5.4: Withhold of Capitated Payment	• Transitions current 2% withhold of monthly capitated payment from incentive for contract compliance to earn back for MCO performance on quality measures and use of value-based payments
		  ○ **1% used to incentivize quality and health outcomes**. Updates quality measures based on stakeholder input and adds stretch goal targets for "money measures" or improving over prior year performance.
		  ○ **1% used to incentivize value-based payments.** Adds withhold earn back for development of an LDH-approved strategic plan to increase Alternative Payment Models use over time.
		• To focus health plans and providers on shared targets for population health improvement using a limited set of stakeholder-recommended quality measures

Definition of Value-Added Benefits and Cost-Effective Alternative Services	6.26: Value-Added Benefits and Services 6.27: Cost-Effective Alternative Services	• Requires sustained commitment to value added benefits and promotes use of cost effective alternative services • Redefines "expanded services" as Value Added Benefits uniquely proposed by the MCO in response to the RFP (at the MCO's expense) • Adds definition for Cost-Effective Alternative Services an MCO can offer "in lieu of" core benefits and services (included in MCO capitation rate) • To resolve plan-provider disputes and avoid LLA audit findings by clarifying MCO service offerings beyond core benefits and services

REQUIREMENT	SECTION	HOW/WHY
Proactive Discharge Planning for Youth Residing in Out-Of-Home Level of Care	6.30.2: Care Coordination, Continuity of Care, and Care Transition 20.3: Monetary Penalties	• Adds requirement to conduct appropriate, proactive discharge planning for members approaching the end of medical necessity in a psychiatric residential treatment facility or therapeutic group home • Adds requirement that MCOs cannot deny continuation of residential treatment for failure to meet medical necessity when the service can be provided for a lower level of care, with penalties for noncompliance • To incentivize provider network development and proactive discharge planning, reduce overreliance on institutional care, facilitate placement of care, and ensure providers get paid when the member must remain in higher level service
Services for Co-Occurring Behavioral Health (BH) and Developmental Disabilities	6.45: Services for Co-occurring BH and Developmental Disabilities	• Adds requirements for delivery service framework; staff development; policies and procedures; liaison staff to work with OCDD regarding intellectual/developmental disability (I/DD) medical and behavioral health issues; network capacity; and provider directories that clearly identify providers with specialty in serving individuals with dual diagnosis of BH and I/DD • To improve member services and care for those with dual diagnosis, increase access to care, facilitate care coordination between providers, local government entities, and support coordinators
Applied Behavioral Analysis (ABA) as Covered Service	6.46: Applied Behavioral Analysis	• Adds requirements for service delivery, care coordination, and staff expectations • To support ABA as a covered service, effective 2/1/18
Care Management Evaluation	6.47: Care Management Evaluation	• Requires participation in LDH-directed evaluation of care management activities • To increase effectiveness of care management, case management and care coordination practices
Single Source Credentialing	7.6.1: Provider Enrollment	• Adds requirement for a provider management system to include single source credentialing for providers • Creates single point of entry for provider enrollment, transfers credentials verification to State, reduces administrative burden on providers, improves provider satisfaction

REQUIREMENT	SECTION	HOW/WHY
Network Development for Specialized BH Providers	7.8.14: Specialized Behavioral Health Providers	• Adds requirement that provider network be developed to meet the needs of members with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability • Adds requirement for the MCO to report the number of out-of-state placements and that LDH may require the MCO to take corrective action should LDH determine the MCO's rate of out-of-state placements is excessive • To provide equal access to effective care for members with exceptional needs in Louisiana and prohibits excessive out-of-state placements
Accurate Provider Directories	7.18: Provider Directory 20.3: Monetary Penalties	• Adds requirement to maintain a 90% accuracy rate on provider directory data, with monetary penalties for failure to comply and failure to correct inaccurate data within 14 days of notification by LDH • Adds monetary penalty for failure to comply • To increase access to care, improve member satisfaction, reduce provider abrasion
Common Hospital Observation Policy	8.4: Service Authorization	• Requires MCOs to use a common hospital observation policy • To reduce administrative burden on providers, improve provider satisfaction, support hospital payment modernization
Updates to Automatic Assignment	11.4: Automatic Assignment	• Adds preferential treatment of plans with higher quality scores to auto-assignment algorithm, permits LDH to exclude plans from auto-assignment for contract non-compliance • To emphasize value of quality and compliance to LDH
Web/Mobile Based Member Applications with Health Information	12.22: Web and Mobile-Based Member Applications	• Adds requirement to include member health information in existing member-facing portals • To promote member self-care and management
Specialized BH Provider Monitoring Plan and Reporting	14.9: Provider Monitoring Plan and Reporting	• Adds requirement to monitor specialized BH providers and facilities across all levels of care • To reduce inappropriate or substandard provider services, facilitate corrective action

REQUIREMENT	SECTION	HOW/WHY
Fraud, Waste, and Abuse Staffing, Recoupments and Recoveries	15.7: Fraud, Waste, and Abuse Prevention 4.4: In-State Staff Positions	• Doubles the number of MCO fraud, waste, and abuse investigators • Replaces MCO's one-year exclusive right of recovery of FWA with concurrent MCO/LDH right to recovery • Allows LDH to recover an overpayment if the MCO has failed to collect at least a portion of the recovery within a year after notice to LDH • Requires MCOs to consult with LDH before recouping or withholding program integrity-related funds to ensure the action is permissible • To increase collection of overpayments and bolster efforts to fight fraud, waste and abuse by increasing resources for program integrity
Information Systems Access	16.10: Information Systems Availability	• Adds requirements for MCOs to provide LDH with real-time, read-only access to MCO data systems and the ability to query data in a reporting environment • To enable LDH to more effectively oversee MCO operations, ensure contract compliance
Claims Reprocessing	17.2.4: Claims Reprocessing	• Adds requirement to reprocess claims that were processed incorrectly within 30 days of discovery without provider resubmission, or within a timeline approved by LDH • To reduce inappropriate claims denials and provider abrasion from MCO delays in correcting claims payment errors
Updates to Monetary Penalties	20.3: Monetary Penalties	• Adds penalties to address gaps in accountability levers • Adds penalty when MCO denies continuation of higher level services for failure to meet medical necessity when the service can be provided at a lower level of care to ensure providers get paid when the member must remain in higher level service
Hold Harmless Relative to Court Orders	25.24: Hold Harmless	• Adds requirement for MCOs to pay for legal fees and damages arising out of MCO non-compliance with legal judgments against, settlements by LDH (e.g., Wells and Chisolm) • To reduce State's financial risk due to MCO non-compliance