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Department of Health and Hospitals
Bureau of Health Services Financing

Substantive Changes and Public Hearing Notification
Managed Care for Physical and Basic Behavioral Health
(LAC 50:I.Chapters 31-40)

In accordance with the provisions of the Administrative Procedures Act, R.S. 49:950 et seq., the Department of Health and Hospitals, Bureau of Health Services Financing published a Notice of Intent in the October 20, 2014 edition of the *Louisiana Register* (LR 40:2105-2122) to amend LAC 50:I.Chapters 31-40. This Notice of Intent proposed to amend 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. 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.

The department conducted a public hearing on this Notice of Intent on November 26, 2014 to solicit comments and testimony on the proposed Rule. As a result of the comments received, the department proposes to amend the provisions in the following Sections of the proposed Rule: 1) §3103. Recipient Participation, Paragraph C, which

had no changes will now clarify that participants will be notified at enrollment of their rights to disenroll from a health plan; 2) §3105. Enrollment Process, Subparagraph E.5.b shall be amended to provide further clarification of the provisions for transferring out of a managed care organization (MCO) for cause; 3) §3501. Participation Requirements, Subparagraph B.9 shall be amended to remove the last sentence in the Subparagraph relative to the HIPPA and Fraud Assessments; 4) §3503. Managed Care Organization Responsibilities, Paragraph O shall be amended to add MCO committee participation requirements; Paragraph P (formerly Paragraph O) and Subparagraphs 1 – 1.a shall be amended only to ensure proper formatting; Subparagraph 1.b shall be amended to clarify the recipient notice provisions; Paragraphs and Subparagraphs Q. – T.1 shall be amended only to ensure proper formatting; and the provisions, “2. – T.1. Repealed” is being removed for proper formatting; 5) §3507. Benefits and Services, Subparagraph E.2 shall be amended to clarify the provisions for transferring between MCOs; and 6) §3705. General Provisions, Subparagraph B.1 shall be amended to clarify the filing requirements for member grievances; and Subparagraphs C.1.-1a shall be amended to clarify the grievance notice and appeal procedures.

Taken together, all of these proposed revisions will closely align the proposed Rule with the Department’s original intent and the concerns brought forth during the comment period for the Notice of

Intent as originally published. No fiscal or economic impact will result from the amendments proposed in this notice.

Title 50

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

Chapter 31. General Provisions

§3103. Recipient Participation

A. – B.2. …

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

D. – E. …

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 41:

§3105. Enrollment Process

A. – E.5a. …

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. – I.3. …

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:

Chapter 35. Managed Care Organization Participation Criteria

§3501. Participation Requirements

A. – B.8. …

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. – 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:

§3503. Managed Care Organization Responsibilities

A. – N. …

O. A 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;

a. – b. Repealed.

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;

a. – e. Repealed.

3. case management guidelines;

a. – d. Repealed.

4. claims processing guidelines and edits;

a. – c. Repealed.

5. grievance and appeals procedures and process; and

a. – l. Repealed.

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

7. – 9. Repealed.

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.

4. – 6. Repealed.

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:

§3507. Benefits and Services

A. – E.1. …

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. – H.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), LR 39:318 (February 2013), 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 may request a state fair hearing.

B.1.a. – 3.b. …

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.

C.1.b. - 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:

Implementation of these amendments to the proposed 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.

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 these substantive amendments to the proposed Rule. A public hearing on these substantive changes to the proposed Rule is scheduled for Tuesday, March 31, 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