POLICY AND PROCEDURE

DEPARTMENT: Claims	**DOCUMENT NAME**: Provider Reimbursement
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APPROVED DATE: ~~7/15/15~~12/22	**RETIRED:**
EFFECTIVE DATE: 7/15	**REVIEWED/REVISED:** 11/15, 6/16, 6/17, 6/18, 6/19, 7/20, 3/22,12/22
PRODUCT TYPE: All	**REFERENCE NUMBER:** LA.CLMS.02

SCOPE:
Louisiana Healthcare Connections (PLAN and MCO)

PURPOSE:
The purpose of this policy is to clearly define the PLAN/MCO guidelines for Provider Reimbursement.

POLICY:

Provider Reimbursement The PLAN/MCO shall administer an effective, accurate and[KLS1] efficient claims processing system that adjudicates provider claims for MCO covered services that are filed within the time frames specified ~~by the current Louisiana Medicaid MCO Emergency Contract~~ in this contract and in compliance with all applicable State and Federal laws, rules, policies, procedures, manuals and regulations.

PROCEDURE:

1. **Minimum Reimbursement to In-Network Providers**

~~1.~~ The MCO shall provide reimbursement for defined core benefits and services provided by an in-network provider. The MCO rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both the plan and the provider in the provider contract. The MCO shall not enter into alternative reimbursement arrangements with Physicians without written prior approval from LDH ~~**DRG Reimbursement Methodology**~~

~~1. The system shall have the capacity to group claims and to reimburse inpatient hospital services under a Diagnosis Related Grouping (DRG) methodology as defined by LDH within 180 days of notification by LDH that such reimbursement method is required. LDH shall be responsible for establishing DRG rates. Upon implementation, the PLAN shall reimburse no less than the DRG rate established by LDH, unless mutually agreed to by both the plan and the provider in the provider contract.~~

2. **DRG Reimbursement Methodology**

The system shall have the capacity to group claims and to reimburse inpatient hospital services under a Diagnosis Related Grouping (DRG) methodology as defined by LDH within 180 days of notification by LDH that such reimbursement method is required. LDH shall be responsible for

establishing DRG rates. Upon implementation, the PLAN shall reimburse no less than the DRG rate established by LDH, unless mutually agreed to by both the plan and the provider in the provider contract.

~~**2.1. Minimum Reimbursement to In-Network Providers**~~

~~The MCO shall provide reimbursement for defined core benefits and services provided by an in-network provider. The MCO rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both the plan and the provider in the provider contract. The MCO shall not enter into alternative reimbursement arrangements with Physicians without written prior approval from LDH~~.

3. Reimbursement to Out-of-Network Providers[KLS2]

a. The PLAN shall make payment for covered emergency and post-stabilization services that are furnished by providers that have no contractual arrangements[KLS3] with the PLAN for the provision of such services. The PLAN shall reimburse the provider one hundred percent (100%) of the Medicaid rate for emergency services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the PLAN to out-of-network providers for the provision of emergency services shall be no more than the Medicaid rate.

b. For services that do not meet the definition of emergency services, the PLAN[KLS4] shall compensate, at a minimum, ninety percent (90%)~~is not required to reimburse more than 90%~~ of the published Medicaid rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts ~~(as defined in Glossary)~~ to include ~~the provider~~ in their network (except as noted in ~~Section 9.3 and 9.4~~ this section for FQHCs, RHCs and HIS providers). The PLAN may require prior authorization of out-of-network services, unless services are required to treat an emergency medical condition.

c. The[KLS5] PLAN shall not make payments for Community Psychiatric Support Treatment (CPST) or Psychosocial Rehabilitation (PSR) services that are furnished to Enrollees by providers that are out-of-network. The PLAN may make payments for CPST or PSR services only to to those providers who are:

1. Credentialed

2. Participating in the provider network of the PLAN for provisions of such services or who are licensed and accredited AND
3. Have a single case agreement (SCA) with the PLAN.

d. The PLAN[KLS6] shall reimburse out of Network Providers for the provision of services required by the Continuity of Care section at the in network rate, in accordance withteh Minimum Reimbursement to In Network Providers section.

4. Provider State Enrolled Reimbursement[KLS7]

a. Reimbursement shall be provided for dates of service on or after the state enrollment effective date for state enrolled providers with effective dates equal to or less than ninety (90) calendar days prior to execution of the Contractor's Network Provider Agreement.

b. Reimbursement shall be provided for dates of services on or after the Network Provider Agreement execution date for state enrolled providers with effective dates greater than ninety (90) calendar days prior to execution of the Contractor's Network Provider Agreement.

5. Mental Health Rehabilitation (MHR) Reimbursement[KLS8]

~~**b.**~~**a.** Claims submitted for MHR services shall include rendering provider NPIs and other Contractor required identifiers regardless of whether the rendering staff is licensed or unlicensed.The PLAN shall configure internal systems to deny claims for services when rendering providers and NPIs are denoted on Claims for service that have not been credentialed and approved by the Contractor.

~~4.~~6. FQHC/RHC Contracting and Reimbursement

The PLAN shall reimburse contracted FQHC/RHC the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.
The MCO shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without written prior approval from LDH. If the PLAN is unable to contract with an FQHC or RHC, the PLAN is not required to reimburse that FQHC or RHC without prior approval for out-of-network services unless:

a. The medically necessary services are required to treat an emergency medical condition; or

b. FQHC/RHC services are not available through at least one MCO with LDH's established distance travel standards.

~~5.~~7. Indian Health ~~Care~~ Service Providers ~~(IHCPs)~~ (IHS)

The PLAN shall reimburse the ~~IHCP~~ IHS at the annual rates published in the Federal Register by the Indian Health Services (IHS). IHS issues the payment rate based on a calendar year that will be effective retroactive to ~~th~~e January 1st of that year. The PLAN will recycle claims for the calendar year to capture the adjusted rate. See 42 CFR §438.14(c).

~~**6. Capitation Reimbursement**~~

~~To the extent that the provider contract requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than the time period specified in the provider contract between the provider and the PLAN, or if a time period is not specified in the contract:~~

~~**a.** The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or~~

~~If the PLAN is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from LDH.~~

~~7.~~8. Inappropriate Payment Denials or Recoupments

If the PLAN has a pattern, as determined by LDH, of inappropriately denying, delaying, or recouping provider payments for services, the PLAN may be subject to suspension of new enrollments, monetary penalties equal to 1.5 times the value of the claims inappropriately denied, delayed, or recouped, contract cancellation, or refusal to contract in a future time period. This applies not only to situations where LDH has ordered payment after appeal but to situations where no appeal has been made (i.e. LDH is knowledgeable about the documented abuse from other sources).

~~8.~~9. Payment for Emergency Services and Post-stabilization Services

a. The PLAN shall not deny payment for treatment when a representative of the PLAN instructs the member to seek emergency services.

~~a.~~b. The PLAN shall reimburse providers for Emergency Services rendered without a requirement for Service Authorization of any kind[KLS9].

~~b.~~c. The PLAN shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or PLAN of the member's screening and

treatment within 10 calendar days of presentation for emergency services.

~~c.~~d. The PLAN shall be financially responsible for emergency medical services, including transportation, and shall not retroactively deny a claim for emergency services, including transportation, to an emergency provider because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

~~9.~~10. Emergency Medical Conditions

The PLAN shall not deny payment for treatment obtained when a member had an emergency medical condition including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency medical condition.

~~10.~~11. Non-Payment for Specified Services

The PLAN shall deny payment to providers for deliveries occurring before 39 weeks without a medical indication. PLAN will use LEERS data as directed by the state to process claims for all deliveries occurring before 39 weeks.

~~11.~~12. Provider Preventable Conditions

The PLAN shall deny payment to providers for Provider Preventable Conditions ~~as defined by LDH in Section 25.8 of the Louisiana Medicaid Program Hospital Services Provider Manual.~~ The PLAN shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. The MCO shall report all identified provider preventable conditions to LDH in a format specified by LDH.

~~12.~~13. Payment for Newborn Care

The PLAN shall cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another network provider. The PLAN shall compensate, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty calendar days of the member's birth regardless of whether the provider rendering the services is contracted

with the PLAN, but subject to the same requirements as a contracted provider.

~~13.~~14. Payment for Hospital Services

The PLAN is not responsible for reimbursement of Graduate Medical Education (GME) payments or Disproportionate Share Hospital (DSH) payments to providers. ~~The MCO must use the increased hospital funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Attachment D of the emergency contract – Rate Certification, for reimbursement of inpatient and outpatient hospital services.~~LDH will provide a uniform percentage increase for in-state providers of[KLS10] inpatient and outpatient hospital services (excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and log-term acute care, psychiatric services and rehabilitation services for both inpatient and outpatient hospital services for that rating period. This directed payment arrangement shall be detailed in Attachment D, Actuarial Rate Certification Letter.

LDH shall provide a quarterly interim direct payment report to the PLAN for each quarter, which identifies qualified hospitals and payment for that quarter. The PLAN shall pay the interim directed payment as specified in thet report within ten (10) business days of receipt of LDH report.

The direct payments must be based on actual utilization and delivery of services. As such, within twelve months of the of SFY, LDH will perform a reconciliation and provide the PLAN the adjustments to be made to each qualified hospitals's next quarterly interim directed payment.

~~14.~~15. Payment for Ambulance Services

The PLAN must use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing ~~Payment~~[KLS11], as detailed in Attachment D, Acturial Rate Certification Letter ~~of the emergency contract – Rate Certification~~, for reimbursement of ambulance services.

~~15.~~16. Payment for Physician Services

The PLAN must use the increased physician services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing, or any successive[KLS12] payment model, ~~Payment~~, as detailed in Attachment D, Acturial Rate Certification Letter, ~~of the emergency contract – Rate Certification~~, for reimbursement of physician services.

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17. Payment for Pharmacy Services

The PLAN and the Plans PBM are prohibited from reimbursing pharmacies that are oned by the Plan and/or the PBM at a rate higher than pharmacies that are owned by the Plan and/or the PBM.

REFERENCES:

~~PLAN **2020 Louisiana Medicaid MCO Emergency Contract** – Sections 9.0, 9.1, 9~~[KLS13]~~.2, 9.3, 9.4, 9.5, 9.7, 9.8, 9.9, 9.10, 9.11, 9.12, 9.13, 9.14~~ **Plan 2023 Louisiana Medicaid Attachment A – Model Contract Section 2.9.9.4 and Sections 2.11.1 through 2.11.14.**

ATTACHMENTS:

DEFINITIONS:

REVISION LOG	DATE
• Scope Section – added "and MCO" to define MCO in sections 9-11.	• 11/5/15
• Purpose Section – added "/MCO" to define MCO in sections 9-11.	• 11/5/15
• Policy Section – added "/MCO" to define MCO in sections 9-11.	• 11/5/15
• Added Section 9 – Payment for Hospital Services	• 11/5/15
• Added Section 10 – Payment for Ambulance Services	• 11/5/15
• Added Section 11 – Payment for Physician Services	• 11/5/15
• Added the attached document name in the "ATTACHMENT" section.	• 11/5/15
• Changed "Senior Director of Network Accounts" to "Senior Manager of Claims & Contract Support".	• 11/5/15
• Added "Appendix G" to both 9. Payment for Ambulance Services and 10. Payment for Physician Services.	• 6/21/16
• Added "Amendment 4" and "9.0" to REFERENCES and Deleted ATTACHMENTS.	• 6/21/16
• Changed back from "Senior Manager of Claims & Contract Support to "Senior Director of Network Accounts".	• 6/21/16
	• 6/16

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• Changed DHH to LDH	
No revisions	6/17
No revisions	6/18
No revisions	6/19
Updated references per emergency contract	7/20
Added 2020 Louisiana Medicaid Emergency Contract updates	7/20
• Updated Section 1 - DRG Reimbursement Methodology as per 2020 Louisiana Medicaid Emergency Contract • Updated Section 4 - FQHC/RHC Contracting and Reimbursement as per 2020 Louisiana Medicaid Emergency Contract • Added Section 5 – Indian Health Care Providers as per 2020 Louisiana Medicaid Emergency Contract • Added references to Louisiana Medicaid MCO Emergency Contract •	3/22
• Added Section – Out-of-Network CPST/PSR Reimbursement	12/22
• Added Section – State Enrolled Provider Reimbursement based on effective dates	12/22
• Added Section – Pharmacy Service Reimbursement	12/22
• Deleted reference to “MCO Emergency Contract” language	12/22
• Added Section – Mental Health Rehabilitation Reimbursement	12/22
• Removed “Capitation Reimbursement” Section. Included Hospital reimbursement language under one section	12/22
• Updated language referencing “Full Medicaid Pricing, or any successive payment model, as detailed in Attachment D, Actuarial Rate Certification Letter” under Payment for Ambulance and Physician Services.	12/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a physical signature.