Chapter 31. General Provisions

§3101. Introduction

A. It is the department's goal to operate a managed health care delivery system that:

1. improves access to care and care coordination;

2. improves the quality of services;

3. promotes healthier outcomes for Medicaid recipients through the establishment of a medical home system of care;

4. provides budget stability; and

5. results in savings as compared to an unmanaged fee-for-service system.

B. Effective for dates of service on or after February 1, 2015, the department will operate a managed care delivery system for physical and basic behavioral health, named the Bayou Health program, utilizing one model, a risk bearing managed care organization (MCO), hereafter referred to as a "MCO".

C. The department will continue to administer the determinations of savings realized or refunds due to the department for dates of service from February 1, 2012 through January 31, 2015 as described in the primary care case management plan (CCN-S) contract.

D. It is the department's intent to procure the provision of healthcare services statewide to Medicaid enrollees participating in the Bayou Health program from risk bearing MCOs through the competitive bid process.

1. The number of MCOs shall be no more than required to meet the Medicaid enrollee capacity requirements and ensure choice for Medicaid recipients as required by federal statute.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1573 (June 2011), amended LR 41:928 (May 2015).

§3103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in coordinated care networks:

1. categorically needy individuals:

a. children up to 19 years of age and their parents who are eligible under §1931 of the Social Security Act (hereafter referred to as the Act) as poverty-level related groups or optional groups of older children and caretaker relatives;

b. qualified pregnant women and children who are eligible under §1902 and §1905 of the Act;

c. aged, blind and disabled adults over the age of 19 who are eligible under §1619, §1634, §1902 and §1905 of the Act. These individuals may be receiving cash payments through Supplemental Security Income (SSI) or have lost SSI eligibility due to a Social Security cost-of-living adjustment (COLA) or entitlement for, or an increase in Retirement, Survivors or Disability Insurance (RSDI) benefits;

d. uninsured women under the age of 65 who have been screened through the Centers for Disease Control National Breast and Cervical Cancer Early Detection Program and identified as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer, and are not otherwise eligible for Medicaid;

e. uninsured women who are eligible through the Louisiana Children's Health Insurance Program (LaCHIP) prenatal option;

f. children enrolled in the Title XXI stand-alone CHIP program for low-income children under the age of 19 who do not otherwise qualify for Medicaid (LaCHIP Affordable Plan);

g. persons eligible through the Tuberculosis Infected Individual Program;

h. individuals who are Native Americans/Alaskan Natives and members of a federally recognized tribe; or

i. children under the age of 19 who are:

i. eligible under §1902(e)(3) of the Act and receiving Supplemental Security Income (SSI);

ii. in foster care or other out-of-home placement;

iii. receiving foster care or adoption assistance;

iv. receiving services through a family-centered, community-based coordinated care system that receives grant funds under §501(a)(1)(D) of Title V, and is defined by the department in terms of either program participation of special health care needs; or

v. enrolled in the Family Opportunity Act Medicaid Buy-In Program;

2. medically needy individuals:

a. individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program; and

3. individuals receiving hospice services who are not otherwise excluded because of their status as a Medicare dual eligible recipient, or a resident of a long-term care facility (nursing facility or intermediate care facility for persons with intellectual disabilities).

B. Voluntary Participants

1. Participation in an MCO is voluntary for

a. individuals who receive home and community-based waiver services; and

b. effective February 1, 2015, children under the age of 21 who are listed on the New Opportunities Waiver Request for Services Registry. These children are identified as *Chisholm* class members:

i. For purposes of these provisions, *Chisholm* class members shall be defined as those children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* (or her successor) class action litigation.

ii. *Chisholm* class members and home and community-based waiver recipients shall be exempt from the auto-assignment process and must proactively seek enrollment into an available health plan.

C. The enrollment broker will ensure that all participants are notified at the time of enrollment that they may request dis-enrollment from the MCO at any time for cause. All voluntary opt-in populations can dis-enroll from the MCO and return to legacy Medicaid at any time without cause.

D. Participation Exclusion

1. The following Medicaid and/or CHIP recipients are excluded from participation in an MCO and cannot voluntarily enroll in a MCO. Individuals who:

a. are both Medicare and Medicaid recipients;

b. reside in a long-term care facility (nursing facility or intermediate care facility for persons with intellectual disabilities);

c. receive services through the Program of All-Inclusive Care for the Elderly (PACE);

d. have a limited period of eligibility such as eligibility through the Spend-down Medically Needy Program or emergency services only;

e. are participants in the Take Charge Plus Program; or

f. are participants in the Greater New Orleans Community Health Connection (GNOCHC) Program.

g. - h.i. Reserved.

E. The department reserves the right to institute a medical exemption process for certain medically high risk recipients that may warrant the direct care and supervision of a non-primary care specialist on a case by case basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1573 (June 2011), amended LR 40:310 (February 2014), LR 40:1096 (June 2014), LR 40:2258 (November 2014), LR 41:929 (May 2015).

§3105. Enrollment Process

A. The MCO shall abide by all enrollment and disenrollment policy and procedures as outlined in the contract developed by the department.

B. The department will contract with an enrollment broker who will be responsible for the enrollment and disenrollment process for MCO participants. The enrollment broker shall be:

1. the primary contact for Medicaid recipients regarding the MCO enrollment and disenrollment process, and shall assist the recipient to enroll in an MCO;

2. the only authorized entity, other than the department, to assist a Medicaid recipient in the selection of an MCO; and

3. responsible for notifying all MCO members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in the contract.

C. Enrollment Period. The annual enrollment of an MCO member shall be for a period of up to 12 months from the date of enrollment, contingent upon his/her continued Medicaid and MCO eligibility. A member shall remain enrolled in the MCO until:

1. DHH or its enrollment broker approves the member’s written, electronic or oral request to disenroll or transfer to another MCO for cause; or

2. the annual open enrollment period or after the lock-in period; or

3. the member becomes ineligible for Medicaid and/or the MCO program.

D. Enrollment of Newborns. Newborns of Medicaid eligible mothers who are enrolled at the time of the newborn's birth will be automatically enrolled with the mother’s MCO, retroactive to the month of the newborn’s birth.

1. If there is an administrative delay in enrolling the newborn and costs are incurred during that period, the

member shall be held harmless for those costs and the MCO shall pay for these services.

2. The MCO and its providers shall be required to:

a. report the birth of a newborn within 48 hours by requesting a Medicaid identification (ID) number through the department's online system for requesting Medicaid ID numbers; and

b. complete and submit any other Medicaid enrollment form required by the department.

E. Selection of an MCO

1. As part of the eligibility determination process, Medicaid and LaCHIP applicants, for whom the department determines eligibility, shall receive information and assistance with making informed choices about participating MCOs from the enrollment broker. These individuals will be afforded the opportunity to indicate the plan of their choice on their Medicaid financial application form or in a subsequent contract with the department prior to determination of Medicaid eligibility.

2. All new recipients who have made a proactive selection of an MCO shall have that MCO choice transmitted to the Enrollment Broker immediately upon determination of Medicaid or LaCHIP eligibility. The member will be assigned to the MCO of their choosing unless the plan is otherwise restricted by the department.

a. Recipients who fail to choose a CCN shall be automatically assigned to a CCN by the enrollment broker and the CCN shall be responsible to assign the member to a PCP if a PCP is not selected at the time of enrollment into the CCN.

i. Recipients of home and community-based services and Chisholm class members shall be exempt from automatic assignment to a CCN.

3. All new recipients shall be immediately automatically assigned to an MCO by the enrollment broker if they did not select an MCO during the financial eligibility determination process.

4. All new recipients will be given 90 days to change plans if they so choose.

a. Recipients of home and community-based services and *Chisholm* class members shall be exempt from automatic assignment to an MCO.

5. The following provisions will be applicable for recipients who are mandatory participants.

a. If there are two or more MCOs in a department designated service area in which the recipient resides, they shall select one.

b. Recipients may request to transfer out of the MCO for cause and the effective date of enrollment into the new plan shall be no later than the first day of the second month following the calendar month that the request for disenrollment is filed.

F. Automatic Assignment Process

1. The following participants shall be automatically assigned to an MCO by the enrollment broker in accordance with the department's algorithm/formula and the provisions of §3105.E:

a. mandatory MCO participants;

b. pregnant women with Medicaid eligibility limited to prenatal care, delivery, and post-partum services; and

c. other recipients as determined by the department.

2. MCO automatic assignments shall take into consideration factors including, but not limited to:

a. assigning members of family units to the same MCO;

b. existing provider-enrollee relationships;

c. previous MCO-enrollee relationship;

d. MCO capacity; and

e. MCO performance outcome indicators.

3. MCO assignment methodology shall be available to recipients upon request to the enrollment broker.

G. Selection or Automatic Assignment of a Primary Care Provider

1. The MCO is responsible to develop a PCP automatic assignment methodology in accordance with the department's requirements for the assignment of a PCP to an enrollee who:

a. does not make a PCP selection after being offered a reasonable opportunity by the MCO to select a PCP;

b. selects a PCP within the MCO that has reached their maximum physician/patient ratio; or

c. selects a PCP within the MCO that has restrictions/limitations (e.g. pediatric only practice).

2. The PCP automatically assigned to the member shall be located within geographic access standards, as specified in the contract, of the member's home and/or who best meets the needs of the member. Members for whom an MCO is the secondary payor will not be assigned to a PCP by the MCO, unless the member requests that the MCO do so.

3. If the enrollee does not select an MCO and is automatically assigned to a PCP by the MCO, the MCO shall allow the enrollee to change PCP, at least once, during the first 90 days from the date of assignment to the PCP. Effective the ninety-first day, a member may be locked into the PCP assignment for a period of up to nine months beginning from the original date that he/she was assigned to the MCO.

4. If a member requests to change his/her PCP for cause at any time during the enrollment period, the MCO must agree to grant the request.

H. Lock-In Period

1. Members have 90 days from the initial date of enrollment into an MCO in which they may change the MCO for any reason. Medicaid enrollees may only change MCOs without cause within the initial 90 days of enrollment in an MCO. After the initial 90-day period, Medicaid enrollees/members shall be locked into an MCO until the annual open enrollment period, unless disenrolled under one of the conditions described in this Section.

I. Annual Open Enrollment

1. The department will provide an opportunity for all MCO members to retain or select a new MCO during an annual open enrollment period. Notification will be sent to each MCO member and voluntary members who have opted out of participation in Bayou health at least 60 days prior to the effective date of the annual open enrollment. Each MCO member shall receive information and the offer of assistance with making informed choices about MCOs in their area and the availability of choice counseling.

2. Members shall have the opportunity to talk with an enrollment broker representative who shall provide additional information to assist in choosing the appropriate MCO. The enrollment broker shall provide the individual with information on each MCO from which they may select.

3. During the open enrollment period, each Medicaid enrollee shall be given the option to either remain in their existing MCO or select a new MCO. The 90-day option to change is not applicable to MCO linkages as a result of open enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1574 (June 2011), amended LR 40:310 (February 2014), LR 40:1097 (June 2014), LR 41:929 (May 2015).

§3107. Disenrollment and Change of Managed Care Organization

A. A member may request disenrollment from an MCO for cause at any time, effective no later than the first day of the second month following the month in which the member files the request.

B. A member may request disenrollment from an MCO without cause at the following times:

1. during the 90 days following the date of the member's initial enrollment with the MCO or the date the department sends the member notice of the enrollment, whichever is later;

2. at least once a year during the member's annual open enrollment period thereafter;

3. upon automatic re-enrollment if a temporary loss of Medicaid eligibility has caused the member to miss the annual open enrollment opportunity; or

4. if the department imposes the intermediate sanction against the MCO which grants enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to disenroll.

C. All member-initiated disenrollment requests must be made to the enrollment broker.

1. Oral requests to disenroll shall be confirmed by the enrollment broker by return call with written documentation, or in writing to the requestor.

2. A member's oral or written request to disenroll must be acted on no later than the first day of the second month following the month in which the member filed the request. If not, the request shall be considered approved.

3. If the disenrollment request is denied, the member may access the state's fair hearing process as outlined in the contract.

4. The effective date of disenrollment shall be no later than the first day of the second month following the calendar month the request for disenrollment is filed.

D. Disenrollment for Cause

1. A member may initiate disenrollment or transfer from their assigned MCO after the first 90 days of enrollment for cause at any time. The following circumstances are cause for disenrollment:

a. the MCO does not, because of moral or religious objections, cover the service that the member seeks;

b. 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;

c. the contract between the MCO and the department is terminated;

d. to implement the decision of a hearing officer in an appeal proceeding by the member against the MCO or as ordered by a court of law; and

e. other reasons including, but not limited to:

i. poor quality of care;

ii. lack of access to services covered under the contract; or

iii. documented lack of access to providers experienced in dealing with the enrollee's health care needs.

E. Involuntary Disenrollment

1. The MCO may submit an involuntary disenrollment request to the enrollment broker, with proper documentation, for the following reasons:

a. fraudulent use of the MCO identification card. In such cases, the MCO shall report the incident to the Bureau of Health Services Financing; or

b. the member's behavior is disruptive, unruly, abusive or uncooperative to the extent that his/her

enrollment seriously impairs the MCO's ability to furnish services to either the member or other members.

2. The MCO shall promptly submit such disenrollment requests to the enrollment broker. The effective date of an involuntary disenrollment shall not be earlier than 45 calendar days after the occurrence of the event that prompted the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.

3. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the department. All decisions are final and are not subject to MCO dispute or appeal.

4. The MCO may not request disenrollment because of a member's:

a. health diagnosis;

b. adverse change in health status;

c. utilization of medical services;

d. diminished mental capacity;

e. pre-existing medical condition;

f. refusal of medical care or diagnostic testing;

g. uncooperative or disruptive behavior resulting from his or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other members as defined in this Subsection;

h. attempt to exercise his/her rights under the MCO's grievance system; or

i. attempt to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned.

F. Department Initiated Disenrollment

1. The department will notify the MCO of the member's disenrollment due to the following reasons:

a. loss of Medicaid eligibility or loss of MCO enrollment eligibility;

b. death of a member;

c. member's intentional submission of fraudulent information;

d. member becomes an inmate of a public institution;

e. member moves out of state;

f. member becomes Medicare eligible;

g. member is placed in a nursing facility or intermediate care facility for persons with intellectual disabilities;

h. loss of MCO's participation.

G. If the MCO ceases participation in the Medicaid Program, the MCO shall notify the department in accordance with the termination procedures described in the contract.

1. The enrollment broker will notify MCO members of the choices of remaining MCOs.

2. The exiting MCO shall assist the department in transitioning the MCO members to another MCO.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1575 (June 2011), amended LR 40:311 (February 2014), LR 41:930 (May 2015).

§3109. Member Rights and Responsibilities

A. The MCO member's rights shall include, but are not limited to the right to:

1. receive information in accordance with federal regulations and as described in the contract and department issued guides;

2. receive courteous, considerate and respectful treatment provided with due consideration for the member's dignity and privacy;

3. receive information on available treatment options and alternatives in a manner appropriate to the member's condition and ability to understand;

4. participate in treatment decisions, including the right to:

a. refuse treatment;

b. complete information about their specific condition and treatment options including, but not limited to the right to receive services in a home or community setting or in an institutional setting if desired;

c. seek second opinions;

d. information about available experimental treatments and clinical trials and how such research can be accessed; and

e. assistance with care coordination from the PCP's office;

5. be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience;

6. express a concern about their MCO or the care it provides, or appeal an MCO decision, and receive a response in a reasonable period of time;

7. receive a copy of their medical records, including, if the HIPAA privacy rule applies, the right to request that the records be amended or corrected as allowed in federal regulations;

8. be furnished health care services in accordance with federal regulations governing access standards;

9. implement an advance directive as required in federal regulations:

a. the MCO must provide adult enrollees with written information on advanced directive policies and include a description of applicable state law. The written information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of change;

b. members have the right to file a grievance concerning noncompliance with the advance directive requirements to the department or other appropriate licensing or certification agency as allowed in federal regulations;

10. choose his/her health professional to the extent possible and appropriate in accordance with federal regulations; and

11. be furnished health care services in accordance with federal regulations.

B. Members shall have the freedom to exercise the rights described herein without any adverse effect on the member's treatment by the department or the MCO, or its contractors or providers.

C. The MCO member's responsibilities shall include, but are not limited to:

1. informing the MCO of the loss or theft of their MCO identification card;

2. presenting their identification card when using health care services;

3. being familiar with the MCO's policies and procedures to the best of his/her abilities;

4. contacting the MCO, by telephone or in writing (formal letter or electronically, including email), to obtain information and have questions clarified;

5. providing participating network providers with accurate and complete medical information;

6. following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;

7. making every effort to keep any agreed upon appointments and follow-up appointments and contacting the provider in advance if they are unable to do so; and

8. accessing preventive care services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1576 (June 2011), amended LR 40:311 (February 2014), LR 41:930 (May 2015).

Chapter 35. Managed Care Organization Participation Criteria

§3501. Participation Requirements

A. In order to participate in the Bayou Health Program, a managed care organization must be a successful bidder, be awarded a contract with the department, and complete the readiness review.

B. An MCO must:

1. meet the federal definition of an managed care organization as defined in federal regulations;

2. meet the requirements of R.S. 22:2016 and be licensed or have a certificate of authority from the Louisiana Department of Insurance (DOI) pursuant to title 22 of the *Louisiana Revised Statues* at the time a proposal is submitted;

3. be certified by the Louisiana Secretary of State to conduct business in the state;

4. meet solvency standards as specified in federal regulations and Title 22 of the Louisiana Revised Statutes;

5. meet NCQA health plan accreditation or agree to submit an application for accreditation at the earliest possible date as allowed by NCQA and once achieved, maintains accreditation through the life of this agreement;

6. have a network capacity to enroll a minimum of 100,000 Medicaid and LaCHIP eligibles; and

7. not have an actual or perceived conflict of interest that, in the discretion of the department, would interfere or give the appearance of possibly interfering with its duties and obligations under this Rule, the contract and any and all appropriate guides. Conflict of interest shall include, but is not limited to, being the fiscal intermediary contractor for the department; and

8. establish and maintain a performance bond in the amount specified by the department and in accordance with the terms of the contract.

9. Except for licensure and financial solvency requirements, no other provisions of title 22 of the *Revised Statutes* shall apply to an MCO participating in the Louisiana Medicaid Program.

C. An MCO shall ensure the provision of core benefits and services to Medicaid enrollees in a department designated geographic service area as specified in the terms of the contract.

D. Upon request by the Centers for Medicare and Medicaid Services, the Office of Inspector General, the Government Accounting Office, the department or its designee, an MCO shall make all of its records pertaining to its contract (services provided there under and payment for services) with the department available for review, evaluation and audit. The records shall include, but are not limited to the following:

1. pertinent books and documents;

2. financial records;

3. medical records and documents; and

4. provider records and documents involving financial transactions related to the contract.

E. An MCO shall maintain an automated management information system that collects, analyzes, integrates and reports data that complies with department and federal reporting requirements.

1. The MCO shall submit to the department for approval the MCO's emergency/contingency plan if the MCO is unable to provide the data reporting specified in the contract and department issued guides.

F. An MCO shall obtain insurance coverage(s) including, but not limited to, workman's compensation, commercial liability, errors and omissions, and reinsurance as specified in the terms of the contract. Subcontractors, if any, shall be covered under these policies or have insurance comparable to the MCO's required coverage.

G. An MCO shall provide all financial reporting as specified in the terms of the contract.

H. An MCO shall secure and maintain a performance and fidelity bond as specified in the terms of the contract during the life of the contract.

I. In the event of noncompliance with the contract and the department's guidelines, an MCO shall be subject to the sanctions specified in the terms of the contract including, but not limited to:

1. corrective action plans;

2. monetary penalties;

3. temporary management; or

4. suspension and/or termination of the MCO's contract.

AUTHORITY NOTE: Promulgated in accordance with R. S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1583 (June 2011), amended LR 41:933 (May 2015).

§3503. Managed Care Organization Responsibilities

A. The MCO shall be responsible for the administration and management of its requirements and responsibilities under the contract with the department and any and all department issued guides. This includes all subcontracts, employees, agents and anyone acting for or on behalf of the MCO.

1. No subcontract or delegation of responsibility shall terminate the legal obligation of the MCO to the department to assure that all requirements are carried out.

B. An MCO shall possess the expertise and resources to ensure the delivery of core benefits and services to members and to assist in the coordination of covered services, as specified in the terms of the contract.

1. An MCO shall have written policies and procedures governing its operation as specified in the contract and department issued guides.

C. An MCO shall accept enrollees in the order in which they apply without restriction, up to the enrollment capacity limits set under the contract.

1. An MCO shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status, sexual orientation, or need for health care services, and shall not use any policy or practice that has the effect of discriminating on any such basis.

D. An MCO shall be required to provide service authorization, referrals, coordination, and/or assistance in scheduling the covered services consistent with standards as defined in the Louisiana Medicaid State Plan and as specified in the terms of the contract.

E. An MCO shall provide a chronic care management program as specified in the contract.

F. The MCO shall establish and implement a quality assessment and performance improvement program as specified in the terms of the contract and department issued guides.

G. An MCO shall develop and maintain a utilization management program including policies and procedures with defined structures and processes as specified in the terms of the contract and department issued guides.

H. An MCO shall develop and maintain effective continuity of care activities which ensure a continuum of care approach to providing health care services to members.

I. The MCO must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

1. The MCO shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP program as well all requirements set forth in the contract and department issued guides.

J. An MCO shall maintain a health information system that collects, analyzes, integrates and reports data as specified in the terms of the contract and all department issued guides.

1. An MCO shall collect data on enrollees and provider characteristics and on services furnished to members through an encounter data system as specified in the contract and all department issued guides.

K. An MCO shall be responsible for conducting routine provider monitoring to ensure:

1. continued access to care for Medicaid recipients; and

2. compliance with departmental and contract requirements.

L. An MCO shall ensure that payments are not made to a provider who is in non-payment status with the department or is excluded from participation in federal health care programs (i.e., Medicare, Medicaid, CHIP, etc.).

M. Medical records shall be maintained in accordance with the terms and conditions of the contract. These records shall be safeguarded in such a manner as to protect confidentiality and avoid inappropriate disclosure according to federal and state law.

N. An MCO shall participate on the department's Medicaid Quality Committee to provide recommendations for the Bayou Health Program.

O. An MCO shall participate on the department's established committees for administrative simplification and quality improvement, which will include physicians, hospitals, pharmacists, other healthcare providers as appropriate, and at least one member of the Senate and House Health and Welfare Committees or their designees.

P. The MCO shall provide both member and provider services in accordance with the terms of the contract and department issued guides.

1. The MCO shall submit member handbooks, provider handbooks, and templates for the provider directory to the department for approval prior to distribution and subsequent to any material revisions.

a. The MCO must submit all proposed changes to the member handbooks and/or provider manuals to the department for review and approval in accordance with the terms of the contract and the department issued guides.

b. After approval has been received from the department, the MCO must provide notice to the members and/or providers at least 30 days prior to the effective date of any proposed material changes to the plan through updates to the member handbooks and/or provider handbooks.

Q. The member handbook shall include, but not be limited to:

1. a table of contents;

2. a general description regarding:

a. how the MCO operates;

b. member rights and responsibilities;

c. appropriate utilization of services including emergency room visits for non-emergent conditions;

d. the PCP selection process; and

e. the PCP's role as coordinator of services;

3. member rights and protections as specified in 42 CFR §438.100 and the MCO's contract with the department including, but not limited to:

a. a member's right to disenroll from the MCO;

b. a member's right to change providers within the MCO;

c. any restrictions on the member's freedom of choice among MCO providers; and

d. a member's right to refuse to undergo any medical service, diagnoses, or treatment, or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;

4. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or the department, including but not limited to:

a. immediately notifying the MCO if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;

b. reporting to the department if the member has or obtains another health insurance policy, including employer sponsored insurance; and

c. a statement that the member is responsible for protecting his/her identification card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;

5. the amount, duration, and scope of benefits available under the MCO's contract with the department in sufficient detail to ensure that members have information

needed to aid in understanding the benefits to which they are entitled including, but not limited to:

a. information about health education and promotion programs, including chronic care management;

b. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;

c. how members may obtain benefits, including family planning services and specialized behavioral health services, from out-of-network providers;

d. how and where to access any benefits that are available under the Louisiana Medicaid State Plan, but are not covered under the MCO's contract with the department;

e. information about early and periodic screening, diagnosis and treatment (EPSDT) services;

f. how transportation is provided, including how to obtain emergency and non-emergency medical transportation;

g. the post-stabilization care services rules set forth in 42 CFR 422.113(c);

h. the policy on referrals for specialty care, including behavioral health services and other benefits not furnished by the member's primary care provider;

i. for counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO is required to furnish information on how or where to obtain the service;

j. how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";

k. the extent to which and how after-hour services are provided; and

l. information about the MCO's formulary and/or preferred drug list (PDL), including where the member can access the most current information regarding pharmacy benefits;

6. instructions to the member to call the Medicaid Customer Service Unit toll free telephone number or access the Medicaid member website to report changes in parish of residence, mailing address or family size changes;

7. a description of the MCO's member services and the toll-free telephone number, fax number, e-mail address and mailing address to contact the MCO's Member Services Unit;

8. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English and Spanish; and

9. grievance, appeal, and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and the MCO's contract with the department.

R. The provider manual shall include, but not be limited to:

1. billing guidelines;

2. medical management/utilization review guidelines;

3. case management guidelines;

4. claims processing guidelines and edits;

5. grievance and appeals procedures and process; and

6. other policies, procedures, guidelines, or manuals containing pertinent information related to operations and pre-processing claims.

S. The provider directory for members shall be developed in three formats:

1. a hard copy directory to be made available to members and potential members upon request;

2. an accurate electronic file refreshed weekly of the directory in a format to be specified by the department and used to populate a web-based online directory for members and the public; and

3. an accurate electronic file refreshed weekly of the directory for use by the enrollment broker.

T. The department shall require all MCOs to utilize the standard form designated by the department for the prior authorization of prescription drugs, in addition to any other currently accepted facsimile and electronic prior authorization forms.

1. An MCO may submit the prior authorization form electronically if it has the capabilities to submit the form in this manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1583 (June 2011), amended LR 39:92 (January 2013), LR 40:66 (January 2014), LR 41:933 (May 2015).

2. Covered services shall be defined as those health care services and benefits to which a Medicaid and LaCHIP eligible individual is entitled to under the Louisiana Medicaid state plan.

B. The MCO:

1. shall ensure that medically necessary services, defined in LAC 50:I.1101, are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are being furnished;

2. may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member;

3. may place appropriate limits on a service:

a. on the basis of certain criteria, such as medical necessity; or

b. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;

4. shall provide core benefits and services as outlined and defined in the contract and shall provide medically necessary and appropriate care to Medicaid MCO Program members;

5. shall provide all of the core benefits and services consistent with, and in accordance with, the standards as defined in the Title XIX Louisiana Medicaid state plan:

a. the MCO may exceed the limits as specified in the minimum service requirements outlined in the contract;

b. no medical service limitation can be more restrictive than those that currently exist under the Title XIX Louisiana Medicaid State Plan;

6. shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes, but is not limited to prenatal care, delivery, postpartum care, and family planning/interconception care services for pregnant women in accordance with federal regulations; and

7. shall establish a pharmaceutical and therapeutics (P and T) committee or similar committee for the development of its formulary and the PDL.

C. If the MCO elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the MCO must furnish information about the services it does not cover in accordance with §1932(b)(3)(B)(ii) of the Social Security Act and federal regulations by notifying:

1. the department in its response to the department's request for proposals (RFP) or whenever it adopts the policy during the term of the contract;

2. the potential enrollees before and during enrollment in the MCO;

§3507. Benefits and Services

A. Core benefits and services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to enrollees under Louisiana Medicaid state plan.

1. Core benefits and services shall be defined as those health care services and benefits required to be provided to Medicaid MCO members enrolled in the MCO as specified under the terms of the contract and department issued guides.

3. enrollees within 90 days after adopting the policy with respect to any particular service; and

4. members through the inclusion of the information in the member handbook.

D. The following is a summary listing of the core benefits and services that a MCO is required to provide:

1. inpatient hospital services;

2. outpatient hospital services;

3. ancillary medical services;

4. organ transplant-related services;

5. family planning services as specified in 42 CFR §431.51(b)(2) (not applicable to an MCO operating under a moral and religious objection as specified in the contract);

6. EPSDT/well child visits;

7. emergency medical services;

8. communicable disease services;

9. durable medical equipment and certain supplies;

10. prosthetics and orthotics;

11. emergency and non-emergency medical transportation;

12. home health services;

13. basic behavioral health services;

14. school-based health clinic services provided by the Office of Public Health certified school-based health clinics;

15. physician services;

16. maternity services;

17. chiropractic services;

18. rehabilitation therapy services (physical, occupational, and speech therapies);

19. pharmacy services (outpatient prescription medicines dispensed with the exception of those prescribed by a specialized behavioral health provider, and at the contractual responsibility of another Medicaid managed care entity);

20. hospice services;

21. personal care services (age 0-20); and

22. pediatric day healthcare services.

NOTE: This overview is not all inclusive. The contract, policy transmittals, state plan amendments, regulations, provider bulletins, provider manuals, published fee schedules, and guides issued by the department are the final authority regarding services.

E. Transition Provisions

1. In the event a member transitions from an MCO included status to an MCO excluded status before being discharged from a hospital and/or rehabilitation facility, the cost of the entire admission will be the responsibility of the MCO. This is only one example and does not represent all situations in which the MCO is responsible for cost of services during a transition.

2. In the event a member is transitioning from one MCO to another and is hospitalized at 12:01 a.m. on the effective date of the transfer, the relinquishing MCO shall be responsible for both the inpatient hospital charges and the charges for professional services provided through the date of discharge. Services other than inpatient hospital will be the financial responsibility of the receiving MCO.

F. The core benefits and services provided to the members shall include, but are not limited to, those services specified in the contract.

1. Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

G. Excluded Services

1. The following services will continue to be reimbursed by the Medicaid Program on a fee-for-service basis. The MCO shall provide any appropriate referral that is medically necessary. The department shall have the right to incorporate these services at a later date if the member capitation rates have been adjusted to incorporate the cost of such service. Excluded services include:

a. services provided through the Early-Steps Program (IDEA Part C Program services);

b. dental services;

c. intermediate care facility services for persons with intellectual disabilities;

d. personal care services (age 21 and over);

e. nursing facility services;

f. Individualized Education Plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures;

g. specialized behavioral health services;

h. applied behavioral analysis therapy services; and

i. targeted case management services.

H. Utilization Management

1. The MCO shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review. The program shall include service authorization and medical necessity review and comply with the requirements set forth in this Section, the contract and department issued guides.

a. The MCO-P shall submit UM policies and procedures to the department for written approval annually and subsequent to any revisions.

2. The UM Program policies and procedures shall, at a minimum, include the following requirements:

a. the individual(s) who is responsible for determining medical necessity, appropriateness of care, level of care needed, and denying a service authorization request or authorizing a service in amount, duration or scope that is less than requested, must meet the following requirements. The individual shall:

i. be a licensed clinical professional with appropriate clinical expertise in the treatment of a member's condition or disease;

ii. have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions that have been taken or are pending such action by any hospital, governmental agency or unit, or regulatory body, that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character; and

iii. attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise;

b. the methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;

c. the data sources and clinical review criteria used in decision making;

d. the appropriateness of clinical review shall be fully documented;

e. the process for conducting informal reconsiderations for adverse determinations;

f. mechanisms to ensure consistent application of review criteria and compatible decisions;

g. data collection processes and analytical methods used in assessing utilization of healthcare services; and

h. provisions for assuring confidentiality of clinical and proprietary information.

3. The UM Program's medical management and medical necessity review criteria and practice guidelines shall be reviewed annually and updated periodically as appropriate. The MCO shall use the medical necessity definition as set forth in LAC 50:I.1101 for medical necessity determinations.

a. Medical management and medical necessity review criteria and practice guidelines shall:

i. be objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

ii. consider the needs of the members;

iii. be adopted in consultation with contracting health care professionals; and

iv. be disseminated to all affected providers, members, and potential members upon request.

b. The MCO must identify the source of the medical management criteria used for the review of medical necessity and for service authorization requests.

i. The vendor must be identified if the criteria are purchased.

ii. The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society.

iii. The guideline source must be identified if the criteria are based on national best practice guidelines.

iv. The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.

4. The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

5. The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1585 (June 2011), amended LR 39:92 (January 2013), repromulgated LR 39:318 (February 2013), LR 41:936 (May 2015).

§3509. Reimbursement Methodology

A. Payments to an MCO. The department, or its fiscal intermediary, shall make monthly capitation payments to the MCO based on a per member, per month (PMPM) rate.

1. The department will establish monthly payment rates within an actuarially sound rate range certified by its actuaries. Consistent with all applicable federal rules and regulations, the rate range will initially be developed using fee-for-service claims data, Bayou Health shared savings claims experience, Bayou Health prepaid encounter data, financial data reported by Bayou Health plans, supplemental ad hoc data, and actuarial analyses with appropriate adjustments.

2. As the Bayou Health Program matures and fee-for-service data is no longer available, there will be increasing reliance on encounter data and/or financial data to set future rates, subject to comparable adjustments.

3. PMPM payments will be set on the basis of health status-based risk adjustments. An initial universal PMPM

rate will be set for all MCOs at the beginning of each contract period and as deemed necessary by the department.

a. The health risk of the Medicaid enrollees enrolled in the MCO will be measured using a nationally-recognized risk-assessment model.

b. Utilizing this information, the universal PMPM rates will be adjusted to account for the health risk of the enrollees in each MCO relative to the overall population being measured.

c. The health risk of the members and associated MCO risk scores will be updated periodically to reflect changes in risk over time.

d. The department will provide the MCO with advance notice of any major revision to the risk-adjustment methodology.

4. An MCO shall be reimbursed a one-time supplemental lump sum payment, hereafter referred to as a "maternity kick payment", for each obstetrical delivery in the amount determined by the department's actuary.

a. The maternity kick payment is intended to cover the cost of prenatal care, the delivery event, and postpartum care. Payment will be paid to the MCO upon submission of satisfactory evidence of the occurrence of a delivery.

b. Only one maternity kick payment will be made per delivery event. Therefore, multiple births during the same delivery will still result in one maternity kick payment being made.

c. The maternity kick payment will be paid for both live and still births. A maternity kick payment will not be reimbursed for spontaneous or induced abortions.

5. PMPM payments related to pharmacy services will be adjusted to account for pharmacy rebates.

6. - 6.a. Reserved.

7. A withhold of the aggregate capitation rate payment may be applied to provide an incentive for MCO compliance as specified in the contract.

B. As Medicaid is the payor of last resort, an MCO must agree to accept the PMPM rate as payment-in-full from the department and agree not to seek additional payment from a member for any unpaid cost.

C. The MCO rate does not include graduate medical education payments or disproportionate share hospital payments. These supplemental payments will be made to applicable providers outside the PMPM rate by the department according to methodology consistent with existing Rules.

D. An MCO shall assume 100 percent liability for any expenditure above the PMPM rate.

E. The MCO shall meet all financial reporting requirements specified in the terms of the contract.

F. An MCO shall have a medical loss ratio (MLR) for each MLR reporting calendar year of not less than 85 percent using definitions for health care services, quality initiatives, and administrative cost as specified in 45 CFR Part 158.

1. An MCO shall provide an annual MLR report, in a format as determined by the department, by June 1 following the MLR reporting year that separately reports the MCO's medical loss ratio for services provided to Medicaid enrollees and payment received under the contract with the department from any other products the MCO may offer in the state of Louisiana.

2. If the medical loss ratio is less than 85 percent, the MCO will be subject to refund of the difference, within the timeframe specified, to the department by August 1. The portion of any refund due the department that has not been paid by August 1 will be subject to interest at the current Federal Reserve Board lending rate or in the amount of ten percent per annum, whichever is higher.

3. The department shall provide for an audit of the MCO's annual MLR report and make public the results within 60 calendar days of finalization of the audit.

G. Any cost sharing imposed on Medicaid members must be in accordance with the federal regulations governing cost sharing and cannot exceed the amounts reflected in the Louisiana Medicaid State Plan, but the amounts can be less than the cost sharing levels in the State Plan.

H. The department may adjust the PMPM rate, during the term of the contract, based on:

1. changes to core benefits and services included in the capitation rate;

2. changes to Medicaid population groups eligible to enroll in an MCO;

3. changes in federal requirements; and/or

4. legislative appropriations and budgetary constraints.

I. Any adjusted rates must continue to be actuarially sound and will require an amendment to the contract.

J. The MCO shall not assign its rights to receive the PMPM payment, or its obligation to pay, to any other entity.

1. At its option, the department may, at the request of the MCO, make payment to a third party administrator.

2. - 3.a. Reserved.

K. In the event that an incorrect payment is made to the MCO, all parties agree that reconciliation will occur.

1. If an error or overcharge is discovered by the department, it will be handled in accordance with the terms and conditions of the contract.

L. Network Provider Reimbursement

1. Reimbursement for covered services shall be equal to or greater than the published Medicaid fee-for-service rate in effect on the date of service, unless mutually agreed by

both the plan and the provider in the provider contract to pay otherwise.

a. The MCO shall pay a pharmacy dispensing fee, as defined in the contract, at a rate no less than the minimum rate specified in the terms of the contract.

2. The MCO's subcontract with the network provider shall specify that the provider shall accept payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from the department or the member.

a. The term "member" shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served.

3. The MCO shall not enter into alternative payment arrangements with federally qualified health centers (FQHCs) or rural health clinics (RHCs) as the MCO is required to reimburse these providers according to the published FQHC/RHC Medicaid prospective payment schedule rate in effect on the date of service, whichever is applicable.

M. Out-of-Network Provider Reimbursement

1. The MCO is not required to reimburse more than 90 percent of the published Medicaid fee-for-service rate in effect on the date of service to out-of-network providers to whom they have made at least three documented attempts to include the provider in their network as per the terms of the contract.

2. If three attempts to contract with the provider prior to the delivery of the medically necessary service have not been documented, the CNN-P shall reimburse the provider the published Medicaid fee-for-service rate in effect on the date of service.

3. The MCO is not required to reimburse pharmacy services delivered by out-of-network providers. The MCO shall maintain a system that denies the claim at the point-of-sale for providers not contracted in the network.

N. Reimbursement for Emergency Services for In-Network or Out-of-Network Providers

1. The MCO is financially responsible for ambulance services, emergency and urgently needed services and maintenance, and post-stabilization care services in accordance with the provisions set forth in 42 CFR §422.113.

2. The reimbursement rate for medically necessary emergency services shall be no less than the published Medicaid fee-for-service rate in effect on the date of service, regardless of whether the provider that furnished the services has a contract with the MCO.

a. The MCO may not concurrently or retrospectively reduce a provider's reimbursement rate for these emergency services, including ancillary and diagnostic services, provided during an episode of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1587 (June 2011), amended LR 39:92 (January 2013), LR 41:937 (May 2015).

§3705. General Provisions

A. The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the state fair hearing process once the MCO's appeal process has been exhausted.

B. Filing Requirements

1. Authority to file. A member, or a representative of his/her choice, including a network provider acting on behalf of the member and with the member's consent, may file a grievance and an MCO level appeal. Once the MCO's appeals process has been exhausted, a member or his/her representative may request a state fair hearing.

a. An MCO's provider, acting on behalf of the member and with his/her written consent, may file a grievance, appeal, or request a state fair hearing on behalf of a member.

2. Filing Timeframes. The member, or a representative or provider acting on the member's behalf and with his/her written consent, may file an appeal within 30 calendar days from the date on the MCO's notice of action.

3. Filing Procedures

a. The member may file a grievance either orally or in writing with the MCO.

b. The member, or a representative or provider acting on the member's behalf and with the member's written consent, may file an appeal either orally or in writing

C. Grievance Notice and Appeal Procedures

1. The MCO shall ensure that all members are informed of the state fair hearing process and of the MCO's grievance and appeal procedures.

a. The MCO shall provide a member handbook to each member that shall include descriptions of the MCO's grievance and appeal procedures.

b. Forms to file grievances, appeals, concerns, or recommendations to the MCO shall be available through the MCO, and must be provided to the member upon request. The MCO shall make all forms easily available on its website.

D. Grievance and Appeal Records

1. The MCO must maintain records of grievances and appeals. A copy of the grievance logs and records of the disposition of appeals shall be retained for six years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six-year period, whichever is later.

E. Grievance Reports

1. The MCO shall provide an electronic report of the grievances and appeals it has received on a monthly basis in accordance with the requirements specified by the department, which will include, but is not limited to:

a. the member's name and Medicaid identification number;

b. summary of grievances and appeals;

c. date of filing;

d. current status;

e. resolutions; and

f. resulting corrective action.

F. All state fair hearing requests shall be sent directly to the state designated entity.

G. The MCO will be responsible for promptly forwarding any adverse decisions to the department for further review and/or action upon request by the department or the MCO member.

H. The department may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance or appeal.

I. Information to Providers and Subcontractors. The MCO must provide the information about the grievance system as specified in federal regulations to all providers and subcontractors at the time they enter into a contract.

J. Recordkeeping and Reporting Requirements. Reports of grievances and resolutions shall be submitted to the department as specified in the contract. The MCO shall not modify the grievance system without the prior written approval of the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1590 (June 2011), amended LR 41:939 (May 2015).