NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Behavioral Health Integration
(LAC 50:I.Chapters 31-37)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:I.Chapters 31-40 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the coordinated care network in order to change the name in this Subpart to *Managed Care for Physical and Basic Behavioral Health* and to incorporate other necessary programmatic changes (*Louisiana Register,* Volume 41, Number 5). This Notice of Intent also incorporated provisions to permit Medicaid eligible children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* class action litigation (hereafter referred to as *Chisholm* class members) to have the option of voluntarily enrolling into a participating health plan under the Bayou Health program.

Currently, specialized behavioral health services, including State Plan §1915(c) services for children and §1915(i) State Plan

services, are provided under the Louisiana Behavioral Health Partnership through a statewide management organization and carved out of the Bayou Health program.

The department now proposes to amend the provisions governing managed care for physical and basic behavioral health in order to reflect the integration of specialized behavioral health services into Bayou Health as a result of the narrowing of the statewide management organization's scope of service administration for certain behavioral health services. This proposed Rule will also amend the provisions governing recipient participation in order to enroll additional populations into Bayou Health that had been exempt/excluded from participation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and ~~Basic~~ Behavioral Health

Chapter 31. General Provisions

§3101. Introduction

A. - A.5. …

B. Effective for dates of service on or after ~~February~~ December 1, 2015, the department will operate a managed care delivery system for an expanded array of services to include comprehensive, integrated physical and ~~basic~~ behavioral health (basic and specialized) services, 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.~~It is the department's intent to procure the provisions 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.

~~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.~~D. – D.1. Repealed.

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), LR 41:

§3103. Recipient Participation

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

1. ~~categorically needy individuals~~mandatory enrollees:

a. children up to 19 years of age ~~and their parents~~ who are eligible under §1902 and §1931 of the Social Security Act (hereafter referred to as the Act) as poverty-level related groups ~~or~~ and optional groups of older children~~ and caretaker relatives~~;

b. ~~qualified pregnant women and children~~parents and caretaker relatives who are eligible under §1902 and §~~1905~~ 1931 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~~Children's Health Insurance Program (CHIP) (Title XXI) children enrolled in Medicaid expansion program (LaCHIP Phase I, II, III);

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~~CHIP (Title XXI) prenatal care option (LaCHIP Phase IV) and children enrolled in the separate, stand-alone CHIP program (LaCHIP Phase V);

e. ~~uninsured~~ pregnant women whose basis for eligibility is pregnancy, who are only eligible ~~through the Louisiana Children's Health Insurance Program (LaCHIP) Prenatal Option~~for pregnancy-related services, and whose eligibility extends until 60 days after the pregnancy ends;

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)~~non-dually eligible aged, blind, and disabled adults over the age of 19;

g. ~~persons eligible through the Tuberculosis Infected Individual Program~~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;

h. individuals ~~who are Native Americans/Alaskan Natives and members of a federally recognized tribe~~eligible through the Tuberculosis Infected Individual Program; ~~or~~

i. ~~children under the age of 19 who are:~~former foster care children eligible under §1902(a)(10)(A)(i)(IX) and (XVII) of the Act; or

~~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;~~i. - v. Repealed.

j. individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy 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).~~2. – 3. Repealed.

B. Mandatory, Voluntary Opt-In Participants

1. Participation in an MCO for the following participants is mandatory for specialized behavioral health and non-emergency medical transportation (NEMT) services only, and is voluntary for physical health services:

a. individuals who receive services under the authority of the following 1915(c) home and community-based services waivers~~ services~~; and

i. Adult Day Health Care (ADHC) waiver;

ii. Community Choices Waiver (CCW);

iii. New Opportunities Waiver (NOW);

iv. Children's Choice (CC) waiver;

v. Residential Options Waiver (ROW); and

vi. Supports Waiver (SW);

b. ~~effective February 1, 2015, children~~individuals under the age of 21 who are otherwise eligible for Medicaid, and who

are listed on the ~~New Opportunities Waiver~~DHH Office for Citizens with Developmental Disabilities' Request for Services Registry. These children are identified as *Chisholm* class members:

i. ...

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~~Repealed.

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~~Mandatory, voluntary opt-in populations may initially elect to receive physical health services through Bayou Health at any time.

D. ~~Participation Exclusion~~Mandatory, voluntary opt-in populations who elected to receive physical health services through Bayou Health, but returned to legacy Medicaid for physical health services, may return to Bayou Health for physical health services only during the annual open enrollment period.

~~1. The following Medicaid and/or CHIP recipients are excluded from participation in a 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;~~

~~f. are participants in the Greater New Orleans Community Health Connection (GNOCHC) Program.~~1. - 1.f. Repealed.

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.~~Mandatory MCO Populations - Specialized Behavioral Health Services Only

1. The following populations are mandatory enrollees in Bayou Health for specialized behavioral health services only:

a. individuals residing in nursing facilities; and

b. individuals under the age of 21 residing in intermediate care facilities for persons with intellectual disabilities (ICF/ID).

F. Mandatory MCO Populations - Specialized Behavioral Health and NEMT Services Only

1. Individuals who receive both Medicare and Medicaid (e.g. Medicaid dual eligibles) are mandatory enrollees in Bayou Health for specialized behavioral health and non-emergency medical transportation services only.

G. 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.

H. Participation Exclusion

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

a. reside in an ICF/ID (adults);

b. are partial dual eligibles;

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

d. have a limited period of eligibility and participate in either the Spend-Down Medically Needy Program or the Emergency Services Only program;

e. receive services through the Take Charge Plus program; or

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

I. 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 36:2465 (November 2010), LR 37:680 (February 2011)], 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), LR 41:

§3105. Enrollment Process

A. – C.3. ...

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.~~Special Open Enrollment Period for Specialized Behavioral Health Integration

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~~The department, through its enrollment broker, will provide an opportunity for all populations to be mandatorily enrolled into Bayou Health for specialized behavioral health services. These populations will be given a 60-day choice period to proactively choose an MCO.

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~~Each potential MCO member shall receive information and the offer of assistance with making informed choices about the participating MCOs and the availability of choice counseling.

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

3. During the special enrollment period, current members who do not proactively request reassignment will remain with their existing MCO.

4. These new members will be encouraged to make a choice among the participating MCOs. When no choice is made, auto-assignment will be used as outlined in §3105.G.2.a.

E. ~~Selection of an MCO~~Special Enrollment Provisions for Mandatory, Opt-In Population Only

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.~~Mandatory, opt-in populations may request participation in Bayou Health for physical health services at any time. The effective date of enrollment shall be no later than the first day of the second month following the calendar month the request for enrollment is received. Retroactive begin dates are not allowed.

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.~~The enrollment broker will ensure that all mandatory, opt-in populations are notified at the time of enrollment of their ability to disenroll for physical health at any time. The effective date will be the first day of a month, and no later than the first day of the second month following the calendar month the request for disenrollment is received.

~~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.~~2.a. - a.i. Repealed.

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~~Following an opt-in for physical health and selection of an MCO and subsequent 90-day choice period, these members will be locked into the MCO for 12 months from the effective date of enrollment or until the next annual enrollment period unless they elect to disenroll from physical health.

~~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.~~4. - 5.b. Repealed.

F. ~~Automatic Assignment Process~~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. ~~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:~~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.

~~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.~~a. - c. Repealed.

2. The MCO ~~automatic assignments shall take into consideration factors including, but not limited to~~and its providers shall be required to:

a. ~~assigning members of family units to the same MCO~~ 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. ~~existing provider-enrollee relationships;~~complete and submit any other Medicaid enrollment form required by the department.

~~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.~~c. - 3. Repealed.

G. Selection ~~or Automatic Assignment~~ of an ~~Primary Care Provider~~MCO

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:~~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.

~~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).~~a. - c. Repealed.

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~~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 an MCO shall be automatically assigned to an MCO by the enrollment broker, and the MCO shall be responsible to assign the member to a primary care provider (PCP) if a PCP is not selected at the time of enrollment into the MCO.

b. For mandatory populations for all covered services as well as mandatory, specialized behavioral health populations, the auto-assignment will automatically enroll members using a hierarchy that takes into account family/household member enrollment, or a round robin method that maximizes preservation of

existing specialized behavioral health provider-recipient relationships.

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

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.

H. ~~Lock-In Period~~Automatic Assignment Process

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.~~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, with the exceptions noted in §3105.G.2.a.i.;

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.

I. ~~Annual Open Enrollment~~Selection or Automatic Assignment of a Primary Care Provider for Mandatory Populations for All Covered Services

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.~~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. ~~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~~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. ~~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~~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.

J. 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, with the exception of the mandatory, opt-in populations, who may disenroll from Bayou Health for physical health and return to legacy Medicaid at any time.

K. 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.

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), LR 41:

§3107. Disenrollment and Change of Managed Care Organization

A. – D.1.e.ii. …

iii. ~~documented lack of access to providers experienced in dealing with the enrollee's health care needs.~~the member's active specialized behavioral health provider ceases to contract with the MCO; or

iv. 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:~~fraudulent use of the MCO identification card. In such cases, the MCO shall report the incident to the Bureau of Health Services Financing.

~~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.~~a. - b. Repealed.

2. - 4.f. …

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 - i. …

F. Department Initiated Disenrollment

1. The department will notify the MCO of the member's disenrollment or change in eligibility status due to the following reasons:

a. - G.2. …

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 41:931 (Mary 2015), LR 41:

§3109. Member Rights and Responsibilities

A. - A.10. ...

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

B. – C.8. ...

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), LR 41:

Chapter 35. Managed Care Organization Participation Criteria

§3501. Participation Requirements

A. – B.5. …

6. have a network capacity to enroll a minimum of ~~100,000~~250,000 Medicaid and LaCHIP eligibles; and

7. – 9. …

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. – I.4. …

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), LR 41:

§3503. Managed Care Organization Responsibilities

A. – P.1. ...

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

b. ...

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

1. – 3. ...

a. a member's right to disenroll from the MCO, including disenrollment for cause;

b. – 4.c. ...

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~~specialized behavioral health;

b. ~~the procedures for obtaining benefits, including prior authorization requirements and benefit limits~~information about health education and promotion programs, including chronic care management;

c. ~~how members may obtain benefits, including family planning services and specialized behavioral health services, from out-of-network providers~~the procedures for obtaining benefits, including prior authorization requirements and benefit limits;

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~~members may obtain benefits, including family planning services, from out-of-network providers;

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

f. ~~how transportation is provided, including how to obtain emergency and non-emergency medical transportation~~information about early and periodic screening, diagnosis and treatment (EPSDT) services;

g. ~~the post-stabilization care services rules set forth in 42 CFR 422.113(c)~~how transportation is provided, including how to obtain emergency and non-emergency medical transportation;

h. ~~the policy on referrals for specialty care, including behavioral health services and other benefits not furnished by the member's primary care provider~~the post-stabilization care services rules set forth in 42 CFR 422.113(c);

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

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

k. ~~the extent to which and how after-hour services are provided~~how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show"; ~~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~~ the extent to which and how after-hour crisis and emergency services are provided; and

m. 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. – 7. ...

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~~.~~; and

10. information regarding specialized behavioral health services, including but not limited to:

a. a description of covered behavioral health services;

b. where and how to access behavioral health services and behavioral health providers, including emergency or crisis services;

c. general information on the treatment of behavioral health conditions and the principles of:

i. adult, family, child, youth and young adult engagement;

ii. resilience;

iii. strength-based and evidence-based practices; and

iv. best/proven practices;

d. description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and

e. any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment, as per 42 CFR Part 2.

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

1. – 4. ...

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~~.~~;

7. description of the MCO;

8. core benefits and services the MCO must provide, including a description of all behavioral health services;

9. information on how to report fraud, waste and abuse; and

10. information on obtaining transportation for members.

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

1. ...

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~~.~~; and

4. a hard copy abbreviated version, upon request by the enrollment broker.

T. – T.1. ...

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), LR 41:

§3507. Benefits and Services

A. – C.4. ...

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

1. – 5. …

6. EPSDT/Well Child visits, excluding applied behavior analysis (ABA) therapy services and dental services;

7. – 12. …

13. basic and specialized behavioral health services, excluding Coordinated System of Care services;

14. - 18. …

19. pharmacy services (outpatient prescription medicines dispensed, with the exception of those ~~prescribed by a specialized behavioral health provider, and at~~ who are enrolled in Bayou Health for behavioral health services only, or the contractual responsibility of another Medicaid managed care entity)~~.~~:

a. specialized behavioral health only members will receive pharmacy services through legacy Medicaid;

20. …

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

22. pediatric day healthcare services~~.~~;

23. audiology services;

24. ambulatory surgical services;

25. laboratory and radiology services;

26. emergency and surgical dental services;

27. clinic services;

28. pregnancy-related services;

29. pediatric and family nurse practitioner services;

30. licensed mental health professional services, including advanced practice registered nurse (APRN) services;

31. federally qualified health center (FQHC)/rural health clinic (RHC) services;

32. early stage renal disease (ESRD) services;

33. optometry services;

34. podiatry services;

35. rehabilitative services, including crisis stabilization;

36. respiratory services; and

37. section 1915(i) services.

NOTE: …

E. Transition Provisions

1. In the event a member transitions from an MCO included status to an MCO excluded status or MCO specialized behavioral health only 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. – F.1. …

G. Excluded Services

1. The following services will continue to be reimbursed by the Medicaid Program on a fee-for-service basis, with the exception of dental services which will be reimbursed through a dental benefits prepaid ambulatory health plan under the authority of a 1915(b) waiver. 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. …

b. ~~dental services~~intermediate care facility services for persons with intellectual disabilities;

c. ~~intermediate care facility services for persons with intellectual disabilities~~personal care services (age 21 and over);

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

e. ~~nursing facility services~~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;

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~~ABA therapy services;

g. ~~specialized behavioral health services~~targeted case management services; and

h. ~~applied behavioral analysis therapy services; and~~all OAAS/OCDD home and community-based §1915(c) waiver services.

i. ~~targeted case management services~~Repealed.

H. Utilization Management

1. …

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

2. – 5. …

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 37:185 (June 2011), amended LR 39:92 (January 2013), repromulgated LR 39:318 (February 2013), LR 41:936 (May 2015), LR 41:

§3509. Reimbursement Methodology

A. ...

1. The department will establish monthly ~~payment~~ capitation 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~~data, Bayou Health ~~prepaid~~ managed care organization encounter data, Louisiana Behavioral Health Partnership (LBHP) encounter data, financial data reported by Bayou Health plans and the LBHP statewide management organization, supplemental ad hoc data, and actuarial analyses with appropriate adjustments.

2. ...

3. ~~PMPM payments will be set on the basis of health status-based risk adjustments. An initial universal PMPM~~Capitation rates will be set for all MCOs at the beginning of each contract period and will be periodically reviewed and adjusted 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.~~a. – d. Repealed.

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~~Capitation rates for physical and basic behavioral health will be risk-adjusted for the health of Medicaid

enrollees enrolled in the MCO. Capitation rates for specialized behavioral health will not be risk-adjusted.

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

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~~Utilizing this information, the capitation 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 ~~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~~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.

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

6. Capitation rates related to pharmacy services will be adjusted to account for pharmacy rebates.

B. – E. ...

F. An MCO shall have a medical loss ratio (MLR) for each MLR reporting year, which shall be a 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. Following the end of the MLR reporting year, ~~A~~an MCO shall provide an annual MLR report, in ~~a format as determined~~accordance with the financial reporting guide issued 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~~The annual MLR report shall be limited to the MCO's medical loss ratio for services provided to Medicaid enrollees and payment received under the contract with the department, separate from any other products the MCO may offer in the state of Louisiana.

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~~An MLR shall be reported in the aggregate, including all services provided under the contract.

a. The aggregate MLR shall not be less than 85 percent using definitions for health care services, quality initiatives and administrative cost as specified in 45 CFR Part 158. If the aggregate MLR is less than 85 percent, the MCO will be subject to refund the difference, within the timeframe specified, to the department. The portion of any refund due the department that has not been paid, within the timeframe specified, will be subject to

interest at the current Federal Reserve Board lending rate or in the amount of 10 percent per annum, whichever is higher.

b. The department may request MLR reporting that distinguishes physical and basic behavioral health from specialized behavioral health. Neither the 85 percent minimum nor the refund applicable to the aggregate shall apply to distinct MLRs reported.

4. 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. – N.2.a. ...

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), repromulgated LR 39:318 (February 2013), LR 41:937 (May 2015), LR 41:

Chapter 37. Grievance and Appeal Process

Subchapter A. Member Grievances and Appeals

§3705. General Provisions

A. …

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, with the member's written consent, may request a state fair hearing.

a. - J. …

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), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule may have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 by providing families with better coordination of their total health care services and increasing the quality and continuity of care for the individual and the entire family.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule may have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by reducing the financial burden on families through better coordinated health care services and increased continuity of care.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, September 24, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for

receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert

Secretary