

**Bobby Jindal**  
GOVERNOR



**Kathy H. Kliebert**  
SECRETARY

**State of Louisiana**  
Department of Health and Hospitals  
Office of the Secretary

July 2, 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. 15-0021**

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,

A handwritten signature in blue ink, appearing to read "Kathy H. Kliebert", with a date "7/2" written below it.

Kathy H. Kliebert  
Secretary

Attachment (2)

KHK/WJR/JH

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER:  <b>15-0021</b>	2. STATE  <b>Louisiana</b>
		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  <b>December 1, 2015</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>1932(a)(4) of Social Security Act</b>		7. FEDERAL BUDGET IMPACT: a. FFY <u>2016</u> <b>\$0</b> b. FFY <u>2017</u> <b>\$0</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 3.1-F, Pages 1, 1a, 2, 2a, 3, 4, 4a, 5, 7, 8, 8a 9, 10, 11, 12 and 12a Attachment 3.1-F, Page 2b</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Same (TN 15-0010)  None (New Page)</b>	
10. SUBJECT OF AMENDMENT: <b>The SPA proposes to amend the provisions governing managed care for physical and basic behavioral health in order to transition behavioral health services from administration by a single statewide management organization to an integrated behavioral and physical health model which will be administered by the five Bayou Health managed care organizations.</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <b>The Governor does not review state plan material.</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:  		16. RETURN TO:  <b>J. Ruth Kennedy, Medicaid Director State of Louisiana Department of Health and Hospitals 628 N. 4<sup>th</sup> Street PO Box 91030 Baton Rouge, LA 70821-9030</b>	
13. TYPED NAME: <b>Kathy H. Kliebert</b>			
14. TITLE: <b>Secretary</b>			
15. DATE SUBMITTED: <b>July 2, 2015</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

State: Louisiana

Citation	Condition or Requirement						
1932(a)(1)(A)	<p data-bbox="412 302 997 331">A. <u>Section 1932(a)(1)(A) of the Social Security Act.</u></p> <p data-bbox="469 363 1442 758">The State of <u>Louisiana</u> 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 <i>not</i> 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)</p> <p data-bbox="469 789 1442 909"><b>The State of Louisiana also enrolls eligible Medicaid beneficiaries (including individuals exempt from mandatory enrollment under the State Plan) on a mandatory basis into the Bayou Health Program under the companion authority of a Section 1915(b) waiver, titled the “Bayou Health Section 1915(b) Waiver.”</b></p> <p data-bbox="469 940 1442 1123"><b>Individuals enrolled in Bayou Health under the Louisiana Medicaid State Plan receive comprehensive (physical and behavioral health) benefits through a Bayou Health MCO. Individuals enrolled in Bayou Health under the Bayou Health Section 1915(b) Waiver receive either comprehensive (physical and behavioral health) benefits or specialized behavioral-health only benefits through a Bayou Health MCO.</b></p>						
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	<p data-bbox="423 1157 1073 1186">B. <u>General Description of the Program and Public Process.</u></p> <p data-bbox="469 1213 1127 1243">For B.1 and B.2, place a check mark on any or all that apply.</p> <p data-bbox="532 1272 1442 1423">1. The State will contract with an</p> <table data-bbox="586 1335 1442 1423"> <tr> <td data-bbox="586 1335 672 1365"><u>  X  </u></td> <td data-bbox="704 1335 829 1365">i. MCO</td> </tr> <tr> <td data-bbox="586 1367 672 1396">_____</td> <td data-bbox="704 1367 1442 1396">ii. PCCM (including capitated PCCMs that qualify as PAHPs)</td> </tr> <tr> <td data-bbox="586 1398 672 1428">_____</td> <td data-bbox="704 1398 821 1428">iii. Both</td> </tr> </table> <p data-bbox="469 1457 1442 1518"><b>The State of Louisiana will contract with and enroll beneficiaries into risk-bearing managed care organizations (MCOs).</b></p> <p data-bbox="469 1549 699 1579"><b><u>Program Overview</u></b></p> <p data-bbox="469 1608 1442 1904"><b>The Bayou Health Program began operating in February 2012 under contracts with Medicaid MCOs and enhanced Primary Care Case Management (PCCM) entities. MCO contracts included physical health services as well as basic behavioral health services. As noted above, effective December 1, 2015, the State of Louisiana is expanding the service array covered through the Bayou Health MCOs to include comprehensive, integrated physical and behavioral health (basic and specialized) services. Prior to December 1, 2015, specialized behavioral health services (including State Plan, Section 1915(c) services for children, and section 1915(i) services) had been provided under the Louisiana Behavioral Health Partnership “carve-out” managed care arrangement.</b></p>	<u>  X  </u>	i. MCO	_____	ii. PCCM (including capitated PCCMs that qualify as PAHPs)	_____	iii. Both
<u>  X  </u>	i. MCO						
_____	ii. PCCM (including capitated PCCMs that qualify as PAHPs)						
_____	iii. Both						

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Citation	Condition or Requirement
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p><b>Effective December 1, 2015, Bayou Health will also enroll additional populations that had been exempt or excluded from enrollment in Bayou Health under the approved Section 1932(a) State Plan. These individuals will be enrolled in Bayou Health MCOs through the companion Bayou Health Section 1915(b) Waiver for either comprehensive (physical and behavioral health) benefits or specialized behavioral health-only benefits, depending upon the population. All children enrolled in the Section 1915(c) SED waiver will be enrolled Bayou Health MCOs through the Bayou Health 1915(b) Waiver, not the Section 1932(a) State Plan.</b></p> <p><b>Bayou Health MCOs</b></p> <p><b>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 with the exception of behavioral health rates, which will not be risk adjusted. PMPM payments related to pharmacy services will be adjusted to account for pharmacy rebates.</b></p> <p><b>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.</b></p> <p>2. The payment method to the contracting entity will be:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i. fee for service; (E-PCCM only)</li> <li><input checked="" type="checkbox"/> ii. capitation; (MCO only)</li> <li><input type="checkbox"/> iii. a case management fee; (E-PCCM only)</li> <li><input type="checkbox"/> iv. a bonus/incentive payment; (E-PCCM only)</li> <li><input type="checkbox"/> v. a supplemental payment, or</li> <li><input type="checkbox"/> vi. other. (Please provide a description below).</li> </ul> <p><b>*The MCOs will be paid actuarially sound capitation rates subject to actuarial soundness requirements at 42 CFR 438.6(c).</b></p>
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	<p>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.</p> <p>If applicable to this state plan, place a check mark to affirm the state has met <i>all</i> 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)).</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> i. Incentive payments to the PCCM will not exceed 5% of the total</li> </ul>

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CFR 438.50(b)(4)	<p data-bbox="706 331 1380 394">FFS payments for those services provided or authorized by the PCCM for the period covered.</p> <ul style="list-style-type: none"> <li data-bbox="592 426 1291 453">__ ii. Incentives will be based upon specific activities and targets.</li> <li data-bbox="592 485 1274 512">__ iii. Incentives will be based upon a fixed period of time.</li> <li data-bbox="592 543 1193 571">__ iv. Incentives will not be renewed automatically.</li> <li data-bbox="592 602 1347 665">__ v. Incentives will be made available to both public and private PCCMs.</li> <li data-bbox="592 697 1396 760">__ vi. Incentives will not be conditioned on intergovernmental transfer agreements.</li> <li data-bbox="592 791 1242 819"><u>X</u> vii. Not applicable to this 1932 state plan amendment.</li> </ul> <p data-bbox="532 850 1437 970">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. (<i>Example: public meeting, advisory groups.</i>)</p> <p data-bbox="592 1001 1437 1085"><b>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.</b></p> <p data-bbox="592 1117 1437 1306"><b>A website (<a href="http://www.MakingMedicaidBetter.com">www.MakingMedicaidBetter.com</a>) 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.</b></p> <p data-bbox="592 1337 1437 1484"><b>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.</b></p> <p data-bbox="592 1516 1437 1789"><b>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.</b></p> <p data-bbox="592 1820 1437 1904"><b>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</b></p>

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	<p>input from stakeholders, the Notice of Intent (NOI) was published on February 20, 2011 in the <i>Louisiana Register</i>. 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 <i>Louisiana Register</i> 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.</p> <p>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.</p> <p>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.</p> <p>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 community based organizations) will be utilized to provide information and one-on-one assistance.</p> <p>The Louisiana Medicaid Quality Committee meets quarterly and has been a forum for ongoing public involvement. The website <a href="http://www.MakingMedicaidBetter.com">www.MakingMedicaidBetter.com</a> will be continually updated with information about the State's managed care program and enrollment.</p> <p>Prior to the submission of the State Plan amendment for Bayou Health effective 12/1/2015, DHH worked with stakeholders for almost a year seeking input on the design and implementation of the integration of behavioral health services into the Bayou Health MCOs.</p>

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**Public Input Process**

DHH has been committed to a transparent process with stakeholders leading up to integration of behavioral health services into the Bayou Health MCO Model. In November, 2014, DHH announced through a press release plans to integrate all behavioral health services into the existing Bayou Health Medicaid managed care program effective December 1, 2015. Subsequent to the public announcement, DHH held several meetings with the Behavioral Health Advisory Group, which is comprised of over 30 stakeholders, to help develop guidance to assist with the transition of services to the Bayou Health plans. The meetings thus far have taken place on January 30, 2015, February 20, 2015, March 20, 2015 and April 29, 2015.

In addition to continuing to meet with the advisory group, DHH will continue to utilize the LBHP-Bayou Health Transition Integrated Health Care website as a means to communicate with our stakeholders, including our Bayou Health plans and beneficiaries, of the upcoming Bayou Health changes. DHH maintains a frequently asked questions (FAQs) page on the website to respond to questions DHH has received related to integration. These FAQs are routinely updated as new questions are received. The website location is: <http://new.dhh.louisiana.gov/index.cfm/page/2104/n/434>. DHH published public notice of the waiver changes in newspapers on May 5, 2015.

DHH has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit this State Plan amendment and associated waiver amendments to CMS. This notice was made May 4, 2015.

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Citation	Condition or Requirement
1932(a)(1)(A)	<p>5. The state plan program will <u>X</u> /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):</p> <p>i. county/counties (mandatory) _____</p> <p>ii. county/counties (voluntary) _____</p> <p>iii. area/areas (mandatory) _____</p> <p>iv. area/areas (voluntary) _____</p>

**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)<br>1903(m)<br>42 CFR 438.50(c)(1)                   | 1. <u>X</u> 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)<br>1905(t)<br>42 CFR 438.50(c)(2)<br>1902(a)(23)(A) | 2. <u>N/A</u> 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)<br>42 CFR 438.50(c)(3)                                    | 3. <u>X</u> 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)<br>42 CFR 431.51<br>1905(a)(4)(C)                         | 4. <u>X</u> 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)<br>42 CFR 438<br>42 CFR 438.50(c)(4)<br>1903(m)           | 5. <u>X</u> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.  |
| 1932(a)(1)(A)<br>42 CFR 438.6(c)<br>42 CFR 438.50(c)(6)                 | 6. <u>X</u> 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)<br>42 CFR 447.362<br>42 CFR 438.50(c)(6)                  | 7. <u>N/A</u> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.   |
| 45 CFR 74.40  | 8. <u>X</u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.  |

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**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;
  - 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; and
  - Former foster children eligible under Section 1902(a)(10)(A)(i)(IX).

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.

**Individuals exempt under Section 1932(a) are not enrolled in Bayou Health under this State Plan authority. Individuals exempt under Section 1932(a) State Plan authority are enrolled in Bayou Health under the companion Bayou Health Section 1915(b) Waiver.**

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.)*

1932(a)(2)(C)  
42 CFR 438(d)(2)

- ii.  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.  Children under the age of 19 years who are eligible for Supplemental Security Income (SSI) under title XVI.

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Citation	Condition or Requirement
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	<p data-bbox="462 325 1435 388">iv. <u>N/A</u> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.</p> <p data-bbox="462 409 1435 483">v. <u>  </u> Individuals who receive home and community-based waiver services, and who proactively opt in to a MCO.</p> <p data-bbox="462 504 1435 856">vi. <u>  </u> Children under the age of 19 who are:</p> <ul data-bbox="633 567 1435 856" style="list-style-type: none"> <li>• eligible under §1902(e)(3) of the Act and receiving Supplemental Security Income (SSI);</li> <li>• in foster care or other out-of-home placement;</li> <li>• receiving foster care or adoption assistance under Title IV-E;</li> <li>• 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</li> <li>• enrolled in the Family Opportunity Act Medicaid Buy-In Program.</li> </ul>

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Citation	Condition or Requirement
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	<input type="checkbox"/> Children under the age of 19 years who are in foster care or other out-of- home placement.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(iv)	<input type="checkbox"/> 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)	<input type="checkbox"/> 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

- 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. These children are mandatorily enrolled in Bayou Health under the Bayou Health Section 1915(b) Waiver.**
- 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:
- 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.
- i. yes  
 ii. No

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Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: (<i>Examples: usage of aid codes in the eligibility system, self- identification</i>).</p> <p><b>Individuals exempt from mandatory enrollment in managed care under the Section 1932(a) State Plan option can be identified by aid code, program participation and other identifiers. These exempt individuals are mandatorily enrolled in Bayou Health under the Bayou Health Section 1915(b) waiver.</b></p>
42 CFR 438.50	<p>F. <u>List other eligible groups (not previously mentioned) who will be exempt (excluded) from mandatory enrollment.</u></p> <p>N/A</p> <p><b>Individuals exempt from mandatory enrollment in managed care under the Section 1932(a) State Plan option are mandatorily enrolled in Bayou Health under the Bayou Health Section 1915(b) waiver unless exempt as described in the 1915(b) waiver.</b></p> <p><b>The following Medicaid and/or CHIP recipients are excluded altogether from participation in a Bayou Health MCO:</b></p> <p><b>Individuals who:</b></p> <ul style="list-style-type: none"> <li>• <b>reside in an ICF/DD (Adults);</b></li> <li>• <b>receive services through the Program of All-Inclusive Care for the Elderly (PACE);</b></li> <li>• <b>have a limited period of eligibility such as eligibility through the Spend-down Medically Needy Program or Emergency Services Only (excluding individuals in a presumptive eligibility period);</b></li> <li>• <b>are participants in the Greater New Orleans Community Health Connection (GNOCHC) Program;</b></li> <li>• <b>Partial dual eligible; or</b></li> <li>• <b>Receive coverage under Louisiana's Take Charge Plus program.</b></li> </ul>

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Citation	Condition or Requirement
42 CFR 438.50	G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u> N/A
1932(a)(4) 42 CFR 438.50	H. <u>Enrollment process.</u> 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).  <b>As part of the financial Medicaid and LaCHIP application process, applicants will be given the option to indicate their preferred choice of MCO and will have access to the DHH enrollment broker. If the choice of MCO is not indicated on the new enrollee file transmitted by DHH to the Enrollment Broker once an applicant has been determined Medicaid eligible, the Enrollment Broker will utilize available information about relationships with existing PCPs in the assignment process. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a MCO.</b>  <b>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.</b>  <b>If no MCO choice is made, the enrollment broker will utilize available information about relationships with existing PCPs in the assignment process. Individuals who fail to choose a MCO are automatically assigned to a MCO by the enrollment broker and the MCO is responsible to assign the member to a PCP.</b>  <b>Enrollees have 90 days from the initial date of enrollment into a MCO 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.</b>

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Citation	Condition or Requirement
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- 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.**

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1932(a)(4) 42 CFR 438.50	<p>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). <i>(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</i></p> <p><b>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. Auto assignments will end in accordance with MCO contract. (However potential members will be allowed to proactively select the MCO.)</b></p> <p>3. As part of the state's discussion on the default enrollment process, include the following information:</p> <p>i. The state will <u> X </u> /will not <u> </u> use a lock-in for mandatory managed care.</p> <p>ii. The time frame for recipients to choose a health plan before being auto-assigned will be <u> see below. </u></p> <p><b>Note: All new potential enrollees 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.</b></p> <p>iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i></p> <p><b>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 the enrollees within two (2) business days of the linkage, and it provides the MCO contact information.</b></p> <p>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. <i>(Examples: state generated correspondence, HMO enrollment packets etc.)</i></p> <p><b>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 without cause within 90 days of their enrollment.</b></p>
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Citation	Condition or Requirement
v.	<p>Describe the default assignment algorithm used for auto-assignment. <i>(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</i></p> <p><b>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 contact with the Department prior to determination of Medicaid eligibility.</b></p> <p><b>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.</b></p> <p><b>Potential enrollees are auto-assigned based on the State's algorithm taking into consideration:</b></p> <ul style="list-style-type: none"> <li>▪ <b>The member's previous MCO;</b></li> <li>▪ <b>Inclusion in the MCO provider network of the member's historic provider as identified by Medicaid claims history;</b></li> <li>▪ <b>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;</b></li> <li>▪ <b>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; and</b></li> <li>▪ <b>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.</b></li> </ul>
vi.	<p>Describe how the state will monitor any changes in the rate of default assignment. <i>(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</i></p> <p><b>The State will use regular reports generated by the enrollment broker to monitor MCO choice rates, auto-assignments, and disenrollments.</b></p>

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- **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, including behavioral health care, needs.**
- **The member requests to be assigned to the same MCO as family members;**
- **The member moves out of the MCO service area, i.e. out of state; 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

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.)

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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 (excluding Applied Behavioral Analysis services and Dental);
7. Emergency medical services;
8. Communicable disease services;
9. Durable medical equipment and certain supplies;
10. Prosthetics and orthotics;
11. Emergency and non-emergency medical transportation;
12. Home health services;
13. Basic and Specialized behavioral health services;
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 (including nurse midwife services);
17. Chiropractic services;
18. Rehabilitation therapy services (physical, occupational, and speech therapies);
19. Pharmacy services;
20. Hospice services;
21. Personal care services (Age 0-20);
22. Pediatric day healthcare services;
23. Audiology services;
24. Ambulatory Surgical Services;
25. Lab and X-ray Services;
26. Emergency and surgical dental services;
27. Clinic services;
28. Pregnancy-related services;
29. Pediatric and Family Nurse Practitioner services;
30. Licensed mental health professional services (including Advanced Practice Registered Nurse services);
31. FQHC/RHC Services;
32. ESRD services;
33. Optometrist services;
34. Podiatry services;
35. Rehabilitative services (including Crisis Stabilization);
36. Respiratory services; and
37. Section 1915(i) state plan services.

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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.

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. Applied behavior analysis therapy services;
8. Targeted case management services; and
9. All Office of Aging and Adult Services/Office for Citizens with Developmental Disabilities home and community-based Section 1915(c) waiver services.

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6/22/2015

The newspapers of **Louisiana** make public notices from their printed pages available electronically in a single database for the benefit of the public. This enhances the legislative intent of public notice - keeping a free and independent public informed about activities of their government and business activities that may affect them. Importantly, Public Notices now are in one place on the web ([www.PublicNoticeAds.com](http://www.PublicNoticeAds.com)), not scattered among thousands of government web pages.

**County:** Terrebonne  
**Printed In:** The Courier  
**Printed On:** 2015/05/04

**LA SPA TN 15-0021**

X000393325, Publication 05/04/2015  
PUBLIC NOTICE

Department of Health and Hospitals  
Bureau of Health Services Financing and  
Office of Behavioral Health

Louisiana Behavioral Health Partnership

The Department of Health and Hospitals provides a comprehensive system for behavioral health services to eligible children and adults through the Louisiana Behavioral Health Partnership under the authority of Sections 1915(b), 1915(c), and 1915(i) of Title XIX of the Social Security Act. Effective December 1, 2015 the implementation of behavioral health services will transition from a single statewide management organization to an integrated behavioral and physical health model which will be administered by the five Bayou Health managed care organizations.

One of our primary goals with Bayou Health is to create better coordination of care and the integration of behavioral health services with other acute care services as the best way for us to meet the health care needs of Louisiana residents. The specialized behavioral health services will be coordinated along with the physical health services managed by Bayou Health plans. The primary purpose of integration is to care for the individual as a whole person rather than compartmentalizing types of services by the provider type. Integrating responsibility for coordinating these services into one entity allows us to better manage an individual's care to promote improvements for both physical and behavioral health care. In addition, certain children with special health care needs that were voluntarily enrolled in managed care will now be mandatory enrollees under the new integrated model.

The department hereby gives public notice of its intent to submit to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), amendments to the 1915(b) Behavioral Health Services Waiver, 1915(c) Coordinated System of Care Waiver, the 1932(a) State Plan authority (which will replace the single statewide management organization with the Bayou Health MCOs), the 1915(i) Behavioral Health section of the State Plan, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program section of the State Plan, and the associated reimbursement pages of the Medicaid State Plan to: 1) exclude coverage of the medically needy spend down population; 2) revise the payment methodology for children's services to include a per member per month actuarially sound risk-adjusted rate; 3) add crisis stabilization and therapeutic foster care services to the Medicaid State plan; 4) update the quality improvement strategy performance measures in the 1915(c) Waiver and the 1915(i) State Plan; 5) change language in the outpatient reimbursement pages of the State Plan to allow Medicaid coverage of methadone treatment for persons diagnosed with substance use disorder; and 6) update language in the associated reimbursement pages of the State Plan to clarify when annual cost reports must be submitted to the Department by psychiatric residential treatment facility (PRTF) and therapeutic group home (TGH) providers.

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

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to [MedicaidPolicy@la.gov](mailto:MedicaidPolicy@la.gov). Ms. Kennedy is responsible for responding to inquiries regarding this public notice. The draft version of the 1915(c) and corresponding State Plan amendments will be available for online viewing at <http://new.dhh.louisiana.gov/index.cfm/subhome/43>. The deadline for receipt of all written comments is June 6, 2015 by 4:30 p.m.

Kathy H. Kliebert  
Secretary

**Public Notice ID:**



# State of Louisiana

Department of Health and Hospitals  
Bureau of Health Services Financing

## VIA ELECTRONIC MAIL ONLY

May 4, 2015

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

Angela Martin  
Chitimacha Tribe of Louisiana  
P. O. Box 640  
Jeanerette, LA 70544

Anita Molo  
Chitimacha Tribe of Louisiana  
P. O. Box 640  
Jeanerette, LA 70544

Marshall Pierite, Chairman  
Misty Hutchby, Health Director  
Tunica-Biloxi Tribe of Louisiana  
P. O. Box 1589  
Marksville, LA 71351-1589

Lovelin Poncho, Chairman  
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 Integrated Behavioral Health and Physical Health Managed Care Model**

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 this opportunity to notify you of our proposal to transition the delivery of behavioral health services from a single statewide management organization to an integrated behavioral and physical health managed care model which will be administered by the five Bayou Health managed care organizations. This transition may have an impact on your tribe.

One of the primary goals with Bayou Health is to create better coordination of care, and the integration of behavioral health services with other acute care services is the best way for us to meet the health care needs of Louisiana residents. The specialized behavioral health services will be coordinated along with the physical health services managed by Bayou Health plans. The primary purpose of integration is to care for the individual as a

whole person rather than compartmentalizing types of services by the provider type. Integrating responsibility for coordinating these services into one entity allows the Department to better manage an individual's care to promote improvements for both physical and behavioral health care. In addition, certain children with special health care needs that were voluntarily enrolled in managed care will now be mandatory enrollees under the new integrated model.

To secure federal approval for the proposed integration, the Department intends to submit to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), amendments to the:

- 1915(b) Behavioral Health Services Waiver;
- 1915(c) Coordinated System of Care Waiver;
- 1932(a) State Plan authority;
- 1915(i) Behavioral Health section of the Medicaid State Plan;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program section of the Medicaid State Plan; and
- Associated reimbursement pages of the Medicaid State Plan.

Upon CMS approval of the afore-mentioned authorities, the integration will allow the Medicaid Program to:

1. Exclude coverage of the Spend-Down Medically Needy population;
2. Revise the payment methodology for children's special services to include a per member per month actuarially sound risk-adjusted rate;
3. Add crisis stabilization and therapeutic foster care services to the Medicaid State Plan;
4. Update the quality improvement strategy performance measures in the 1915(c) waiver and the 1915(i) State Plan;
5. Change language in the outpatient reimbursement pages of the Medicaid State Plan to allow Medicaid coverage of methadone treatment for persons diagnosed with substance use disorder; and
6. Update language in the associated reimbursement pages of the Medicaid State Plan to clarify when annual cost reports must be submitted to the Department by psychiatric residential treatment facility and therapeutic group home providers.


Please provide any comments you may have by June 3, 2015 to Mrs. Darlene Budgewater via email to [Darlene.Budgewater@la.gov](mailto: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  
Baton Rouge, LA 70821-9030

Integrated Behavioral Health Tribal Notice  
May 4, 2015  
Page 3

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,

*for*   
J. Ruth Kennedy  
Medicaid Director

JRK/DAB/KS

c: Ford J. Blunt, III  
Jeanne Levelle  
Stacie Shuman