§3103. Recipient Participation

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

1. mandatory enrollees:

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

b. parents and caretaker relatives who are eligible under §1902 and §1931 of the Act;

c. Children's Health Insurance Program (CHIP) (title XXI) children enrolled in Medicaid expansion program (LaCHIP Phase I, II, III);

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

e. pregnant women whose basis for eligibility is pregnancy, who are only eligible for pregnancy-related services, and whose eligibility extends until 60 days after the pregnancy ends;

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

g. 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 eligible through the Tuberculosis Infected Individual Program;

i. former foster care children eligible under §1902(a)(10)(A)(i)(IX) and (XVII) of the Act; or

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.

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; 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. individuals under the age of 21 who are otherwise eligible for Medicaid, and who are listed on the DHH Office for Citizens with Developmental Disabilities' 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.

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

D. 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.

E. 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.

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Chapter 33. Coordinated Care Network Shared Savings Model

§3301. Participation Requirements

A. In order to participate in the Bayou Health Program after January 31, 2015, a coordinated care network shared savings model (CCN-S) must be an entity that operated as a CCN-S contracted with the department during the period of February 1, 2012 through January 31, 2015.

B. Participation in the Bayou Health program shared savings model after January 31, 2015 is for the exclusive purpose of fully executing provisions of the CCN-S contract relative to the determinations of savings realized or refunds due to the department for CCN-S operations during the period of February 1, 2012 through January 31, 2015.

C. A CCN-S is required to maintain a surety bond for an amount specified by the department for the at-risk portion of the enhanced care management fee through the full execution of the provisions of the CCN-S contract relative to determinations of savings realized or refunds due to the department for CCN-S operations during the period of February 1, 2012 through January 31, 2015 as determined by the department.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1577 (June 2011), amended LR 41:932 (May 2015).

§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.

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;

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 an 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, excluding applied behavior analysis (ABA) therapy services and dental services;

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

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

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

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

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

d. nursing facility services;

e. 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. ABA therapy services;

g. targeted case management services; and

h. all OAAS/OCDD home and community-based §1915(c) waiver 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 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.

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§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 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 data, Bayou Health 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. 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. 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.

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

b. 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 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. 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. 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 year, which shall be a calendar year.

1. Following the end of the MLR reporting year, an MCO shall provide an annual MLR report, in accordance with the financial reporting guide issued by the department.

2. 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. 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. 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.

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