DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

September 21, 2015

Our Reference: SPA LA 15-0021

Ms. Ruth Kennedy, State Medicaid Director
Department of Health and Hospitals
Bienville Building
628 North 4th Street
Post Office Box 91030
Baton Rouge, LA 70821-9030

Attn: Darlene Budgewater
Jodie Hebert

Dear Ms. Kennedy:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 15-0021. The state plan amends 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.

Transmittal Number 15-0021 is approved with an effective date of December 1, 2015 as requested. A copy of the HCFA-179, Transmittal No. 15-0021 dated July 2, 2015 is enclosed along with the approved plan pages.

If you have any questions, please contact Ford Blunt III at ford.blunt@cms.hhs.gov or by phone at (214) 767-6381.

Sincerely,

Bill Brooks

Bill Brooks
Associate Regional Administrator

Enclosures

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: **15-0021**

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: **December 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 **2016** ~~$0~~ 487.98
b. FFY **2017** ~~$0~~ 601.96

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
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

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 15-0010)
None (New Page)

10. SUBJECT OF AMENDMENT: **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.**

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:
July 2, 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: July 2, 2015

18. DATE APPROVED: September 21, 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
December 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
Bill Brooks

21. TYPED NAME:
Bill Brooks

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:
Please see pen and ink change in box 7.

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)

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."

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. 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 risk-bearing managed care organizations (MCOs).

Program Overview

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.

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	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. **Bayou Health MCOs** **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.** **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.**
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).**
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

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	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.

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

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	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.** **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 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.** **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.**

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Citation	Condition or Requirement
	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)	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)_____

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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.
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) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. _N/A_ 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. _X_ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

State: **Louisiana**

Citation	Condition or Requirement

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.

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____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.

State: **Louisiana**

Citation	Condition or Requirement
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. __ Individuals who receive home and community-based waiver services, and who proactively opt in to a MCO.
	vi. _ 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.

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Citation	Condition or Requirement
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

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:

__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

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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).* **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.**
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt (excluded) from mandatory enrollment. N/A **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.** **The following Medicaid and/or CHIP recipients are excluded altogether from participation in a Bayou Health MCO:** **Individuals who:** • **reside in an ICF/DD (Adults);** • **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 (excluding individuals in a presumptive eligibility period);** • **are participants in the Greater New Orleans Community Health Connection (GNOCHC) Program;** • **Partial dual eligible; or** • **Receive coverage under Louisiana's Take Charge Plus program.**

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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 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.

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. 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.

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.

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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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	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. Auto assignments will end in accordance with MCO contract. (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 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.
	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 the enrollees within two (2) business days of the linkage, 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 without cause within 90 days of their enrollment.

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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 contact 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 MCO;**
- **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; and**
- **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.

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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	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.)

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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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