Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

March 31, 2015

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

RE: Louisiana Title XIX State Plan
Transmittal No. 15-0010

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan.

Sincerely,

Approved for

Kathy H. Kliebert
Secretary

Attachments (18)

KHK/WJR/JH

Bienville Building • 628 North 4th Street • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
Phone #: 225/342-9509 • Fax #: 225/342-5568 • *WWW.DHH.LA.GOV*
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0010**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **February 1, 2015**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

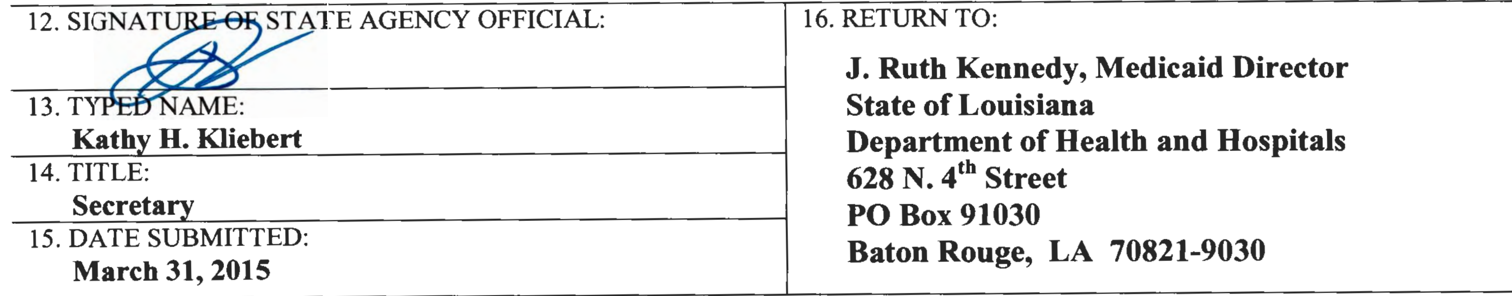
6. FEDERAL STATUTE/REGULATION CITATION:
1932(a)(4) of Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY **2015** **$19,493.22**
b. FFY **2016** **$78,760.23**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, Pages 1, 2, 2a, 3, 9, 10a, 11, and 13	**Same (TN 11-21) remove page 2b**
Attachment 3.1-F, Page 1a	**Same (TN 12-65)**
Attachment 3.1-F, Page 4, 4a, 5, 7, 8, 8a, 10, and 12	**Same (TN 14-0015)**
Attachment 3.1-F, Page 12a	**None (New Page)**

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the provisions governing the coordinated care network and Medicaid managed care in order to change the name and to incorporate programmatic changes resulting from the inclusion of basic behavioral health services in the program and the voluntary enrollment of Medicaid eligible children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* class action litigation.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.



12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 31, 2015

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

LOUISIANA TITLE XIX STATE PLAN
TRANSMITTAL #: 15-0010
TITLE: Managed Care for Physical & Basic Behavioral Health
EFFECTIVE DATE: February 1, 2015

FISCAL IMPACT
Decrease

	year	% inc.		*# mos	range of mos.	dollars
1st SFY	2015	N/A		5	February 1, 2015 - June 30, 2	($52,358,896)
2nd SFY	2016			12	July 2015 - June 2016	($129,431,191)
3rd SFY	2017			12	July 2016 - June 2017	($133,314,127)

*#mos-Months remaining in fiscal year

Total Decrease in Cost FFY 2015

SFY	2015	($52,358,896)	for	5	months	ebruary 1, 2015 - June 30, 201		
		($52,358,896)	/	5 X	3 months	July 2015 - September 2015	=	($31,415,338)
								($31,415,338)

FFP (FFY 2015)= ($31,415,338) X 62.05% = ($19,493,217)

Total Decrease in Cost FFY 2016

SFY	2015	($52,358,896)	for	5	months	ebruary 1, 2015 - June 30, 201		
		($52,358,896)	/	5 X	9	October 2015 - June 2016	=	($94,246,013)
SFY	2016	($129,431,191)	for	12	months	July 2015 - June 2016		
		($129,431,191)	/	12 X	3	July 2016 - September 2017	=	($32,357,798)
								($126,603,811)

FFP (FFY 2016)= ($126,603,811) X 62.21% = ($78,760,231)

State: **Louisiana**

Citation | Condition or Requirement

1932(a)(1)(A) A. Section 1932(a)(1)(A) of the Social Security Act.

The State of **Louisiana** enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

_X_ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

The State of Louisiana will contract with and enroll beneficiaries into a risk-bearing managed care organization (MCO):

Program Overview

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

The capitated MCO model is a managed care model in which entities establish a robust network of providers and receive a monthly per member per month (PMPM) payment for each enrollee to guarantee access to specified Medicaid State Plan services (referred to as core benefits and services) and care management services. The MCO will also provide additional services not included in the Medicaid State Plan and provide incentive programs to their network providers. All plans will be paid the same actuarially determined risk adjusted rates. PMPM payments related to pharmacy services will be adjusted to account for pharmacy rebates.

The state program includes significant administrative monitoring and controls to ensure that appropriate access, services and levels of quality are maintained, including sanctions for non-reporting or non-performance.

State: **Louisiana**

Citation	Condition or Requirement
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be:

____ i. fee for service; (E-PCCM only)
_X*_ ii. capitation; (MCO only)
____ iii. a case management fee; (E-PCCM only)
____ iv. a bonus/incentive payment; (E-PCCM only)
____ v. a supplemental payment, or
_**_ vi. other. (Please provide a description below).

***The MCOs will be paid actuarially sound capitation rates subject to actuarial soundness requirements at 42 CFR 438.6(c).**

****The MCO shall pay a pharmacy dispensing fee, as defined in the contract, at a rate no less than the minimum specified in the terms of the contract. The MCO is not required to reimburse for pharmacy services delivered by out-of-network providers, except for emergency and periods of care transition as defined in the contract. The MCO shall maintain a system that denies the claim at point-of-sale for providers not contracted in the network.**

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

__i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

__ii. Incentives will be based upon specific activities and targets.

__ iii. Incentives will be based upon a fixed period of time.

__ iv. Incentives will not be renewed automatically.

__ v. Incentives will be made available to both public and private PCCMs.

__ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

_X_ vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

In February 2012, the State incrementally implemented the managed care model as coordinated care networks in three geographic service areas and completed statewide implementation in June 2012.

State: **Louisiana**

Citation	Condition or Requirement

A website (www.MakingMedicaidBetter.com) was established to keep the public informed during the design of the MCO Program and provide current information on progress toward implementation. The website is a "one stop shop" for documents and information regarding MCOs and includes an online form that interested parties can submit electronically to provide suggestions or ask questions.

A MCO Resource Guide for Providers was developed and posted on the website to inform providers of the MCO Program and included a program overview, timelines for implementation, how the DHH addressed provider concerns, MCO provider recruitment process, information to know about interacting with MCOs, marketing guidelines, etc.

Meetings and presentations were made to legislative committees, advocates such as Covering Kids and Families Coalition, Louisiana Consumer Healthcare Coalition, Louisiana Maternal and Child Health Coalition, Interagency Council on Homelessness, and Office of Developmental Disabilities; associations such as the Louisiana Primary Care Association, Hospital Association, Louisiana Medical Society; health care providers such as physician groups, hospitals, transportation providers and health care plans. Nine public forums were conducted in each of the nine major geographic regions of the state.

An emergency rule creating the managed care model was published in the eight major daily newspapers in Louisiana in September 2010 but was withdrawn to obtain greater public input. After obtaining additional input from stakeholders, the Notice of Intent (NOI) was published on February 20, 2011 in the *Louisiana Register*. DHH solicited written comments and received 24 written comments which were each responded to individually. The public hearing on the Notice of Intent was held on March 30, 2011 with approximately 67 attendees. Feedback received during the administrative rulemaking process was incorporated into both the Request for Proposals issued April 11, 2011 and the Final Rule that was published in the *Louisiana Register* on June 20, 2011. Public input continued during and after the implementation of the program, through website recommendations, public meetings, provider meetings, and DHH Advisory Council meetings, etc. The State continues to utilize the administrative rulemaking process, as mandated by State law (R.S. 49:950 et seq), to ensure adequate public notice is given, and public comments are solicited for each major change implemented in its managed care program.

The final rule and the proposed State Plan Amendment were shared with the four federally recognized Tribes in Louisiana (Coushatta, Chitimacha, Biloxi-Tunica, and Jena Band of Choctaws) prior to the submittal of the State Plan Amendment pages to CMS. The Department provided a notification letter to the tribal contacts for each of the four tribes and gave them time to comment on the proposed amendment. The Department continues to utilize every opportunity to engage the tribes post-implementation through its CMS-approved tribal notification and comment process.

State: **Louisiana**

Citation	Condition or Requirement

Outreach and education for Medicaid enrollees who would be enrolled began in early October 2011 and robust efforts continue to ensure that consumers are abreast of program changes and to provide information on the benefits available in the MCO.

In addition to DHH's marketing strategies to raise awareness of managed care, the Medicaid/CHIP outreach infrastructure (eligibility employees throughout the state in concert with existing contracts with community based organizations) will be utilized to provide information and one-on-one assistance.

The Louisiana Medicaid Quality Committee meets quarterly and has been a forum for ongoing public involvement. The website www.MakingMedicaidBetter.com will be continually updated with information about the State's managed care program and enrollment.

State: **Louisiana**

Citation	Condition or Requirement
1932(a)(1)(A)	5. The state plan program will _X_/will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) ____________________ ii. county/counties (voluntary)____________________ iii. area/areas (mandatory)____________________ iv. area/areas (voluntary)____________________
	C. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. _X_ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. _N/A_ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. _X_ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. _X_ he state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. _X_ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

State: **Louisiana**

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. _X_ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 447.362 42 CFR 438.50(c)(6)	7. N/A The state assures that all applicable requirements of 42 CFR 447.362 for 42 CFR payments under any non-risk contracts will be met.
45 CFR 74.40	8. _X_ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a **mandatory basis.**

- Children (under 19 years of age) including those eligible under Section 1931 poverty-level related groups and optional groups of older children;
- Parents, including those eligible under Section 1931 and optional groups of caretaker relatives;
- CHIP (Title XXI) children enrolled in Medicaid-expansion CHIP (LaCHIP Phase I, II, III, and V);
- CHIP (Title XXI) unborn option (Phase 4)
- Pregnant Women: Individuals whose basis of eligibility is pregnancy, who are only eligible for pregnancy-related services, and whose eligibility extends 60 days after the end of the pregnancy;
- 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;
- Non-dually eligible Aged, Blind & Disabled Adults age 19 or older (note: dual eligibles are exempt and children are voluntary as noted below).
- Individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program.
- Persons eligible through the Tuberculosis Infected Individual Program.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is **voluntary enrollment** of any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare

If enrollment is voluntary, describe the circumstances of enrollment.
(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)

State: **Louisiana**

Citation		Condition or Requirement
1932(a)(2)(C) 42 CFR 438(d)(2)	ii.	_X_ An Indian Health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service. All enrollees are informed through required member materials that if they are a member of a federally recognized Tribe they may self-identify, provide documentation of Tribal membership, and request disenrollment through the enrollment broker.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii.	_X_ Children under the age of 19 years who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.	_N/A_ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
	v.	_X_ Individuals who receive home and community-based waiver services, and who proactively opt in to a MCO.
	vi.	_X_ Children under the age of 19 who are: • eligible under §1902(e)(3) of the Act and receiving Supplemental Security Income (SSI); • in foster care or other out-of-home placement; • receiving foster care or adoption assistance under Title IV-E; • receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs; or • enrolled in the Family Opportunity Act Medicaid Buy-In Program.
	vii.	_X_ Children under the age of 21 who are listed on the New Opportunities Waiver Request for Services Registry, and who proactively opt in to a MCO. These children are identified as *Chisholm* class members: • 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.

Note: Voluntary enrollment is allowed under the MCO Program.

State: **Louisiana**

Citation	Condition or Requirement
	Louisiana does not cover these optional groups.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	__Children under the age of 19 years who are in foster care or other out-of- home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	__ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50 (3)(v)	__Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* **The State defines the above referenced children as those children receiving services at a Children's Special Health Services (CSHS) clinic operated by the Louisiana DHH, Office of Public Health.**
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: _X_ i. program participation (**receipt of services at a CSHS clinic**), ____ ii. special health care needs, or ____ iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, and coordinated care system. _X_ i. yes ____ ii. No

State: **Louisiana**

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification).*

The following Medicaid and/or CHIP recipients are excluded from participation in a CCN and cannot voluntarily enroll in a CCN.

Individuals who:

- are both Medicaid and Medicare recipients (identified by Medicare Indicator in the MMIS recipient file);
- reside in a long-term care facility (nursing facility or intermediate care facility for persons with intellectual disabilities);
- receive services through the Program of All-Inclusive Care for the Elderly (PACE);
- have a limited period of eligibility such as eligibility through the Spend-down Medically Needy Program or Emergency Services Only;
- are participants in the Take Charge Plus Program; or
- are participants in the Greater New Orleans Community Health Connection (GNOCHC) Program.

42 CFR 438.50 F. List other eligible groups (not previously mentioned) who will be exempt (excluded) from mandatory enrollment.

N/A

State: **Louisiana**

Citation		Condition or Requirement
42 CFR 438.50	G.	List all other eligible groups who will be permitted to enroll on a voluntary basis **N/A**
	H.	Enrollment process.
1932(a)(4) 42 CFR 438.50		1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous six months. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

As part of the financial Medicaid and LaCHIP application process, applicants may be given the option to indicate their preferred choice of MCO and PCP. If the choice of MCO and PCP is not indicated on the new enrollee file transmitted by DHH to the Enrollment Broker, the Enrollment Broker shall contact the enrollee to request their choice of MCO and PCP. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a MCO.

Enrollment Broker staff will be available by telephone to assist program enrollees. Program enrollees will be offered multilingual enrollment materials or materials in alternative formats, large print, and/or Braille when needed. The enrollment broker shall assist the Medicaid enrollee with the selection of a MCO that meets the enrollee's needs by explaining in a non-biased manner the criteria that may be considered when selecting a MCO.

If no MCO choice is made, the enrollment broker will utilize available information about relationships with existing PCPs in the assignment process.

With the implementation of the MCOs in a geographic service area, enrollees will be given the chance to choose a MCO. Enrollees have 90 days from the initial date of enrollment into a CCN in which they may change the MCO for any reason. If the enrollee does not request disenrollment from the MCO within 90 days, the enrollee will be locked-in to the MCO for up to 12 months, or until their next open enrollment period unless they are disenrolled for cause.

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

State: **Louisiana**

Citation	Condition or Requirement

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

All MCOs will contract with providers who have traditionally served Medicaid recipients and will be available for choice and default assignment. Preexisting relationships are a factor in the auto-assignment algorithm.

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

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

State: **Louisiana**

Citation	Condition or Requirement

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

If there is capacity, the system then will auto-assign enrollees based on the State's algorithm to ensure an equitable distribution among qualified MCOs. Once a MCO reaches 40% of the market share statewide at the end of a quarter, they will no longer receive auto assignments. (However potential members will be allowed to proactively select the MCO.)

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will _X_/will not____ use a lock-in for mandatory managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be___**see below**.________

Note: All new recipients, with the exception of home and community-based waiver recipients and *Chisholm* class members, shall be immediately automatically assigned to a MCO by the enrollment broker if they did not select an MCO during the financial eligibility determination process.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

The State's enrollment broker generates confirmation letters to all enrollees who make a choice, or were auto-assigned to an available MCO. The letters are mailed to reach the enrollees by the 1st of the month that the enrollment is effective, and it provides the MCO contact information.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The confirmation letter that is mailed by the enrollment broker to all enrollees that become linked by choice, change or auto-assignment states the enrollee may change MCO or PCP without cause within 90 days of their enrollment.

State: **Louisiana**

Citation	Condition or Requirement

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

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.**

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.

Potential enrollees are auto-assigned based on the State's algorithm taking into consideration:

- **The member's previous CCN;**
- **Inclusion in the MCO provider network of the member's historic provider as identified by Medicaid claims history;**
- **If the provider with which the member has a historic provider relationship contracts with more than one MCO, the member will be assigned to a MCO with which the provider contracts, on a round robin basis;**
- **If the provider with which the family member has a current or historic provider relationship contracts with more than one MCO, the member will be assigned to a MCO with which that provider contracts, on a round robin basis;**
- **If neither the member nor a family member has a current or historic provider relationship, the member will be auto-assigned to a MCO with one or more PCPs accepting new patients in the member's parish of residence, on a round robin basis subject to MCO capacity.**

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State will use regular reports generated by the enrollment broker to monitor MCO choice rates, auto-assignments, and disenrollments.

State: **Louisiana**

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. X The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ___ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   X This provision is not applicable to this 1932 State Plan Amendment.

4. ___The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

5. __X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   ___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _X_ /will not___ use lock-in for mandatory managed care.

2. The lock-in will apply for _12_ months (up to 12 months).

NOTE: Or until the next open enrollment period, whichever occurs first.

3. Place a check mark to affirm state compliance.

   _X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

   The State will evaluate requests for disenrollment for "cause" after the lock-in period on a case-by-case basis. Examples of additional circumstances for cause include:

State: **Louisiana**

Citation	Condition or Requirement

- **The MCO does not, because of moral or religious objections cover the service the enrollee seeks;**
- **Contract between the MCO and the Department is terminated;**
- **To implement the decision of a hearing officer in an appeal proceeding by the member against the MCO or as ordered by a court of law; and**
- **Other reasons including, but not limited to:**
  - **poor quality of care;**
  - **lack of access to services covered under the contract; or**
  - **documented lack of access to providers experienced in dealing with the enrollee's health care needs.**
- **The member requests to be assigned to the same MCO as family members; or**
- **The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.**

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

State: **Louisiana**

Citation | Condition or Requirement

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

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Ancillary medical services;
4. Organ transplant-related services;
5. Family planning services as specified in 42 CFR §431.51(b)(2) (not applicable to MCO operating under a moral and religious objection as specified in the contract);
6. EPSDT/well-child visits;
7. Emergency medical services;
8. Communicable disease services
9. Durable medical equipment and certain supplies;
10. Prosthetics and orthotics;
11. Emergency and non-emergency medical transportation;
12. Home health services;
13. Basic behavioral health services;
14. School-Based health clinic services provided by the DHH Office of Public Health certified school-based health clinics;
15. Physician services;
16. Maternity services;
17. Chiropractic services;
18. Rehabilitation therapy services (physical, occupational, and speech therapies);
19. Pharmacy services (outpatient prescription medicines dispensed, with the exception of those prescribed by a specialized health provider, and at the contractual responsibility of another Medicaid managed care entity);
20. Hospice services;
21. Personal care services (Age 0-20); and
22. Pediatric day healthcare services.

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

State: **Louisiana**

Citation	Condition or Requirement

1932 (a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

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:

1. Services provided through the Early-Steps Program (IDEA Part C Program services);
2. Dental Services;
3. Intermediate care facility for persons with intellectual disabilities;
4. Personal care services (Age 21 and over);
5. Nursing facility services;
6. 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;
7. Specialized behavioral health services;
8. Applied behavior analysis therapy services; and
9. Targeted case management services.

State: **Louisiana**

Citation	Condition or Requirement
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will _X__/will not___ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. __X___ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   Contractors were determined through a competitive procurement process. The State's contracted Medicaid fiscal intermediary, its subsidiary companies, parent, or affiliated entities cannot also participate in the Louisiana Medicaid program as a Medicaid provider.

   __ The selective contracting provision is not applicable to this state plan.

MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Wednesday, November 26, 2014 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.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Inpatient Hospital Services—Non-Rural, Non-State Hospitals—Supplemental Payments

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed Rule will result in estimated state general fund programmatic savings of $1,488,981 for FY 14-15, $1,479,725 for FY 15-16 and $1,476,192 for FY 16-17. It is anticipated that $328 ($164 SGF and $164 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed Rule and the final Rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.06 percent in FY 14-15 and 62.30 in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 15 is the federal rate for disaster-recovery FMAP adjustment states.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed Rule will decrease federal revenue collections by approximately $2,435,691 for FY 14-15, $2,445,275 for FY 15-16 and $2,448,808 for FY 16-17. It is anticipated that $164 will be expended in FY 14-15 for the federal administrative expenses for promulgation of this proposed rule and the final Rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.06 percent in FY 14-15 and 62.30 in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 15 is the federal rate for disaster-recovery FMAP adjustment states.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule continues the provisions of the November 20, 2013 Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient hospital services to reduce the total supplemental payments pool for non-rural, non-state hospitals, and to change the frequency of payments. It is anticipated that implementation of this proposed Rule will reduce program expenditures for inpatient hospital services by approximately $3,925,000 for FY 14-15, $3,925,000 for FY 15-16 and $3,925,000 for FY 16-17.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed Rule will not have an effect on competition. However, we anticipate that the implementation may have a negative effect on employment as it will reduce the overall payments made to non-rural, non-state hospitals. The reduction in payments may adversely impact the financial standing of these providers and could possibly cause a reduction in employment opportunities.

J. Ruth Kennedy	Evan Brasseaux
Medicaid Director	Staff Director
1410#074	Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Managed Care for Physical and Basic Behavioral Health
(LAC 50:I.Chapters 31-40)

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 adopted provisions which implemented a coordinated system of care in the Medicaid Program designed to improve quality of care and health care outcomes through a healthcare delivery system of coordinated care networks named the Bayou Health program (*Louisiana Register*, Volume 37, Number 6).

The department now proposes 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 will also incorporate 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.

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

1. improves access to care and care coordination;
2. improves the quality of services;
3. promotes healthier outcomes for Medicaid recipients through the establishment of a medical home system of care;
4. provides budget stability; and
5. results in savings as compared to an unmanaged fee-for-service system.

B. Effective for dates of service on or after February 1, 2015, the department will operate a managed care delivery

LA SPA 15-0010

system for physical and basic behavioral health, named the Bayou Health program, utilizing one model, a risk bearing managed care organization (MCO), hereafter referred to as an "MCO".

1. - 2. Repealed.

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

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

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

1.a. - 2. 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:

§3103. Recipient Participation

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

1. categorically needy individuals:

a. - e. ...

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

g. persons eligible through the Tuberculosis Infected Individual Program;

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

i. children under the age of 19 who are:

i. eligible under §1902(e)(3) of the Act and receiving supplemental security income (SSI);

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

iii. receiving foster care or adoption assistance;

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

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

2. - 3. ...

B. Voluntary Participants

1. Participation in an MCO is voluntary for

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

i. - ii. Repealed.

b. effective February 1, 2015, children under the age of 21 who are listed on the new opportunities waiver request for services registry. These children are identified as Chisholm class members:

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

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

1.b.iii. - 2. Repealed.

C. ...

D. 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. - d. ...

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

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

g. Repealed.

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

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

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

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

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

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

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

2. ...

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

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

1. If there is an administrative delay in enrolling the newborn and costs are incurred during that period, the member shall be held harmless for those costs and the MCO shall pay for these services.

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

a. report the birth of a newborn within 48 hours by requesting a Medicaid identification (ID) number through

the department's online system for requesting Medicaid ID numbers; and

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

E. Selection of an MCO

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

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

a. - a.i. ...

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

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

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

b. - d. Repealed.

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 shall be no later than the first day of the second month following the calendar month that the request for disenrollment is filed.

F. Automatic Assignment Process

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

a. mandatory MCO participants;

b. - c. ...

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.

4. Repealed.

G. Selection or Automatic Assignment of a Primary Care Provider

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

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

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

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

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

a. - d. Repealed.

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

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

5. Repealed.

H. Lock-In Period

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

2. Repealed.

I. Annual Open Enrollment

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR

37:1574 (June 2011), amended LR 40:310 (February 2014), LR 40:1097 (June 2014), LR 41:

§3107. Disenrollment and Change of Managed Care Organization

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

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

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

2. - 3. …

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

C. - C.4. …

D. Disenrollment for Cause

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

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

b. the member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;

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

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

e. other reasons including, but not limited to:

i. poor quality of care;

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

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

f. - i.iii. Repealed.

E. Involuntary Disenrollment

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

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

b. the member's behavior is disruptive, unruly, abusive or uncooperative to the extent that his/her enrollment seriously impairs the MCO's ability to furnish services to either the member or other members.

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

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

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

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

i. …

F. Department Initiated Disenrollment

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

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

b. - f. …

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

h. loss of MCO's participaqion.

i. - k. Repealed.

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

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

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

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

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

§3109. Member Rights and Responsibilities

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

1. - 5. …

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

7. - 8. …

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

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

9.b. - 11. …

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

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

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

2. ...

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

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

5. - 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:

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.

1. - 8. Repealed.

C. A CCN-Sis 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.

C.1. - J.4. 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 37:1577 (June 2011), amended LR 41:

§3303. Shared Savings Model Responsibilities

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 37:1578 (June 2011), LR 40:66 (January 2014), amended LR 40:311 (February 2014), repealed LR 41:

§3305. Coordination of Medicaid State Plan Services

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 37:1579 (June 2011), repealed LR 41:

§3307. Reimbursement Methodology

A. The department or its fiscal intermediary shall make lump sum savings payments to the CCN-S, if eligible, as described in the CCN-S contract.

B. The department will determine savings realized or refunds due to the department on a periodic basis.

1. The department may make an interim determination and will make a final determination of savings achieved or refunds due for each CCN-S for each contract year.

a. Interim determinations may be made for less than 12 months of service during the contract year. For dates of service with less than 12 months of elapsed time after the end of the contract period an adjustment for incurred but not reported (IBNR) claims will be made.

b. Final determinations will not be made for less than 12 months of service during the contract year. Final determinations will be made when all dates of service during the contract year have 12 months of elapsed time from the last date of service. Final determinations will use data updated since the interim determination.

2. The determination will calculate the difference between the actual aggregate cost of authorized services and the aggregate per capita prepaid benchmark (PCPB).

3. The PCPB will be set on the basis of health status-based risk adjustment.

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

b. Utilizing this information, the PCPBs will be adjusted to account for the health risk for the enrollees in each CCN-S relative to the overall population being measured.

c. The health risk of the enrollees and associated CCN-S risk scores and the PCPBs will be updated periodically to reflect changes in risk over time.

4. Costs of the following services will not be included in the determination of the PCPB. These services include, but are not limited to:

a. nursing facility;

b. dental services;

c. personal care services (children and adults);

d. hospice;

e. school-based individualized education plan services provided by a school district and billed through the intermediate school district;

f. specified Early Steps Program services;

g. specialized behavioral health services (e.g. provided by a psychiatrist, psychologist, social worker, psychiatric advanced nurse practitioner;

h. targeted case management;

i. non-emergency medical transportation;

j. intermediate care facilities for persons with intellectual disabilities;

k. home and community-based waiver services;

l. durable medical equipment and supplies; and

m. orthotics and prosthetics.

5. Individual member total cost for the determination year in excess of an amount specified in the contract will not be included in the determination of the PCPB, nor will it be included in actual cost at the point of determination so that outlier cost of certain individuals and/or services will not jeopardize the overall savings achieved by the CCN-S.

6. The CCN-S will be eligible to receive up to 60 percent of savings if the actual aggregate costs of authorized services, including enhanced primary care case management

fees advanced, are determined to be less than the aggregate PCPB (for the entire CCN-S enrollment).

a. Shared savings will be limited to five percent of the actual aggregate costs, including the enhanced primary care case management fees paid. Such amounts shall be determined in the aggregate and not for separate enrollment types.

b. The department may make an interim payment to the CCN for savings achieved based on the interim determination. Interim payments shall not exceed 75 percent of the eligible amount.

c. The department will make a final payment to the CCN for savings achieved based on the final determination. The final payment amount will be up to the difference between the amount of the interim payment (if any) and the final amount eligible for distribution.

d. For determination periods during the CCN-S first two years of operation, any distribution of CCN-S savings will be contingent upon the CCN meeting the established "early warning system" administrative performance measures and compliance under the contract. After the second year of operation, distribution of savings will be contingent upon the CCN-S meeting department established clinical quality performance measure benchmarks and compliance with the contract.

7. In the event the CCN-S exceeds the PCPB in the aggregate (for the entire CCN-S enrollment) as calculated in the final determination, the CCN-S will be required to refund up to 50 percent of the total amount of the enhanced primary care case management fees paid to the CCN-S during the period being determined.

C. - C.8. 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 37:1581 (June 2011), amended LR 40:311 (February 2014), LR 41:

Chapter 35. Managed Care OrganizationParticipation Criteria

§3501. Participation Requirements

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

B. An MCO must:

1. ...

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

3. - 4. ...

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

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

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

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

9. except for licensure and financial solvency requirements, no other provisions of title 22 of the *Revised Statutes* shall apply to an MCO participating in the Louisiana Medicaid Program. Neither the HIPAA assessment nor the fraud assessment levied by the Department of Insurance shall be payable by a Medicaid MCO.

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

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

1. - 4. ...

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

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

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

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

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

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

1. - 3. ...

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

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

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

§3503. Managed Care Organization Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. - 2. …

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

M. …

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

O. 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 a minimum of 30 days' notice to the members and/or providers of any proposed material changes to the plan through updates to the member handbooks and/or provider handbooks.

P. 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.

Q. 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.

R. 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.

S. 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.

S.2. - T.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 37:1583 (June 2011), amended LR 39:92 (January 2013), LR 40:66 (January 2014), LR 41:

§3505 Network Access Standards and Guidelines

A. The MCO must maintain and monitor a provider network that is supported by written agreements and is sufficient to provide adequate access of healthcare to enrollees as required by federal law and the terms as set forth in the contract. The MCO shall adhere to the federal regulations governing access standards as well as the specific requirements of the contract and all department issued guides.

B. The MCO must provide for service delivery out-of-network for any core benefit or service not available in network for which the MCO does not have an executed contract for the provision of such medically necessary services. Further, the MCO must arrange for payment so that the Medicaid enrollee is not billed for this service.

C. The MCO shall cover all medically necessary services to treat an emergency medical condition in the same amount, duration, and scope as stipulated in the Medicaid state plan.

1. - 3. …

D. The MCO must maintain a provider network and in-area referral providers in sufficient numbers, as determined by the department, to ensure that all of the required core benefits and services are available and accessible in a timely manner in accordance with the terms and conditions in the contract and department issued guide.

E. Any pharmacy or pharmacist participating in the Medicaid Program may participate as a network provider if licensed and in good standing with the Louisiana State Board of Pharmacy and accepts the terms and conditions of the contract offered to them by the MCO.

1. The MCO shall not require its members to use mail service pharmacy.

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

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

§3507. Benefits and Services

A. …

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. …

B. The MCO:

1. - 3.b. …

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. …

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

5.b. - 7. …

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. …

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

3. - 4. …

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

1. - 4. …

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. - 17. …

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

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

20. hospice services;

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

22. pediatric day healthcare services.

NOTE: …

E. Transition Provisions

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

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

F. - F.1. …

G. Excluded Services

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

a. - c. …

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

e. nursing facility services;

f. individualized education plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures;

g. specialized behavioral health services;

h. applied behavioral analysis therapy services; and

i. targeted case management services.

j. Repealed.

H. Utilization Management

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

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

2. - 2.h. …

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. - a.iv. …

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. - iii. …

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

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

5. The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not

structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:185 (June 2011), amended LR 39:92 (January 2013), LR 39:318 (February 2013), LR 41:

§3509. Reimbursement Methodology

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

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

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

3. PMPM payments will be set on the basis of health status-based risk adjustments. An initial universal PMPM rate will be set for all MCOs at the beginning of each contract period and as deemed necessary by the department.

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

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

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

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

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

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

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

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

d. Repealed.

5. ...

6. - 6.a. Reserved.

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

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

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

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

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

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

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

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

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

G. ...

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. ...

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. ...

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. ...

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.

a. Repealed.

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. ...

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

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

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

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

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

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

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

§3511. Prompt Pay of Claims

A. Network Providers. All subcontracts executed by the MCO shall comply with the terms in the contract. Requirements shall include at a minimum:

1. ...

2. the full disclosure of the method and amount of compensation or other consideration to be received from the MCO; and

3. the standards for the receipt and processing of claims are as specified by the department in the MCO's contract with the department and department issued guides.

B. Network and Out-of-Network Providers

1. The MCO shall make payments to its network providers, and out-of-network providers, subject to the conditions outlined in the contract and department issued guides.

a. The MCO shall pay 90 percent of all clean claims, as defined by the department, received from each provider type within 15 business days of the date of receipt.

b. The MCO shall pay 99 percent of all clean claims within 30 calendar days of the date of receipt.

c. The MCO shall pay annual interest to the provider, at a rate specified by the department, on all clean claims paid in excess of 30 days of the date of receipt. This interest payment shall be paid at the time the claim is fully adjudicated for payment.

2. The provider must submit all claims for payment no later than 180 days from the date of service.

3. The MCO and all providers shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws.

3.a. - 4. ...

C. Claims Management

1. The MCO shall process a provider's claims for covered services provided to members in compliance with all applicable state and federal laws, rules and regulations as well as all applicable MCO policies and procedures including, but not limited to:

a. - f. ...

D. Provider Claims Dispute

1. The MCO shall:

a. - d. ...

E. Claims Payment Accuracy Report

1. The MCO shall submit an audited claims payment accuracy percentage report to the department on a monthly basis as specified in the contract and department issued MCO guides.

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 37:1589 (June 2011), amended LR 41:

Chapter 37. Grievance and Appeal Process

Subchapter A. Member Grievances and Appeals

§3701. Introduction

A. An MCO must have a grievance system for Medicaid enrollees that complies with federal regulations. The MCO shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws and as specified in the contract and all department issued guides.

1. - 3. Repealed.

B. The MCO's grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation and must include, at a minimum, the requirements set forth herein.

1. The MCO shall refer all members who are dissatisfied, in any respect, with the MCO or its subcontractor to the MCO's designee who is authorized to review and respond to grievances and to require corrective action.

2. The member must exhaust the MCO's internal grievance/appeal process prior to accessing the state fair hearing process.

C. The MCO shall not create barriers to timely due process. If the number of appeals reversed by the state fair hearing process exceeds 10 percent of appeals received within a 12 month period, the MCO may be subject to sanctions.

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 37:1589 (June 2011), amended LR 41:

§3703. Definitions

Action—the denial or limited authorization of a requested service, including:

1. the type or level of service;

2. reduction, suspension, or termination of a previously authorized service;

3. denial, in whole or in part, of payment for a service for any reason other than administrative denial;

4. failure to provide services in a timely manner as specified in the contract; or

5. failure of the MCO to act within the timeframes provided in this Subchapter.

* * *

Grievance—an expression of dissatisfaction about any matter other than an action as that term is defined in this Section. The term is also used to refer to the overall system that includes MCO level grievances and access to a fair hearing. Possible subjects for *grievances* include, but are not limited to:

1. the quality of care or services provided;

2. aspects of interpersonal relationships, such as rudeness of a provider or employee; or

3. failure to respect the member's rights.

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 37:1589 (June 2011), amended LR 41:

§3705. General Provisions

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

B. Filing Requirements

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

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

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

a. - b. Repealed.

3. Filing Procedures

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

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

C. Grievance Notice and Appeal Procedures

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

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

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

D. Grievance and Appeal Records

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

E. Grievance Reports

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

a. …

b. summary of grievances and appeals;

c. - f. …

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

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

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

1. Repealed.

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

1. Repealed.

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

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

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

§3707. Handling of Member Grievances and Appeals

A. In handling grievances and appeals, the MCO must meet the following requirements:

1. give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free telephone numbers that have adequate TTY/TTD and interpreter capability;

2. acknowledge receipt of each grievance and appeal;

3. ensure that the individuals who make decisions on grievances and appeals are individuals who:

a. were not involved in any previous level of review or decision-making; and

b. if deciding on any of the following issues, are health care professionals who have the appropriate clinical expertise, as determined by the department, in treating the member's condition or disease:

i. an appeal of a denial that is based on lack of medical necessity;

ii. a grievance regarding denial of expedited resolution of an appeal; or

iii. a grievance or appeal that involves clinical issues.

B. Special Requirements for Appeals

1. The process for appeals must:

a. provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal);

b. provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The MCO must inform the member of the limited time available for this in the case of expedited resolution;

c. provide the member and his/her representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents and records considered during the appeals process; and

d. include, as parties to the appeal:

i. the member and his/her representative; or

ii. the legal representative of a deceased member's estate.

2. The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

3. The appropriate individual or body within the MCO having decision making authority as part of the grievance and appeal procedures shall be identified.

4. Failure to Make a Timely Decision

a. Appeals shall be resolved no later than the stated time frames and all parties shall be informed of the MCO's decision.

b. If a determination is not made by the above time frames, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

5. The MCO shall inform the member that he/she may seek a state fair hearing if the member is not satisfied with the MCO's decision in response to an appeal.

C. - G.3. 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 37:1590 (June 2011), amended LR 41:

§3709. Notice of Action

A. Language and Format Requirements. The notice must be in writing and must meet the language and format requirements of federal regulations in order to ensure ease of understanding. Notices must also comply with the standards set by the department relative to language, content, and format.

1. - 2. Repealed.

B. Content of Notice. The notice must explain the following:

1. the action the MCO or its subcontractor has taken or intends to take;

2. …

3. the member's right to file an appeal with the MCO;

4. the member's right to request a state fair hearing after the MCO's appeal process has been exhausted;

5. the procedures for exercising the rights specified in this Section;

6. the circumstances under which expedited resolution is available and the procedure to request it; and

7. the member's right to have previously authorized services continue pending resolution of the appeal, the procedure to make such a request, and the circumstances under which the member may be required to pay the costs of these services.

C. Notice Timeframes. The MCO must mail the notice within the following timeframes:

1. for termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action, except as permitted under federal regulations;

2. for denial of payment, at the time of any action taken that affects the claim; or

a. - b. Repealed.

3. for standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service. A possible extension of up to 14 additional calendar days may be granted under the following circumstances:

a. the member, or his/her representative or a provider acting on the member's behalf, requests an extension; or

b. the MCO justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

D. If the MCO extends the timeframe in accordance with this Section, it must:

1. - 3. …

E. For service authorization decisions not reached within the timeframes specified in this Section, this constitutes a denial and is thus an adverse action on the date that the timeframes expire.

1. - 2. Repealed.

F. For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain

maximum function, the MCO must make an expedited authorization decision.

1. A notice must be furnished as expeditiously as the member's health condition requires, but no later than 72 hours or as expeditiously as the member's health requires, after receipt of the request for service.

2. The MCO may extend the 72 hour time period by up to 14 calendar days if the member or provider acting on behalf of the member requests an extension, or if the MCO justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

G. The department shall conduct random reviews to ensure that members are receiving such notices in a timely 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 37:1591 (June 2011), amended LR 41:

§3711. Resolution and Notification

A. The MCO must dispose of a grievance, resolve each appeal, and provide notice as expeditiously as the member's health condition requires, within the timeframes established in this Section.

1. - 2. Repealed.

B. Specific Timeframes

1. For standard disposition of a grievance and notice to the affected parties, the timeframe is established as 90 days from the day the MCO receives the grievance.

2. For standard resolution of an appeal and notice to the affected parties, the timeframe is established as 30 calendar days from the day the MCO receives the appeal.

3. For expedited resolution of an appeal and notice to affected parties, the timeframe is established as 72 hours or as expeditiously as the member's health requires after the MCO receives the appeal.

C. Extension of Timeframes

1. The MCO may extend the timeframes by up to 14 calendar days under the following circumstances:

a. the member requests the extension; or

b. the MCO shows to the satisfaction of the department, upon its request, that there is need for additional information and that the delay is in the member's interest.

D. If the MCO extends the timeframes for any extension not requested by the member, it must give the member written notice of the reason for the delay.

E. Format of Notice

1. The MCO shall follow the method specified in the department issued guide to notify a member of the disposition of a grievance.

2. For all appeals, the MCO must provide written notice of disposition.

3. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

F. Content of Notice of Appeal Resolution. The written notice of the resolution must include, at a minimum, the following information:

1. the results of the resolution process and the date it was completed;

2. for appeals not resolved wholly in favor of the members:

a. the right to request a state fair hearing and the procedure to make the request;

b. the right to request to receive previously authorized services during the hearing process and the procedure to make such a request; and

c. that the member may be held liable for the cost of those services if the hearing decision upholds the MCO's action.

G. Requirements for State Fair Hearings

1. The department shall comply with the federal regulations governing fair hearings. The MCO shall comply with all of the requirements as outlined in the contract and department issued guides.

2. If the member has exhausted the MCO level appeal procedures, the member may request a state fair hearing within 30 days from the date of the MCO's notice of appeal resolution.

3. The parties to the state fair hearing include the MCO as well as the member and his/her representative or the representative of a deceased member's estate.

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 37:1591 (June 2011), amended LR 41:

§3713. Expedited Resolution of Appeals

A. The MCO must establish and maintain an expedited review process for appeals when the MCO determines (either from a member's request or indication from the provider making the request on the member's behalf or in support of the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

1. Repealed.

B. If the MCO denies a request for expedited resolution of an appeal, it must:

1. transfer the appeal to the timeframe for standard resolution in accordance with the provisions of this Subchapter; and

2. make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

C. This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an action or require a notice of action. The member may file a grievance in response to this decision.

D. Failure to Make a Timely Decision. Appeals shall be resolved no later than the established timeframes and all parties shall be informed of the MCO's decision. If a determination is not made by the established timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

E. The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution.

1. The member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required.

2. The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

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 37:1592 (June 2011), amended LR 41:

§3715. Continuation of Services during the Pending MCO Appeal or State Fair Hearing

A. *Timely Filing*—filing on or before the later of the following, but no greater than 30 days:

1. within 10 calendar days of the MCO's mailing of the notice of action; or

2. the intended effective date of the MCO's proposed action.

B. Continuation of Benefits. The MCO must continue the member's benefits if the:

1. member or the provider, with the member's written consent, files the appeal timely;

2. appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. services were ordered by an authorized provider;

4. original period covered by the original authorization has not expired; and

5. member requests continuation of benefits.

C. Duration of Continued or Reinstated Benefits

1. If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

a. the member withdraws the appeal;

b. 10 calendar days pass after the MCO mails the notice providing the resolution of the appeal against the member, unless the member has requested a state fair hearing with continuation of benefits, within the 10-day timeframe, until a state fair hearing decision is reached;

c. a state fair hearing entity issues a hearing decision adverse to the member; or

d. the time period or service limits of a previously authorized service has been met.

D. Member Liability for Services. If the final resolution of the appeal is adverse to the member, the MCO may recover from the member the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with federal regulations.

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 41:

§3717. Effectuation of Reversed Appeal Resolutions

A. Provision of Services during the Appeal Process

1. If the MCO or the state fair hearing entity reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

B. If the MCO or the state fair hearing entity reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services in accordance with the contract.

C. At the discretion of the secretary, the department may overrule a decision made by the Division of Administration, Division of Administrative Law (the state fair hearing entity).

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 41:

Subchapter B. Provider Grievance and Appeal Process

§3721. General Provisions

A. If the provider is filing a grievance or appeal on behalf of the member, the provider shall adhere to the provisions outlined in Subchapter A of this Chapter.

B. The MCO must have a grievance and appeals process for claims, medical necessity, and contract disputes for providers in accordance with the contract and department issued guides.

1. The MCO shall establish and maintain a procedure for the receipt and prompt internal resolution of all provider initiated grievances and appeals as specified in the contract and all department issued guides.

2. The MCO's grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation.

3. Notwithstanding any MCO or department grievance and appeal process, nothing contained in any document, including, but not limited to Rule or contract, shall preclude an MCO provider's right to pursue relief through a court of appropriate jurisdiction.

4. The MCO shall report on a monthly basis all grievance and appeals filed and resolutions in accordance with the terms of the contract and department issued guide.

C. 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 37:1592 (June 2011), amended LR 41:

§3723. Definitions

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 37:1592 (June 2011), repealed LR 41:

§3725. General Provisions

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 37:1592 (June 2011), repealed LR 41:

§3727. Handling of Enrollee Grievances and Appeals

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 37:1593 (June 2011), repealed LR 41:

§3729. Notice of Action

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 37:1593 (June 2011), repealed LR 41:

§3731. Resolution and Notification

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 37:1594 (June 2011), repealed LR 41:

§3733. Expedited Resolution of Appeals

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 37:1595 (June 2011), repealed LR 41:

§3735. Continuation of Services during the Pending CCN-P Appeal or State Fair Hearing

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 37:1595 (June 2011), repealed LR 41:

§3737. Effectuation of Reversed Appeal Resolutions

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 37:1595 (June 2011), repealed LR 41:

Subchapter C. Grievance and Appeals Procedures for Providers

§3743. General Provisions

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 37:1595 (June 2011), repealed LR 41:

Chapter 39. Sanctions and Measures to Obtain Compliance

§3901. General Provisions

A. The MCO agrees to be subject to intermediate sanctions and other measures to obtain compliance with the terms and conditions of the contract.

1. The specific grounds for intermediate sanctions and other measures to obtain compliance shall be set forth within the contract.

a. - b. Repealed.

2. The determination of noncompliance is at the sole discretion of the department.

3. It shall be at the department's sole discretion as to the proper recourse to obtain compliance.

B. Intermediate Sanctions

1. The department may impose intermediate sanctions on the MCO if the department finds that the MCO acts or fails to act as specified in 42 CFR §438.700 et seq., or if the department finds any other actions/occurrences of misconduct subject to intermediate sanctions as specified in the contract.

2. The types of intermediate sanctions that the department may impose shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §438.700 et seq.

3. The department will provide the MCO with due process in accordance with 42 CFR 438.700 et seq., including timely written notice of sanction and pre-termination hearing.

4. The department will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR §438.700 et seq., specifying the affected MCO, the kind of sanction, and the reason for the department's decision to lift a sanction.

C. Other Measures. In addition to intermediate sanctions, the department may impose other measures to obtain MCO compliance with the terms and conditions of the contract, including but not limited to administrative actions, corrective action plans, and/or monetary penalties as specified in the contract.

1. Administrative actions exclude monetary penalties, corrective action plans, intermediate sanctions, and termination, and include but are not limited to a warning through written notice or consultation and education regarding program policies and procedures.

2. The MCO may be required to submit a corrective action plan (CAP) to the department within the timeframe specified by the department. The CAP, which is subject to approval or disapproval by the department, shall include:

a. steps to be taken by the MCO to obtain compliance with the terms of the contract;

b. a timeframe for anticipated compliance; and

c. a date for the correction of the occurrence identified by the department.

3. The department, as specified in the contract, has the right to enforce monetary penalties against the MCO for certain conduct, including but not limited to failure to meet the terms of a CAP.

4. Monetary penalties will continue until satisfactory correction of an occurrence of noncompliance has been made as determined by the department.

D. Any and all monies collected as a result of monetary penalties or intermediate sanctions against an MCO or any of its subcontractors, or any recoupment(s)/repayment(s) received from the MCO or any of its subcontractors, shall be placed into the Louisiana Medical Assistance Trust Fund established by R.S. 46:2623.

E. Termination for Cause

1. Issuance of Notice Termination

a. The department may terminate the contract with an MCO when it determines the MCO has failed to perform, or violates, substantive terms of the contract or fails to meet applicable requirements in §§1903(m), 1905(t) or 1932 of the Social Security Act in accordance with the provisions of the contract.

b. The department will provide the MCO with a timely written Notice of Intent to Terminate notice. In accordance with federal regulations, the notice will state:

i. the nature and basis of the sanction;

ii. pre-termination hearing and dispute resolution conference rights, if applicable; and

iii. the time and place of the hearing.

c. The termination will be effective no less than 30 calendar days from the date of the notice.

d. The MCO may, at the discretion of the department, be allowed to correct the deficiencies within 30 calendar days of the date that the notice was issued, unless other provisions in this Section demand otherwise, prior to the issue of a notice of termination.

F. Termination due to Serious Threat to Health of Members

1. The department may terminate the contract immediately if it is determined that actions by the MCO or its subcontractor(s) pose a serious threat to the health of members enrolled in the MCO.

2. The MCO members will be enrolled in another MCO.

G. Termination for Insolvency, Bankruptcy, Instability of Funds. The MCO's insolvency or the filing of a bankruptcy petition by or against the MCO shall constitute grounds for termination for cause.

1. Repealed.

H. Termination for Ownership Violations

1. The MCO is subject to termination unless the MCO can demonstrate changes of ownership or control when a person with a direct or indirect ownership interest in the MCO (as defined in the contract and PE-50) has:

a. been convicted of a criminal offense as cited in §1128(a), (b)(1) or (b)(3) of the Social Security Act, in accordance with federal regulations;

b. had civil monetary penalties or assessment imposed under §1128(A) of the Social Security Act; or

c. been excluded from participation in Medicare or any state health care program.

I. MCO Requirements Prior to Termination for Cause. The MCO shall comply with all of the terms and conditions stipulated in the contract and department issued guides during the period prior to the effective date of termination. The MCO is required to meet the requirements as specified in the contract if terminated for cause.

1. - 2.t. Repealed.

J. Termination for Failure to Accept Revised Monthly Capitation Rate. Should the MCO refuse to accept a revised monthly capitation rate as provided in the contract, the MCO may provide written notice to the department requesting that the contract be terminated effective at least 60 calendar days from the date the department receives the written request. The department shall have sole discretion to approve or deny the request for termination, and to impose such conditions on the granting of an approval as it may deem appropriate, but it shall not unreasonably withhold its approval.

1. Repealed.

K. - Q. 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 37:1596 (June 2011), amended LR 41:

Chapter 40. Audit Requirements

§4001. General Provisions

A. The MCO and its subcontractors shall comply with all audit requirements specified in the contract and department issued guides.

B. The MCO and its subcontractors shall maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of claims.

1. Such documents, including all original claim forms, shall be maintained and retained by the MCO and or its subcontractors for a period of six years after the contract expiration date or until the resolution of all litigation, claim, financial management review, or audit pertaining to the contract, whichever is longer.

2. The MCO or its subcontractors shall provide any assistance that such auditors and inspectors reasonably may require to complete with such audits or inspections.

C. …

D. Upon reasonable notice, the MCO and its subcontractors shall provide the officials and entities identified in the contract and department issued guides with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the contract.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1597 (June 2011), amended 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.

Family Impact Statement

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 health care services and increasing the quality and continuity of care for the individual and the entire family.

Poverty Impact Statement

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.

Provider Impact Statement

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.

Public Comments

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

Public Hearing

A public hearing on this proposed Rule is scheduled for Wednesday, November 26, 2014 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.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Managed Care for Physical and Basic Behavioral Health

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in a reduction in the rate of expenditure growth in the Medicaid program. The rule is estimated to reduce future state general fund required for the program by $20,370,111 for FY 14-15, $49,591,620 for FY 15-16 and $57,403,189 for FY 16-17. It is anticipated that $6,724 ($3,362 SGF and $3,362 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.06 percent in FY 14-15 and 62.30 in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 15 is the federal rate for disaster-recovery FMAP adjustment states.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that implementation of this proposed rule will result in a reduction in rate of expenditure growth in the Medicaid program. The rule is estimated to reduce future federal revenue collections by approximately $33,322,357 for FY 14-15, $81,951,139 for FY 15-16 and $95,224,274 for FY 16-17. It is anticipated that $3,362 will be expended in FY 14-15 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.06 percent in FY 14-15 and 62.30 in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 15 is the federal rate for disaster-recovery FMAP adjustment states. In addition, the implementation of this proposed rule is anticipated to increase premium tax revenues to the State as a result of the addition of new populations to the full-risk Managed Care Organization (MCO) model.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule amends the provisions governing coordinated care networks in order to change the program name, include provisions for enrollment of Shared Savings plan members in full-risk MCOs, voluntary enrollment of Home and Community-Based Waiver recipients and Chisholm class members and mixed service protocol for behavioral health, and incorporate other programmatic changes. It is anticipated that implementation of this proposed rule will result in a reduction in rate of expenditure growth in the Medicaid program. The rule is estimated to decrease future program expenditures in the Medicaid Program by approximately $53,699,192 for FY 14-15, $131,542,759 for FY 15-16 and $152,627,463 for FY 16-17.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1410#086

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Nursing Facilities
Leave of Absence Days
Reimbursement Reduction
(LAC 50:II.20021)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:II.20021 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 reimbursement to nursing facilities to reduce the reimbursement paid to nursing facilities for leave of absence days (*Louisiana Register,* Volume 35, Number 9). The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities to further reduce the reimbursement rates for leave of absence days (*Louisiana Register*, Volume 39, Number 7). This proposed Rule is being promulgated to continue the provisions of the July 1, 2013 Emergency Rule.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement
Chapter 200. Reimbursement Methodology
§20021. Leave of Absence Days [Formerly LAC 50:VII.1321]

A. - E. ...

F. Effective for dates of service on or after July 1, 2013, the reimbursement paid for leave of absence days shall be 10 percent of the applicable per diem rate in addition to the provider fee amount.

1. The provider fee amount shall be excluded from the calculations when determining the leave of absence days payment amount.

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 35:1899 (September 2009), amended LR 41:

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

February 13, 2015

Karen Matthews, Health Director
Chitimacha Health Clinic
3231 Chitimacha Trail
Jeanerette, LA 70544

Angela Martin
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Paula Manuel, Health Director
Coushatta Tribe of Louisiana
P. O. Box 818
Elton, LA 70532

Chief Beverly Cheryl Smith
Holly Vanhoozen, Health Director
The Jena Band of Choctaw Indians
P. O. Box 14
Jena, LA 71342

Dear Louisiana Tribal Contact:

RE: Notification of Louisiana Medicaid State Plan Amendments

In compliance with the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009, the Department of Health and Hospitals, Bureau of Health Services Financing is taking the opportunity to notify you of State Plan Amendments (SPAs) that may have an impact on your tribe.

Attached for your review and comments is a summary of the proposed SPAs. Please provide any comments you may have by March 16, 2015 to Mrs. Darlene Budgewater via email to Darlene.Budgewater@la.gov or by postal mail to:

Department of Health and Hospitals
Bureau of Health Services Financing
Medicaid Policy and Compliance
P.O. Box 91030

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone #: 888/342-6207 • Fax #: 225/342-9508 • *WWW.DHH.LA.GOV*
"An Equal Opportunity Employer"

Baton Rouge, LA 70821-9030

Should you have additional questions about Medicaid policy, Ms. Budgewater will be glad to assist you. You may reach her by email or by phone at (225) 342-3881. Thanks for your continued support of the tribal consultation process.

Sincerely,

M Roberta Diaz

for J. Ruth Kennedy
Medicaid Director

JRK/DAB/KS

c: Ford J. Blunt, III
Stacie Shuman

State Plan Amendment for submittal to CMS

Request for Tribal Comments
February 13, 2015

TN 15-010 Managed Care for Physical and Basic Behavioral Health

The SPA proposes to amend the provisions governing the coordinated care network and Medicaid managed care in order to change the name and to incorporate programmatic changes resulting from the inclusion of basic behavioral health services in the program and the voluntary enrollment of Medicaid eligible children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* class action litigation.

TN 15-011 Medicaid Eligibility – Children's Supplemental Security Income

The SPA proposes to discontinue Medicaid eligibility for children who received Medicaid coverage as a result of Section 4913 of the Social Security Act due to the fact that these children receiving Supplemental Security Income (SSI) and born August 22, 1996 or prior would have reached age 18 by August 22, 2014 and are no longer eligible under this provision. Due to the provisions governing coverage of the Section 4913 children, there cannot be any new children to qualify for this coverage group as these children have aged out.