

MCO Manual

February 2019

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PART 1: INTRODUCTION

1.1 Overview

The Managed Care Organization (MCO) Manual is a compilation of policies, instructions, and guidelines established by the Louisiana Department of Health (LDH) for the administration of the Louisiana Medicaid managed care program.

The MCO Manual applies to MCOs with contracts with LDH to provide covered services to Louisiana Medicaid managed care program enrollees. The MCO Manual also applies to material subcontractors with delegated responsibilities for the provision of all, or part, of any program area or function that relates to the delivery or payment of covered services, including, but not limited to, behavioral health, claims processing, care management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy providers.

The MCO is responsible for complying with the requirements set forth within the MCO Manual and for ensuring that its subcontractors are notified when modifications are made to the MCO Manual.

LDH is publishing this draft MCO Manual in the MCO Request for Proposals, RFP #3000011953, procurement library as a good faith representation of current and/or future policies, instructions, and guidelines which may be applicable to Louisiana Medicaid MCOs. LDH intends to refine the content of this MCO Manual up to contract execution, at which point a final draft of this document, and its subsequent revisions, will be published online. During the procurement process, LDH shall not consider written inquiries and requests for clarification of the content of this MCO Manual, as it is not a guarantee of the state of affairs on January 1, 2020.

1.2 Revisions

The MCO Manual may be revised at the discretion of LDH due to a variety of reasons, including, but not limited to, changes to any provisions of state and federal laws, regulations, rules, the State Plan, and waivers applicable to managed care, contract amendments, internal operational changes, and requests for written guidelines in a particular area.

The LDH Medicaid Executive Management Team (EMT) reviews and approves new provisions and substantive revisions to existing provisions within this Manual. The EMT also determines if proposed revisions require public comment prior to final publication. Upon adoption, LDH will notify the Contractor that updates to the MCO Manual are available on the LDH website.

1.3 Change Log

Section	Description	Reason	Date

PART 2: CONTRACTOR RESPONSIBILITIES

2.1 Compliance

This section provides additional instructions for the Contractor to demonstrate compliance with the overarching requirements of the Contract, including reporting, regulatory, and programmatic responsibilities.

2.1.1 Reporting Requirements

The Contractor shall comply with all reporting requirements established by the Contract in accordance with this Manual and LDH-issued companion and reporting guides.

The Contractor shall create deliverables which may include documents, manuals, files, plans, and reports using the electronic formats, instructions, and timeframes as specified by LDH and at no cost to LDH.

Unless otherwise specified, LDH shall utilize standard rounding (i.e., reported figures shall be rounded up or down to the nearest whole number) to determine compliance.

- Certification of Data and Reports

The Contractor shall ensure the accuracy, completeness, and timely submission of each report.

The Contractor shall submit all data required by 42 C.F.R. §438.604, including any additional data, documentation, or information relating to the performance of its obligations as required by LDH and shall certify all submitted data, documents and reports per 42 C.F.R. §438.606. All data reported must be certified including, but not limited to, enrollment information, financial reports, encounter data, and other information as specified within the Contract and this RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The Contractor must submit the certification concurrently with the certified data and documents. LDH will identify specific data that requires certification.

The data shall be certified by one of the following:

- ❖ The Contractor's Chief Executive Officer (CEO);
- ❖ The Contractor's Chief Financial Officer (CFO); or
- ❖ An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

The Contractor shall provide the necessary data extracts to the LDH or its designee as required by this Contract or specified in the MCO Manual.

- Information Related to Business Transactions

The Contractor shall furnish to LDH and/or to the United States Department of Health and Human Services, information related to significant business transactions as set forth in 42 C.F.R. §455.105. Failure to comply with this requirement may result in termination of this Contract.

The Contractor shall submit, within thirty-five (35) days of a request made by LDH, full and complete information about:

- ❖ The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of this request; and
- ❖ Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5) year period ending on the date of this request.

- Report of Transactions with Parties in Interest

The Contractor shall report to LDH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.

The Contractor shall make the information reported pursuant to this section available to its enrollees upon reasonable request.

Federally qualified MCOs are exempt from this requirement. LDH may require that the information on business transactions be accompanied by a consolidated financial statement for the Contractor and the party in interest.

The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the Contractor's business transactions must be reported.

If the contract is renewed or extended, the Contractor must disclose information on business transactions which occurred during the prior contract period.

- Key Staff Reporting

The Contractor must submit to the LDH the following staff-related items annually:

- ❖ An updated organization chart complete with the Key Staff positions. The chart must include the person's name, title and telephone number and portion of time allocated to this Contract, other Medicaid contracts, and other lines of business.
- ❖ A functional organization chart of the key program areas, responsibilities and the areas that report to that position.
- ❖ A listing of all functions and their locations; and a list of any functions that have moved outside of the state of Louisiana in the past contract year.

- Health Needs Assessment

The Contractor shall maintain health needs assessment (HNA) records and submit them to LDH upon request.

- Encounter Data

The Contractor shall comply with the required encounter data format provided by LDH.

LDH may change the Encounter Data Transaction requirements with sixty (60) calendar days written notice to the Contractor. Current LDH specifications are included in the MCO Manual. The Contractor shall, upon notice from LDH, provide notice of encounter data changes to subcontractors.

- Financial Reporting

The Contractor shall submit to LDH unaudited quarterly financial statements and an annual audited financial statement, using the required format provided by LDH. Quarterly financial statements shall be submitted no later than sixty (60) days after the close of each calendar quarter. Audited annual statements shall be submitted no later than six (6) months after the close of the MCO's fiscal year.

The financial statements shall be specific to the operations of the Contractor's MCO rather than to a parent or umbrella organization. Audited annual statements of a parent organization, if available, shall be also submitted.

All financial reporting shall be based on Generally Accepted Accounting Principles (GAAP).

- Information on Persons Convicted of Crimes

The Contractor shall furnish LDH information related to any person employed or contracted with the MCO convicted of a criminal offense under a program relating to Medicare (Title XVIII), Medicaid (Title XIX), and Title XX as set forth in 42 C.F.R. §455.106 and including SCHIP (Title XXI). Failure to comply with this requirement may lead to termination of this Contract.

- Errors

The Contractor agrees to prepare complete and accurate reports for submission to LDH. If after preparation and submission, an error is discovered either by the Contractor or LDH; the Contractor shall correct the error(s) and submit accurate reports as follows:

- ❖ For encounters – In accordance with the timeframes specified in this Contract and the MCO Manual.
- ❖ For all reports – Fifteen (15) calendar days from the date of discovery by the Contractor or date of written notification by LDH (whichever is earlier). LDH may at its discretion extend the due date if an acceptable plan of correction has been submitted and the Contractor can demonstrate to LDH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.

Failure of the Contractor to respond within the above specified timeframes may result in a loss of any money due the Contractor and the assessment of monetary penalties.

- Submission Timeframes

The Contractor shall ensure that all required deliverables, which may include documents, manuals, files, plans, and reports are submitted to LDH in an accurate, complete, and timely manner for review and approval. The Contractor's failure to submit the deliverables as specified may result in the assessment of monetary penalties.

LDH may, at its discretion, require the Contractor to submit additional deliverables both ad hoc and recurring. If LDH requests any revisions to the deliverables already submitted, the Contractor shall make the changes and re-submit the deliverables, according to the time period and format required by LDH. If not otherwise restricted by federal or state laws or regulations, LDH will provide the Contractor with sixty (60) day notice on changes to all on-going reports.

Unless otherwise specified in the contract, deadlines for submitting deliverables are as follows:

- ❖ Monthly deliverables shall be submitted no later than the fifteenth (15) calendar day of the following month;
- ❖ Quarterly deliverables shall be submitted by April 30, July 30, October 30, and

January 30, for the calendar quarter immediately preceding the due date;

- ❖ Annual reports and files, and other deliverables due annually, shall be submitted within thirty (30) calendar days following the twelfth (12th) month of the contract year; except those annual reports that are specifically exempted from this 30-calendar-day deadline by this Contract. This Contract will specify the due date of any annual report it exempts from this 30-calendar-day deadline; and
- ❖ If a due date falls on a weekend or State-recognized holiday, deliverables will be due the next business day.

- **Recurring Reports**

The Contractor shall prepare and submit deliverables in the report format prescribed by LDH. The Contractor shall comply with the **Managed Care Reporting Guide** in submitting required deliverables, including the report formats, templates, instructions, data specifications, submission timelines and locations, and other requirements. Unless otherwise specified or required, all reports shall be submitted electronically.

The MCO Manual and related LDH Managed Care Reporting website will serve as the definitive source of all required recurring deliverable reports and will be updated by LDH.

LDH will require that some or all deliverables be reviewed and/or approved by LDH during the readiness review and/or during operations. As specified by LDH, material modifications to certain deliverables must be reviewed and/or approved by LDH.

A complete list MCO reporting deliverables and timelines can be found at <http://ldh.la.gov/index.cfm/page/1700>. Ad Hoc Reports

The Contractor shall prepare and submit any other reports as required and requested by LDH, any of LDH's designees, Legislature and/or CMS, that is related to the Contractor's duties and obligations under this Contract. Information considered to be of a proprietary nature shall be clearly identified as such by the Contractor at the time of submission.

Ad Hoc reports shall be submitted within five (5) business days from the date of request, unless otherwise approved by LDH.

- **Transparency Report**

The Contractor shall designate one staff member to serve as the single point of contact for all Transparency Report requests.

The Contractor shall comply with all data requests and independent surveys from LDH or its designee. The Contractor shall comply with all instructions and definitions as disseminated by LDH for transparency reporting.

Failure to comply with reporting instructions will require resubmission of data by the Contractor to LDH. To validate that the reports are submitted correctly, the Contractor may be required to supply its data code upon request of LDH or its designee. Repeat deficiencies may subject the Contractor to monetary penalties at the discretion of LDH.

2.1.2 Responsibilities with Respect to Chisholm vs. Gee Class

LDH must comply with three stipulations and several judgments under the litigation known as *Chisholm vs. Gee*. This class action lawsuit was filed in 1997 by the Advocacy Center on behalf of children who were under 21, Medicaid-eligible, and on the waiting list of what is now known as the Intellectual/Developmental Disabilities Registry. The lawsuit alleged that the children on the waiting list were not receiving all medically necessary EPSDT services..

- LDH has strict requirements and limited flexibility in the way the Medicaid program is administered to Chisholm Class Members. The Contractor shall refer to the **Chisholm Compliance Guide** for guidance on the administration of services to these members.
- The Contractor shall also maintain an outreach and referral system to direct class members of Chisholm vs. Gee with an Autism Spectrum Disorder diagnosis to qualified healthcare professionals, who can provide Comprehensive Diagnostic Evaluations required to establish medical necessity for Applied Behavior Analysis services.

2.2 Contract Transition & Readiness

Contract Transition includes the requirements for the Transition Work Plan to ensure that the MCO is progressing towards contract readiness. Contract readiness outlines and identifies any risks to program success. Readiness review activities are conducted by LDH and a third party subcontractor to ensure that the MCO can meet the requirements outlined in the Contract.

2.3 Administration & Contract Management

The Contractor's business plan, organization, and oversight of all contracted responsibilities is critical to achieving LDH's goal of building a Medicaid managed care delivery system that improves the health of populations, enhances the experience of care for individuals, and effectively manages Medicaid per capita care costs.

2.3.1 Additional Staff Required

In addition to the key personnel requirements of the Contract, the Contractor shall have these additional staff.

- The **Program Integrity Officer** shall be qualified by training and experience in health care or risk management, to oversee monitoring and enforcement of the fraud, waste, and abuse compliance program to prevent and detect potential fraud, waste, and abuse activities pursuant to state and federal rules and regulations, and carry out the provisions of the compliance plan, including fraud, waste, and abuse policies and procedures, investigating unusual incidents and implementing any corrective action plans. As a management official, this position shall have the authority to assess records and independently refer suspected enrollee fraud, provider fraud, and enrollee abuse cases to LDH and other duly authorized enforcement agencies. The Program Integrity Officer must report directly to the CEO.
- The **Grievance System Manager** shall manage and adjudicate enrollee and provider disputes arising under the Grievance System including enrollee grievances, appeals and requests for hearing and provider complaints and disputes.
- The **Business Continuity Planning and Emergency Coordinator** shall manage and oversee the Contractor's emergency management plan during disasters and ensure continuity of covered services for enrollees who may need to be evacuated to other areas of the state or out-of-state.
- The **Information Technology Director** shall be trained and experienced in information systems, data processing and data reporting and shall be responsible for oversight of all MCO information systems functions including, but not limited to, establishing and maintaining connectivity with LDH.
- The **Provider Claims Educator** must be a full-time (forty [40] hours per week) employee. This position is fully integrated with the MCO's complaint, claims processing, and provider relations systems and facilitates the exchange of information between these systems and providers, with a minimum of five (5) years management and supervisory experience in the health care field. The primary functions of the Provider Claims Educator include:
 - ❖ Educating in-network and out-of-network providers regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available MCO resources, such as provider manuals, websites, fee schedules, etc.;
 - ❖ Interfacing with the MCO's provider call center to compile, analyze, and disseminate information from provider calls;

- ❖ Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction; and
 - ❖ Frequently communicating (i.e., telephonic and on-site) with providers to ensure the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.
- The **Encounter Data Quality Coordinator** shall organize and coordinate services and communication between MCO administration and LDH for the purpose of identifying, resolving, and monitoring encounter and data validation/management issues. The Coordinator as the Contractor's encounter expert to answer questions, provide recommendations, and participate in problem solving and decision-making related to encounter data, submissions, and processing. The Coordinator analyzes activities related to the processing of encounter data and data validation studies to enhance accuracy and throughout.
 - The **Quality Management (QM) Coordinator** shall be a full-time, Louisiana-licensed registered nurse, physician or physician's assistant or is a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. Six Sigma or other training in quality management is preferred. The QM Coordinator must have experience in quality management and quality improvement as described in 42 C.F.R. §§438.200 – 438.242. The primary functions, including those targeting specialized behavioral health services, of the QM Coordinator position include:
 - ❖ Ensuring individual and systemic quality of care;
 - ❖ Integrating quality throughout the organization;
 - ❖ Implementing process improvement;
 - ❖ Resolving, tracking and trending quality of care grievances; and,
 - ❖ Ensuring a credentialed provider network.
 - The **Performance/Quality Improvement Coordinator** shall be a certified professional in healthcare quality (CPHQ) or certified in health care quality management (CHCQM) or comparable education and experience in data and outcomes measurement as described in 42 C.F.R. §§438.200–438.242. The primary functions of the Performance/Quality Improvement Coordinator, including those targeting specialized behavioral health services, include:

- ❖ Focusing organizational efforts on improving clinical quality performance measures;
 - ❖ Developing and implementing performance improvement projects;
 - ❖ Utilizing data to develop intervention strategies to improve outcome; and,
 - ❖ Reporting quality improvement/performance outcomes.
- The **Maternal Child Health/EPSDT Coordinator** shall be a Louisiana licensed registered nurse, physician, or physician's assistant; or has a Master's degree in health services, public health, or health care administration or other related field and/or a CPHQ or CHCQM. Staffing under this position should be sufficient to meet quality and performance measure goals. The primary functions of the MCH/EPSDT Coordinator include:
 - ❖ Ensuring delivery of EPSDT services;
 - ❖ Ensuring delivery of maternal and postpartum care;
 - ❖ Promoting family planning services;
 - ❖ Promoting preventive health strategies;
 - ❖ Identifying and coordinating assistance for identified enrollee needs specific to maternal/child health and EPSDT; and
 - ❖ Interfacing with community partners.
 - The **Medical Management Coordinator** shall be a Louisiana-licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration, if not required to make medical necessity determinations, to manage all required Medicaid management requirements under LDH policies, rules and the contract. The primary functions of the Medical Management Coordinator include:
 - ❖ Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;
 - ❖ Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted;
 - ❖ Developing, implementing and monitoring the provision of care coordination, disease management and case management functions;
 - ❖ Monitoring, analyzing and implementing appropriate interventions based on

utilization data, including identifying and correcting over- or under- utilization of services; and,

- ❖ Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards.
- The **Case Management Administrator/Manager** shall oversee the case management functions and shall have the qualifications of a case manager with a minimum of five (5) years of management/supervisory experience in the health care field.
- The **Provider Services Manager** shall coordinate communications between the Contractor and its network providers.
- The **Enrollee Services Manager** shall coordinate communications between the Contractor and its enrollees. There shall be sufficient Enrollee Services staff to enable enrollees to receive prompt resolution of their problems or inquiries and appropriate education about participation in the MCO program.
- **Behavioral Health Coordinator** shall meet the requirements for a licensed mental health professional (LMHP) and have at least seven (7) years' experience in managing behavioral healthcare operations. The Behavioral Health Coordinator shall have responsibility for clinical program development and oversight of staff and services related to the delivery of covered mental health and addiction services to children/youth, adults with serious mental illness and/or with substance use disorders in compliance with federal and state laws and the requirements set forth in this contract, including all documents incorporated by reference. The Behavioral Health Coordinator will share responsibility to manage the specialized behavioral health services delivery system with the Behavioral Health Medical Director. The Behavioral Health Coordinator shall regularly review integration performance, performance improvement projects, and surveys related to integration and shall work closely with the Performance/Quality Improvement Coordinator and Quality Management Coordinator and Behavioral Health Quality Management Coordinator.
- The **Behavioral Health Children's System Administrator** must meet the requirements for a LMHP and have at least seven (7) years' experience and expertise in the specialized behavioral health needs of children with severe behavioral health challenges and their families. Prior experience working with other child serving systems is preferred. The ideal candidate will have at least three (3) years' experience with delivering or managing Evidenced Based Practices (EBPs) and best practices for children and youth, including experience within system of care and wraparound environments. The Children's BH System Administrator shall work closely with LDH and the CSoC Governance Board, as needed.
- The **Addictionologist or an Addiction Services Manager (ASM)** shall meet the

requirements of a licensed addiction counselor (LAC) or LMHP with at least seven (7) years of clinical experience with addiction treatment of adults and children experiencing substance use problems and disorders. The ASM shall be responsible for oversight and compliance with the addiction principles of care and application of American Society of Addiction Medicine (ASAM) placement criteria for all addiction program development. The ASM will work closely with the COO, the Behavioral Health Coordinator, the Quality Management Coordinator, and the Behavioral Health Medical Director in assuring quality, appropriate utilization management, and adequacy of the addiction provider network.

- The **Behavioral Health Case Management Supervisor** for specialized behavioral health services shall be a Louisiana-licensed psychiatrist or a Louisiana-licensed Mental Health Practitioner (i.e., Medical Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marital and Family Therapist, Licensed Addictions Counselor, or Advanced Practice Registered Nurse, who is a nurse practitioner specialist in Adult Psychiatric and Mental Health, family Psychiatric and Mental Health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health). A Case Management Supervisor for medical services is a Louisiana-licensed registered nurse. The Case Management Supervisor shall be responsible for all staff and activities related to the case management program, and shall be responsible for ensuring the functioning of case management activities across the continuum of care.
- The **Claims Administrator** shall be responsible for the administration of a comprehensive claims processing system capable of paying claims in accordance with state and federal requirements. The primary functions of the Claims Administrator are:
 - ❖ Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;
 - ❖ Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted;
 - ❖ Developing, implementing and monitoring the provision of care coordination, disease management and case management functions;
 - ❖ Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services; and,
 - ❖ Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards.

- The **Housing Specialist** shall be responsible for ensuring that enrollees transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of potential enrollees to Contractor's Permanent Supportive Housing liaison for application to the Louisiana Permanent Supportive Housing program. The Housing Specialist shall also serve on the multi-disciplinary care team.
- **Prior Authorization Staff** to authorize health care 24 hours per day, 7 days per week. This staff shall include a Louisiana licensed registered nurse, physician or physician's assistant. The staff will work under the direction of a Louisiana-licensed registered nurse, physician or physician's assistant.
 - ❖ The Contractor shall have a sufficient number of LMHPs, including licensed addiction counselors (LACs), as well as a board-certified psychiatrist and a board-certified addictionologist. If an addictionologist cannot be retained full-time due to limited availability, the Contractor shall contract with a qualified consultant. With the exception of the addictionologist who shall be available at least 10 hours per week, the other LMHPs shall be available 24 hours per day, 7 days per week. The Contractor shall provide UM staff, both experienced and specifically assigned to children, youth, adults, and older adults, and permanent support housing (PSH).
- **Concurrent Review Staff** to conduct inpatient concurrent review. This staff shall include of a Louisiana licensed nurse, physician, or physician's assistant. The staff will work under the direction of a Louisiana licensed registered nurse, physician or physician's assistant.
 - ❖ The Contractor shall have a sufficient number of LMHPs, including licensed addiction counselors (LACs), as well as a board-certified psychiatrist and a board-certified addictionologist. If an addictionologist cannot be retained full-time due to limited availability, the Contractor shall contract with a qualified consultant. With the exception of the addictionologist who shall be available at least 10 hours per week, the other LMHPs shall be available 24 hours per day, 7 days per week. The Contractor shall provide UM staff, both experienced and specifically assigned to children, youth, adults, and older adults, and permanent support housing (PSH).
- **Clerical and Support Staff** to ensure proper functioning of the MCO's operation.
- **Physical Health Provider Services Staff** to enable providers to receive prompt responses and assistance and handle physical health provider complaints and appeals. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution of their problems and inquiries and appropriate education about participation in the MCO and to maintain a sufficient provider network.
- **Behavioral Health Provider Services Staff** to enable providers to receive prompt responses

and assistance and handle behavioral health provider complaints and appeals. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution of their problems and inquiries and appropriate education about participation in the MCO and to maintain a sufficient provider network.

- **Peer Support Specialist staff** to focus on peer to peer activities providing advocacy and the creation of a system which will enable an individual's resiliency and recovery.
- **Enrollee Services Staff** to enable enrollees to receive prompt responses and assistance. There shall be sufficient Enrollee Services staff to enable enrollees and potential enrollees to receive prompt resolution of their problems or inquiries.
- **Claims Processing Staff** to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
- **Encounter Processing Staff** to ensure the timely and accurate processing and submission to LDH of encounter data and reports.
- **Care Management Staff** to assess, plan, facilitate and advocate options and services to meet the enrollees' health needs through communication and available resources to promote quality cost-effective outcomes. The Contractor shall provide and maintain in Louisiana, appropriate levels of care management staff necessary to ensure adequate local geographic coverage for in-field face-to-face contact with physicians and enrollees as appropriate and may include additional out of state staff providing phone consultation and support.
 - ❖ An adequate number of care management staff necessary to support enrollees in need of specialized behavioral health services shall be certified in treatment planning through the completion of specialized training in the Treatment Planning Philosophy.
 - ❖ For the population receiving specialized behavioral health services, the Contractor shall have integrated care management centers/care management staff that physically co-locate with care management staff. The Contractor shall employ case managers to coordinate follow-up to specialty behavioral health providers and follow-up with enrollees to improve overall health care.
 - ❖ The Contractor shall have an adequate number of care management staff necessary to support enrollees who meet target population criteria for the DOJ agreement. This care management staff for the DOJ Agreement Target Population shall include coverage for in field face-to-face contact with physicians/providers, enrollees, family members, LDH Transition Coordinators, and other community resources/supports as appropriate.

- **Fraud, Waste, and Abuse Investigators** are responsible for all fraud, waste, and abuse detection activities, including the fraud and abuse compliance plan, MCO employee training and monitoring, sampling investigation of paid claim discrepancies, and day-to-day provider investigation related inquiries.
- **Licensed Mental Health Professionals (LMHP)** to perform evaluations for adult mental health rehabilitation services. Whether through subcontract or direct employment, the Contractor shall maintain appropriate levels of LMHP staff to ensure adequate local geographic coverage for in field face-to-face contact with enrollees. LMHP staff must be trained to determine the medical necessity criteria as established by the State. LMHPs shall be certified in administering the Level of Care Utilization System (LOCUS).
- **LMHPs to perform PASRR Level II evaluations** upon referrals from OBH to assess the appropriateness of nursing facility placement and the need for, and facilitation of, behavioral health services. PASRR Level II evaluations must be performed by an LMHP independent of OBH and not delegated to a nursing facility or an entity that has a direct or indirect affiliation or relationship with a nursing facility as per 42 C.F.R. §483.106. Whether through subcontract or direct employment, the Contractor shall maintain appropriate levels of LMHP staff to ensure adequate local geographic coverage for in field face-to-face contact with enrollees in need of such evaluations. These staff must be administratively separate from staff performing utilization review but may be the same staff as listed under the "Licensed Mental Health Professionals (LMHP)" additional staff requirement.
- **Behavioral Health Liaisons and Coordination with Partner Agencies** — the Contractor shall have staff identified to provide liaison activities for the following entities. The liaison shall be available for response to inquiries within one (1) business day of inquiry. Any change in liaison personnel shall be sent to respective entity within 48 hours of notice to the Contractor.
 - ❖ A liaison dedicated solely to LDOE, DCFS and OJJ. This liaison shall also be responsible for outreach, education and community involvement for the court systems, education systems and law enforcement. This staff position must be located in Louisiana. The designated liaison must attend all CSoC Governance Board meetings. The liaison shall have experience in child welfare and delinquency. The liaison shall also outreach to local school systems to educate on the services available. The liaison shall be knowledgeable and provide education on the entire behavioral health service array including, CSoC, crisis services and process for obtaining services and out of home placements and process for placement.
 - ❖ A single point of contact dedicated to liaising with the judicial system. Functions include serving as a point of contact for judges, court personnel and appearing in court when requested by the court system or LDH. This contact shall also serve as a point of

contact for LDH legal and staff working with LDH custody cases. This person shall have familiarity with drug court, juvenile court, family court and criminal court processes and issues. This person shall provide continuous outreach and education to the judicial system on access to services. This staff person may also serve the function listed above as the DCFS/OJJ point of contact; however, if LDH determines the caseload to be too voluminous, LDH may request an additional staff person be hired.

- ❖ Local Governing Entity (LGE) liaison who shall serve as a point of contact for inquiries, barriers and resolution for LGEs. The liaison shall have experience with the LGE structure, services provided, members served and responsibilities. This liaison may be required to attend Human Services Interagency Council (HSIC) meetings if requested by LDH. The liaison shall have knowledge of the non-Medicaid uninsured system.
- ❖ Tribal liaison that is the single point of contact regarding delivery of covered services to Native Americans.
- ❖ Behavioral health consumer and family organizations liaison for children, youth and adults. This person shall be a peer, former consumer of services and/or in recovery. This liaison shall be engaged with the advocacy community.
- ❖ A Permanent Supportive Housing (PSH) program liaison, to be approved by LDH, to work with LDH PSH program staff to ensure effective implementation of PSH program deliverables.
An Intellectual/Developmental Disability (I/DD) liaison to work with OCDD staff to ensure effective medical and behavioral services are in place for the I/DD population. The liaison shall have knowledge of the I/DD service delivery system.
- ❖ A liaison dedicated to ensuring MCO compliance with both the provision of supports and services for individuals referred to and residing in Nursing Facilities (NF), as well as all activities related to the DOJ Agreement and the My Choice Louisiana program. The liaison shall ensure compliance with all requirements associated with these activities, including the provision of care management and services to populations impacted through these initiatives. The liaison shall respond to inquiries within one (1) business day. Any change in liaison personnel shall be sent to respective entity within 48 hours of notice to the Contractor.

2.3.2 MCO Policy and Provider Manual Submission Guidance

MCOs should submit clinical policies using the new *MCO Clinical Policy Submission and Attestation Form* as an informational filing only. This form provides for the submission of necessary documentation and confirmation that the MCO has researched and reviewed all appropriate sources to ensure clinical policies are not more restrictive than the Medicaid fee-for-service program. The

new process for clinical policy submission alleviates the requirement of policy approval by Medicaid. These clinical policies and attestation forms must be submitted to MCOPolicies@la.gov as well. Emails should not be sent to specific individuals or to ProviderRelations@la.gov.

All MCO non-clinical policy and provider manual changes must be sent to MCOPolicies@la.gov. Emails should **not** be sent to specific individuals or to ProviderRelations@la.gov. A brief description should be provided in the subject line, and revisions should have a redlined version attached. Appropriate LDH staff members will review new and revised submissions within 30 days, in most cases. If documents are submitted in bulk at one time, review may take longer than 30 days. **Reminder:** Providers must be notified at least 30 days prior to implementation of a new or revised policy or provider manual change.

Although the list below is not exhaustive, it should help in making the determination of what policies should be submitted.

Requires Medicaid Review and/or Approval:	Does Not Require Medicaid Review or Approval:
Incentive/VBP plans	Rebranding only
Coding changes	Non-material verbiage changes
Utilization management	Provider website/portal information
Policies affecting reimbursement	Refund letter templates
Provider Newsletters	Audit letter templates
	On-hold scripting/messaging

2.3.3 Material Subcontracts/Subcontractors

The Contractor shall request prior approval of all material subcontracts as defined in the Contract and amendments from LDH. To obtain such approval, the Contractor shall submit a written request and a completed material subcontractor checklist using the template attached. The request must also describe how the Contractor will oversee the material subcontractor.

2.3.4 Reports and Requests for Information

The Contractor shall comply with the timelines, definitions, formats and instructions contained in the Reporting Requirements appendix.

2.3.5 Integration Assessment of BH and PH

The Contractor must use an integration assessment tool to self-assess annually. The assessment should be inclusive of, but not limited to, such factors as provider locations, integrated or collocated provider numbers, programs focusing on enrollees with both behavioral health and primary care

needs, use of multiple treatment plans, and unified systems across behavioral and physical health management. This assessment must be approved by LDH and results reported annually to LDH.

The Contractor shall assist the State with the annual assessments of practice integration using the publicly available Integrated Practice Assessment Tool (IPAT) by sending the IPAT link provided by LDH to a statistically valid sampling of providers to include, but not be limited to, behavioral health providers and primary care providers: internists, family practitioners, pediatrics, OB-GYNs and any other providers that are likely to interface with BH populations. The Contractor shall use results of these assessments to guide integration efforts by the Contractor.

2.4 Eligibility and Enrollment

The Louisiana Medicaid managed care program is comprised of mandatory and voluntary opt-in populations. LDH is responsible for determining eligibility and enrolling individuals from these populations in the MCO, and the MCOs are required to accept these enrollees for the provision of covered services. Additional guidance regarding special populations and enrollment processes are provided in the following subsections.

2.4.1 Newborn Enrollment

The Contractor shall be responsible for ensuring that hospitals report the births of newborns within twenty-four (24) hours of birth for enrolled enrollees via the LDH Self-Service Provider Portal. If the enrollee makes a PCP selection during the hospital stay and one was not already identified, this information shall be reported to the MCO. If no selection is made, the Contractor shall provide the enrollee with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.

2.4.2 Justice-Involved Enrollees

LDH, in conjunction with the Department of Corrections (DOC), has developed a pre-release program for the offender population that is covered by Medicaid under the New Adult Group through Medicaid expansion. All justice-involved enrollees releasing from incarceration shall be enrolled in accordance with the process outlined in the **Justice-Involved Pre-Release Enrollment Program Manual**.

2.4.3 Eligibility Updates

The enrollment broker shall make available to the Contractor daily via electronic media (ASC X12N 834 Benefit Enrollment and Maintenance transaction), updates on beneficiaries newly enrolled into the MCO in the format specified in the **Systems Companion Guide**.

2.5 Services

The Contract identifies all services the Contractor must provide as well as the in lieu of services and value-added benefits that the Contractor may offer. Definitions for all MCO covered services are provided in this section, plus detailed descriptions, limitations, and additional guidelines for select services.

2.5.1 MCO Covered Services

- Physical Health Services
 - ❖ **Ambulatory Surgical Services:** Outpatient surgical and related diagnostic medical services.
 - ❖ **Audiology Services:** Audiologist exams and evaluations.
 - ❖ **Chiropractic Services** (ages 0-20): Medically necessary manual manipulations of the spine when the service is provided as a result of a referral from an EPSDT medical screening provider or Primary Care Provider (PCP).
 - ❖ **Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies:** Services include medical equipment, medical supplies, and appliances such as, but not limited to, wheelchairs, bed rails, crutches, leg braces, ostomy supplies, and diapers and blue pads for children aged 0-20.
 - ❖ **Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services** (excluding Applied Behavior Analysis (ABA) and dental services): Screening services include, but are not limited to, medical screenings (including immunizations and certain lab services), vision screenings, hearing screenings, dental screenings, lead screening, and periodic and interperiodic screenings, through a PCP or designee.
 - ❖ **Emergency Dental Services:** Dental services provided in an emergency room.
 - ❖ **Emergency Medical Services:** Emergency room services.
 - ❖ **Emergency Medical Transportation:** Transportation during an emergency via ambulance or helicopter.
 - ❖ **Non-Emergency Medical Transportation:** Transportation to and from medical appointments. The medical provider the beneficiary is being transported to does not have to be a Medicaid enrolled provider, but the services must be Medicaid-covered services. Enrollees under 17 years old must be accompanied by an attendant.
 - ❖ **Non-Emergency Ambulance Transportation:** Scheduled/regular non-emergency

transportation by which an ambulance is medically necessary. Enrollees under 17 years old must be accompanied by an attendant.

- ❖ **End Stage Renal Disease Services:** Dialysis treatment (including routine laboratory services), medically necessary non-routine lab services and medically necessary injections.
- ❖ **Eye Care and Vision Services:** Optometrist or ophthalmologist services and annual eye exam.
- ❖ **Eyewear** (ages 0-20): Regular eyeglasses when an enrollee meets a certain minimum strength requirement; medically necessary specialty eyewear and contact lenses with prior authorization; and contact lenses if they are the only means for restoring vision.
- ❖ **Family Planning Services:** Office visits, including a well visit and care related to family planning, including, but not limited to, birth control, cervical cancer screening and treatment, contraceptive counseling and education, treatment from complications from certain family planning procedures, voluntary sterilization for males and females (over age 21), HPV vaccine, and transportation to family planning appointments.
- ❖ **Federally Qualified Health Center (FQHC)/Rural Health Clinic Services:** Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists and dentists. Immunizations are covered for enrollees under age 21.
- ❖ **Home Health-Extended Services** (ages 0-20): Multiple hours of skilled nursing services, including all medically necessary medical tasks that are part of an enrollee's plan of care and can be administered at home.
- ❖ **Home Health Services:** Services include, but are not limited to, intermittent/part-time nursing services including skilled nurse visits, aide visits, physical therapy services, occupational therapy, and speech/language therapy.
- ❖ **Hospice Services:** Care provided by a certified hospice agency for terminally ill enrollees.
- ❖ **Immunizations:** For children—all immunizations; for adults (21 and older)—immunizations for flu, HPV, PPSV and tetanus.
- ❖ **Inpatient Hospital Services:** Inpatient hospital care needed for the treatment of an illness or injury which can only be provided safely and adequately in a hospital setting.

- ❖ **Lab and X-ray Services:** Most diagnostic testing and radiological services ordered by the attending or consulting physician. Portable (mobile) x-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician ordered x-rays.
- ❖ **Limited Abortion Services:** Prior authorized abortions in cases where (1) a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; or (2) the pregnancy is the result of an act of rape or incest.
- ❖ **Optical Services** (ages 0 -20): Examinations and treatment of eye conditions, including examinations for vision correction and refraction error. Other related services, if medically necessary.
- ❖ **Optometrist Services** (age 21 and older, non-EPSTD): Examinations and treatment of eye conditions, such as infections and cataracts.
- ❖ **Outpatient Hospital Services:** Includes diagnostic & therapeutic outpatient services, including, but not limited to, outpatient surgery and rehabilitation services, therapeutic and diagnostic radiology services, chemotherapy and hemodialysis.
- ❖ **Pediatric Day Healthcare Services:** Nursing care, respiratory care, physical therapy, speech-language therapy, occupational, personal care services and transportation to and from PDHC facility.
- ❖ **Personal Care Services** (ages 0-20): Includes basic personal care-toileting & grooming activities. Assistance with bladder and/or bowel requirements or problems, assistance with eating and food preparation. Performance of incidental household chores, only for the enrollee, and accompanying, not transporting, the enrollee to medical appointments. Personal care services do not include any medical tasks such as medication administration, tube feedings, urinary catheters, ostomy or tracheostomy care.
- ❖ **Pharmacy Services:** Outpatient prescription medicines on the Covered Drug List and all drugs deemed medically necessary for enrollees under the age of twenty-one (21).
 - Otherwise Restricted Drugs:
 - Agents used for cosmetic purposes or hair growth only when medical necessity has been determined.

- Select drugs for erectile dysfunction.
- ❖ **Physician/Professional Services:** Professional medical services including, but not limited to, those provided by a physician, nurse midwife, nurse practitioner, clinical nurse specialist, physician assistant or audiologist. Services also may include:
 - Advance Practice Registered Nursing Services;
 - Pediatric and Family Nurse Practitioner Services; and
 - Physician administered drugs.
- ❖ **Podiatry Services:** Office visits, certain radiology and lab procedures, and other diagnostic procedures.
- ❖ **Pregnancy-Related Services:** Office visits, pre and post-natal care and delivery, related lab and radiology services, and family planning services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant.
- ❖ **Rehabilitative Services:** Admissions to long-term care facility/nursing home for rehabilitative purposes.
- ❖ **Surgical Dental Services:** Outpatient surgical and related diagnostic dental services.
- ❖ **Therapy Services:** Including, but not limited to, audiological services, occupational therapy, physical therapy, and speech and language therapy.
- ❖ **Tobacco Cessation Services:** Cessation medications and, for pregnant women, individual or group cessation counseling, telephone quit-line support, and/or intensive cessation support services.
- Behavioral Health Covered Services
 - ❖ **Basic Behavioral Health Services:** Services provided through primary care, including, but not limited to, screening for mental health and substance use issues, prevention, early intervention, medication management, and treatment and referral to specialty services.
 - ❖ Specialized Behavioral Health Services
 - Licensed Practitioner Outpatient Therapy, including, but not limited to, individual outpatient psychotherapy, family outpatient psychotherapy; group outpatient

psychotherapy; mental health assessment; evaluation; testing; medication management; psychiatric evaluation; medication administration; and individual therapy with medical evaluation and management and case consultation.

- Psychiatrist (all ages): visits with a licensed psychiatrist or psychiatric nurse practitioner.

❖ Mental Health Rehabilitation Services

- Community Psychiatric Support and Treatment (CPST): supportive interventions that are provided in the home, at work or at school.
- Community Psychiatric Support and Treatment (CPST), specialized for high-risk populations. This includes, but it not limited to:
 - Multi-Systemic Therapy (MST) (under age 21): family-based services aimed at keeping the youth at home and providing a more safe, secure and enhanced quality of life for the family.
 - Functional Family Therapy (FFT) (under age 21): a systems-based, strength-based model of intervention/prevention focused on reducing negative behaviors, increasing family communication, parent practices and problem solving skills, and increasing family's ability to access community resources.
 - Homebuilders® (under age 21): an intensive, home-based, evidence based practice using motivational interviewing, cognitive and behavioral interventions, relapse prevention and skills training, for families with children at risk of imminent out of home placement, or being reunified from placement.
 - Assertive Community Treatment (age 18 and older): an intensive team-based service that is strength-based and focused on promoting symptom stability and supporting individuals to remain in the community.
- Psychosocial Rehabilitation (PSR): community-based services which provide assistance in day-to-day life skills designed to help enrollees achieve their goals and work and live in the community.
- Crisis Intervention: services provided to an individual experiencing a psychiatric crisis that are designed to interrupt and/or ameliorate a crisis experience through a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services.

- Crisis Stabilization (under age 21): services intended to provide short-term and intensive support resources for the youth and his family, focused on providing an out-of-home crisis stabilization option for the family in order to avoid potential inpatient placement.
- ❖ **Therapeutic Group Homes (TGH)** (under age 21): Community-based 24-hour live-in services where the youth lives in a homelike setting with other youth to receive behavioral health services. Therapeutic Group Homes have a non-Medicaid funded room and board component that must be addressed prior to placement.
- ❖ **Psychiatric Residential Treatment Facilities (PRTF)** (under age 21): long term residential care in a 24-hour group living facility for enrollees under age 21.
- ❖ **Inpatient Hospitalization** (age 21 and under; 65 and older) for Behavioral Health Services.
- ❖ **Outpatient and Residential Substance Use Disorder Services** in accordance with the American Society of Addiction Medicine (ASAM) levels of care.
- ❖ **Medication Assisted Treatment**, including buprenorphine and naltrexone, available in multiple settings including residential settings.
- **Applied Behavioral Analysis Therapy** (under age 21): The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior.

2.5.2 Applied Behavior Analysis (ABA)

The Contractor shall coordinate and ensure continuity of care between behavioral health specialists, primary care physicians, and other health care specialists, including but not limited to, providers qualified to perform Comprehensive Diagnostic Evaluations (CDE), occupational therapists, physical therapists, and speech therapists as indicated and based on medical necessity criteria for such services.

The Contractor shall ensure enrollee and provider call center staff and utilization management staff are knowledgeable in ABA services. Staff shall be capable of providing an explanation of ABA services, a list of ABA providers, and information regarding the prior authorization process to enrollees or providers seeking information.

ABA service shall not be denied solely because an enrollee does not have an Autism Spectrum Disorder (ASD) diagnosis.

2.5.3 DME, Prosthetics, Orthotics, and Certain Supplies (DMEPOS)

The Contractor shall provide coverage for medically necessary durable medical equipment, prosthetics, orthotics, certain supplies, appliances, and assistive devices including, but not limited to, hearing aids for enrollees under the age of 21. DME for those under 21 includes disposable incontinence supplies and enteral formula.

2.5.4 EPSDT Program

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is a comprehensive and preventive child health program for individuals under the age of 21. The EPSDT statute and federal Medicaid regulations require that states cover all services within the scope of the federal Medicaid program, including services outside the Louisiana Medicaid State Plan, if necessary to correct or ameliorate a known medical condition.

The program consists of two mutually supportive, operational components: (1) ensuring the availability and accessibility of required health care services; and (2) helping Medicaid enrollees and their parents or guardians effectively use these resources. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

The Contractor is responsible for the provision of screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (The EPSDT benefit guarantees coverage of “screening services” which must, at a minimum, include a comprehensive health and developmental history – including assessment of both physical and mental health.) Section 1905(r)(1)(B)(i) of the Social Security Act, 42 U.S.C. §1396d(r)(1)(B)(i)).

The Contractor shall have written procedures for EPSDT services in compliance with 42 C.F.R. Part 441 Subpart B-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), as well as be in compliance with the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, Part 5 – EPSDT. These articles outline the requirements for EPSDT, including assurance that all EPSDT eligible members are notified of EPSDT available services; that necessary screening, diagnostic, and treatment services are available and provided; and tracking or follow-up occurs to ensure all necessary services were provided to all of the Contractors’ enrollees under the age of 20.

The Contractor shall comply with the Louisiana Medicaid EPSDT Periodicity Schedule published at www.lamedicaid.com for the health supervision of infants, children and individuals under the age of 21 years related to medical screenings, developmental and behavioral assessments, applicable procedures, and sensory screenings guidelines. LDH has adopted the Bright Futures EPSDT Periodicity Schedule promulgated by the American Academy of Pediatrics with two exceptions:

- The LDH guidelines are for individuals under 21 years of age (The AAP Bright Futures EPSDT

Periodicity Schedule provides guidance for patients through age 21); and

- The LDH schedule has stricter requirements for lead assessment and blood lead screening.

The Contractor shall accurately report, via encounter data submissions all EPSDT and well-child services, blood lead screening access to preventive services, and any other services as required for LDH to comply with federally mandated CMS 416 reporting requirements.

- See **Systems Companion Guide** for format and timetable for reporting of EPSDT data.
- LDH shall use encounter data submissions to determine the Contractor's compliance with the state's established EPSDT goal of ensuring eighty percent (80%) of eligible enrollees under the age of twenty-one (21) are receiving EPSDT well-child visits in accordance with the periodicity schedule. Some EPSDT preventive screening claims should be submitted sooner than within twelve (12) months from date of service due to the fact that the screenings periodicity can range from every two months and up.

2.5.5 Eye Care and Vision Services

The Contractor shall not require a referral for in-network providers.

The Contractor's requirements for provision and authorization of services within the scope of licensure for optometrists cannot be more stringent than those requirements for participating ophthalmologists.

2.5.6 Family Planning Services

The Contractor shall provide coverage for family planning services, including but not limited to:

- Comprehensive medical history and physical exam at least once per year. This visit includes anticipatory guidance and education related to enrollees' reproductive health/needs;
- Contraceptive counseling to assist enrollees in reaching an informed decision (including natural family planning, education follow-up visits, and referrals);
- Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health;
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered;
- Pharmaceutical supplies and devices to prevent conception, including all methods of

contraception approved by the Federal Food and Drug Administration;

- Male and female sterilization procedures provided in accordance with 42 C.F.R. Part 441, Subpart F;
- Treatment of major complications from certain family planning procedures such as: treatment of perforated uterus due to intrauterine device insertion; treatment of severe menstrual bleeding caused by a medroxyprogesterone acetate injection requiring dilation and curettage; and treatment of surgical or anesthesia-related complications during a sterilization procedure; and
- Transportation services to and from family planning appointments provided all other criteria for Non-Emergency Medical Transportation (NEMT) are met.

Family planning services shall also include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection or treatment of sexually transmitted infections (STIs), and age-appropriate vaccination for the prevention of HPV and cervical cancer. Prior authorization shall not be required for treatment of STIs.

The Contractor shall address high STI prevalence by incentivizing providers to conduct screening, prevention education and early detection, including targeted outreach to at risk populations.

The Contractor shall ensure that its enrollees have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 C.F.R. §431.51(b)(2).

The out-of-network Medicaid enrolled family planning services provider shall bill the Contractor and be reimbursed no less than the fee-for-service rate in effect on the date of service.

The Contractor shall encourage its enrollees to receive family planning services through the Contractor's network of providers to ensure continuity and coordination of an enrollee's total care. No additional reimbursements shall be made to the Contractor for MCO enrollees who elect to receive family planning services outside the MCO's provider network.

The Contractor shall encourage family planning providers to communicate with the enrollee's PCP once any form of medical treatment is undertaken.

The Contractor shall maintain accessibility for family planning services through promptness in scheduling appointments (appointments available within one (1) week).

The Contractor shall not provide assisted reproductive technology for treatment of infertility.

2.5.7 Home Health Services

A home health agency (HHA) enrolled in the Louisiana Medicaid Program provides patient care services in the enrollee's residential setting, under the order of a physician, that are necessary for the diagnosis and treatment of the enrollee's illness or injury. Such services include part-time skilled nursing services, extended skilled nursing services (for enrollees under 21 years of age), home health aide services, physical therapy (PT), speech therapy (ST), occupational therapy (OT) and medical supplies recommended by the physician as required in the care of the enrollee and suitable for use in any setting in which normal life activities take place.

Covered home health services include the following:

- Skilled Nursing (Intermittent or part-time)
- Home Health Aide Services are provided in accordance with the plan of care as recommended by the attending physician.
- Extended Skilled Nursing Services (also referred to as Extended Home Health), as part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, is extended nursing care by a an RN or a licensed practical nurse (LPN) and may be provided to enrollees under age 21 who are considered "medically fragile".
- Rehabilitation Services are physical, occupational and speech therapies, including audiology services.
- Medical Supplies, Equipment and Appliances as recommended by the physician, required in the POC for the beneficiary and suitable for use in any setting in which normal life activities take place are covered under the Durable Medical Equipment (DME) program when approved by the Prior Authorization Unit (PAU).

A face-to-face encounter between the patient and the physician or an allowed non-physician provider (NPP) must occur no more than 90 days prior to, or 30 days after, admission to the home health agency.

2.5.8 Hysterectomies

The Contractor shall cover the cost of medically necessary hysterectomies as provided in 42 C.F.R. §441.255.

Non-elective, medically necessary hysterectomies provided by the Contractor shall meet the following requirements:

- The enrollee or her representative, if any, must be informed orally and in writing that the

hysterectomy will render the individual permanently incapable of reproducing;

- The individual or her representative, if any, must sign and date the **Acknowledgment of Receipt of Hysterectomy Information** form prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.
 - ❖ The **Acknowledgment of Receipt of Hysterectomy Information** form is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.
 - ❖ The **Acknowledgment of Receipt of Hysterectomy Information** form is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required.

Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

2.5.9 Immunizations

The Contractor shall provide all enrollees with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

The Contractor shall ensure that all providers use vaccines available without charge under the Vaccine for Children (VFC) Program for Medicaid children eighteen (18) years old and younger. Immunizations shall be given in conjunction with EPSDT/Well Child visits or when other appropriate opportunities exist.

The Contractor's providers shall report the required immunization data into the Louisiana Immunization Network for Kids (LINKS) administered by the LDH/Office of Public Health.

The Contractor shall provide all enrollees twenty-one (21) years of age and older with all vaccines and immunizations in accordance with State Plan services as identified at: http://www.lamedicaid.com/provweb1/fee_schedules/Immune_FS_Adults_6.pdf.

2.5.10 Institutional Long-Term Care Facilities/Nursing Homes

The Contractor shall cover enrollee admissions to a long-term care facility/nursing home for rehabilitative purposes and prior to the time the enrollee is disenrolled from the MCO.

2.5.11 Laboratory and Radiological Services

The Contractor shall provide inpatient and outpatient diagnostic laboratory testing, therapeutic radiology, and radiological services ordered and/or performed by network providers.

The Contractor is responsible for laboratory or radiological services that may be required to treat an emergency or provide surgical services for an excluded service, such as dental services.

The Contractor shall provide clinical lab services and portable (mobile) x-rays for enrollees who are unable to leave their place of residence without special transportation or assistance to obtain PCP ordered laboratory services and x-rays.

The Contractor may require service authorization for diagnostic testing and radiological services ordered or performed by any provider for their enrollees.

2.5.12 Limitations on Abortions

The Contractor shall provide prior authorization for abortions in accordance with 42 C.F.R. Part 441, Subpart E, and the requirements of the Hyde Amendment (currently found in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2014, Public Law 113-76, Division H, Title V, §506 and §507) and only if:

- A woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician place the woman in danger of death unless an abortion is performed; or
- The pregnancy is the result of an act of rape or incest.

For abortion services performed because of a life-endangering physical condition, a physician must certify in their handwriting, that on the basis of their professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term. The provider shall:

- Attach the certification statement to the claim form that shall be retained by the Contractor. The certification statement shall contain the name and address of the patient. The diagnosis or medical condition which makes the pregnancy life endangering shall be specified on the claim.

For abortion services performed as the result of an act of rape or incest the following requirements shall be met:

- The enrollee shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest;
- The report of the act of rape or incest to law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest shall be submitted to the Contractor along with the treating physician's claim for reimbursement for performing an abortion;
- The enrollee shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician; and
- The **Certification of Informed Consent--Abortion**, which must be obtained from the Louisiana Office of Public Health via this [request form](#), shall be witnessed by the treating physician. Providers shall attach a copy of the **Certification of Informed Consent--Abortion** form to their claim form.
- All claim forms and attachments shall be retained by the Contractor. The Contractor shall forward a copy of the claim and its accompanying documentation to LDH.
- The Contractor shall provide no other abortions, regardless of funding, under this Contract.
- The Contractor shall not make payment for any core benefit or service under the Contract to a network or non-network provider if any abortion performed hereunder violates federal regulations (Hyde Amendment).

2.5.13 Maternity Services

The Contractor shall provide coverage for a hospital stay following a normal vaginal delivery of at least 48 hours for both the mother and newborn child, and at least 96 hours following a cesarean section for both mother and newborn child. All medically necessary procedures listed on the claim are the responsibility of the Contractor regardless of primary or secondary mental health diagnosis appearing on the claim.

2.5.14 Medical Transportation Services

- The Contractor shall provide emergency and non-emergency medical transportation for its enrollees. The Contractor may provide these services through a transportation broker.
- Coverage information by enrollment type is provided in the following matrix:

Enrollment	Non-Ambulance	Non-Emergency Ambulance	Emergency Ambulance
Managed care for physical and behavioral health	MCO	MCO	MCO
Managed care for physical health only (CSoc children)	MCO	MCO	MCO
Managed care for behavioral health only	MCO	MCO	MCO
Nursing home residents	Included in facility per diem	MCO	MCO – month of admission* FFS Medicaid – subsequent months
Children in ICF-DDs	Included in facility per diem	MCO	FFS Medicaid
Adults in ICF-DDs	Included in facility per diem	FFS Medicaid	FFS Medicaid
Excluded populations	FFS Medicaid	FFS Medicaid	FFS Medicaid

**During the single transitional month where an enrollee is both in a P-linkage and certified in LTC, the MCO will remain responsible for all transportation services that are not the responsibility of the nursing facility.*

- The Contractor shall establish and maintain a transportation call center which shall be responsible for scheduling all NEMT and Non-Emergency Ambulance Transportation (NEAT) reservations and dispatching of trips during the business hours of 7:00am to 7:00pm Monday through Friday, with the exception of recognized state holidays. The call center shall adhere to the call center performance standards specified in the Contract.
- The Contractor shall provide NEMT to and from all covered services (including carved out services) for those enrollees who lack viable alternate means of transportation.
- NEMT to non-Medicaid covered services is not a Medicaid covered service.
- NEMT transportation includes the following, when necessary to ensure the delivery of necessary medical services:
 - ❖ Transportation for the enrollee and one attendant, by any means permitted by law, including but not limited to the requirements of La. R.S. 40:1203.1 et seq.;
 - ❖ The use of any service that utilizes drivers that have not met the requirements of La. R.S. 40: 1203.1 et seq. is strictly prohibited; and
 - ❖ For trips requiring long distance travel, the cost of meals and lodging and other related

travel expenses determined to be necessary to secure medical examinations and treatment for a enrollee.

- The Contractor must have an established process for coordinating medically necessary long distance travel for enrollees who require covered Medicaid state plan services out of state. This may include air travel, lodging, and reimbursement for meals, as supported by medical necessity.
 - ❖ Coverage and reimbursement for meals and lodging for both the enrollee and one attendant, shall be included when treatment requires more than twelve (12) hours of total travel. "Total travel" includes the duration of the health care appointment and travel to and from that appointment.
 - ❖ The Contractor shall allow for meals and lodging, for each trip that are not otherwise covered in the inpatient per diem, primary insurance, or other payer source.
 - ❖ If the Contractor denies meals and lodging services to an enrollee who requests these services, the enrollee must receive a written notice of denial explaining the reason for denial and the enrollee's right to an appeal.
- The Contractor shall provide transportation to a covered service even where other primary private insurance coverage is responsible for the service provision, including out of state services.
- The Contractor may require prior authorization and/or scheduling of NEMT and may require documentation to verify coverage of medical services by the primary insurer prior to approval.
 - ❖ For all NEMT services requiring scheduling and/or prior authorization, the Contractor shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of the request for services. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service or no less than 24 hours prior to the date of service, unless the request is received less than 48 hours prior to service.
 - ❖ In cases where the request is made less than 48 hours in advance of needed transportation, the Contractor shall make reasonable efforts to schedule transportation and provide notice in advance of the scheduled appointment.
 - ❖ Expedited service authorizations for services that are deemed urgent but not emergent, shall be determined by the Contractor as expeditiously as the enrollee's health condition requires. For NEMT ambulance services the timeframe for approval must allow ambulance providers to comply with any local ordinances governing their

response times.

- MCO Transportation Broker

The Contractor may elect to contract with a transportation broker. Whether provided directly or through such broker, the Contractor shall ensure:

- ❖ Transportation providers are selected to ensure proximity to the enrollee to the maximum extent reasonable given all other contractual, legal, and regulatory requirements;
- ❖ Maintenance, by the Contractor or its transportation broker, in an electronic format, of all records necessary to establish and validate NEMT claims, including but not limited to:
 - Authorization data, including all enrollee, provider, pick-up, drop-off, and mileage information necessary to establish a claim or as requested by LDH;
 - Trip dispatch and passenger records, including logs and driver and passenger transportation verifications; and
 - Vehicle and driver compliance records, including all required licensure and credentialing;
- ❖ All NEMT service claims are reviewed against physical claims for potential abuse and affirmatively reported to LDH upon reasonable suspicion of impropriety; and
- ❖ LDH is able, without additional expense to LDH, within three (3) business days of a written request by LDH, to inspect, audit, and copy all records maintained by the Contractor or its transportation broker in compliance with this agreement.

2.5.15 Perinatal Services

The Contractor will include in the proposal a plan to address prematurity prevention and improved perinatal outcomes. The plan may include but not be limited to the following:

- Routine cervical length assessments for pregnant women;
- Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy. The Contractor shall not require prior authorization of progesterone for the prevention of premature birth unless written approval from the Medicaid Medical Director is obtained. The Contractor will provide progesterone access to eligible enrollees in a timely fashion.

- Incentives for vaginal birth after cesarean (VBAC);
- Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery; and
- Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age

The Contractor shall provide case management services to women postpartum who were identified as high risk during the pregnancy or who have had an adverse pregnancy outcome during the pregnancy including preterm birth less than 37 weeks. Case management services shall include referral to safety net services for inter-pregnancy care and breastfeeding support (if indicated).

2.5.16 Pharmacy Services

The MCO may follow the FFS limit of four prescriptions per calendar month. However, it may not enact prescription limits more stringent than the Medicaid State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber

Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.

- Covered Drug List
 - ❖ In accordance with 42 C.F.R. §438.3, the MCO shall maintain a Covered Drug List (CDL) which includes all outpatient drugs for which the manufacturer has entered into a Federal rebate agreement and met the standards in Section 1927 of the Social Security Act.
 - ❖ The CDL shall include all drugs deemed medically necessary for enrollees under the age of twenty-one (21).
 - ❖ The CDL shall exclude only those drugs or drug categories permitted for exclusion under Section 1927(d) of the Social Security Act, with exceptions listed in the Louisiana State Plan.
 - ❖ The CDL shall be updated at least weekly using a national drug database.
 - ❖ When drugs (OTC or legend) are being covered as a pharmacy benefit and offered as a value-added benefit, pharmacy encounters shall indicate such in the Character 1: Submission type (Q, F, or V) of the 4-character prefix on the ICN of the Rx encounter.

- ❖ The MCO may apply Point of Sale safety and utilization edits that align with FDA indications.
 - ❖ Self-administered drugs dispensed by a pharmacy, including specialty pharmacies, shall be covered as a pharmacy benefit unless otherwise approved by LDH.
 - ❖ Physician-administered drugs that are not listed on the FFS fee schedule but for which the manufacturer has signed a federal rebate agreement shall be covered as either a pharmacy benefit or a medical benefit. If the physician administered drug is not on the FFS fee schedule, but the MCO covers as a medical benefit, then reimbursement shall be set as a minimum by the current FFS reimbursement methodology in the state plan.
- Preferred Drug List
 - ❖ A subset of the CDL shall be the Preferred Drug List (PDL).
 - ❖ The PDL shall be established by LDH and indicate the preferred and non-preferred status of covered drugs.
 - ❖ The PDL shall be maintained by LDH and made available on the LDH website. The MCO shall make the PDL available to its providers and enrollees through electronic prescribing tools and a static link on the MCO website to the PDL maintained on the LDH website.
 - ❖ LDH shall provide the MCO with a list of drugs included on the PDL by NDC number after each FFS P&T meeting and upon the Secretary's approval of P&T committee recommendations. Changes shall be implemented January 1 and July 1 after FFS P&T, unless otherwise directed by LDH. LDH shall provide the MCOs at least 30 days written notice prior to the implementation date of any changes to the list of drugs included on the PDL.
 - ❖ LDH shall monitor the rate of MCO compliance with the PDL. Compliance rate shall be defined as the number of preferred prescriptions paid divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL. The MCO shall maintain a 92 percent compliance rate.
 - ❖ The MCO shall not enter into agreements with manufacturers to acquire discounts or rebates on drugs.
 - ❖ New drugs entering the marketplace in the PDL therapeutic classes shall be added as non-preferred until FFS P&T reviews the drug, unless otherwise directed by LDH.
 - ❖ If a branded product with generic available is preferred on the PDL, the MCO shall not

require the prescriber to indicate in writing that the branded product is medically necessary. The MCO shall reimburse for a brand name drug at a brand reimbursement when the brand drug is preferred. POS denial messaging for the generic entity shall indicate that the brand name is preferred.

- ❖ DXC (formerly Molina) will post weekly drug file data for the MCOs. MCOs shall have 72 hours after receipt of file to download and implement drug file data.
- ❖ There shall be a mandatory generic substitution for drugs outside the PDL, when a generic is available.
- Behavioral Health Specific Pharmacy Policies and Procedures

The MCO shall develop LDH approved policies and procedures that meet or exceed the following requirements:

- ❖ The MCO or its subcontractor(s) shall contract with the psychiatric facilities and residential substance use facilities so that the plans are notified upon patient admission and upon patient planned discharge from the psychiatric facility or residential substance use facilities. Prior to discharge the MCO shall be informed of the recipient's discharge medications. The MCO shall then be responsible to override or allow all behavioral health discharge medications to be dispensed by overriding prior authorization restrictions for a ninety (90) day period. This includes, but is not limited to, naloxone, Suboxone, and long-acting injectable anti-psychotics.
- ❖ If the MCO is not notified prior to the discharge and the enrollee presents at the pharmacy with a medication issued at the time of discharge, the MCO shall provide a prior authorization override for a ninety (90) day period from the date of discharge as long as the enrollee presents the prescription within ninety (90) days of being discharged from a psychiatric and/or residential substance use facility.
- ❖ The MCO shall have a specific Suboxone, Subutex and methadone management program and approach, which shall be approved by LDH. The policy and procedure must be in accordance with current state and federal statutes in collaboration with the State Opioid Treatment Authority/LDH.
- ❖ The MCO shall have a LDH approved pharmacy management program and approach to stimulant prescribing for children under age 6, and persons age 18 or older.
- ❖ The MCO shall have a LDH approved program and approach for the prescribing of antipsychotic medications to persons under 18 years of age.

- ❖ The MCO shall use encounter, beneficiary, and prescription data to compare Medicaid physician, medical psychologist or psychiatric specialist APRN's prescribing practices to nationally recognized, standardized guidelines, including but not limited to, American Psychiatric Association Guidelines, American Academy of Pediatrics Guidelines, American Academy of Child, and Adolescent Psychiatry Practice Parameters.
- Opioid Prescription Policy
 - ❖ Acute Pain
 - 7-day quantity limit for opioid-naïve recipients or Morphine Milligram Equivalent (MME) limit of 90 milligram per day, whichever is less. Opioid-naïve recipient would be identified by no opioid claims in the most current 90 days.
 - ❖ Chronic Pain
 - Morphine Milligram Equivalent (MME) limit of 90 milligram per day for all opioid prescriptions.
 - ❖ Exemptions that bypass opioid quantity limits shall include:

Diagnosis Exemption Chart	
DIAGNOSIS DESCRIPTION	CODE
Cancer	C00.* – C96.*
Palliative Care	Z51.5
Burn of second or third degree of head, face and neck	T20.2* – T20.3*
Corrosion of second or third degree of head, face and neck	T20.6* – T20.7*
Burn of second or third degree of trunk	T21.2* – T21.3*
Corrosion of second or third degree of trunk	T21.6* – T21.7*
Burn of second or third degree of shoulder and upper limb, except wrist and hand	T22.2* – T22.3*
Corrosion of second or third degree of shoulder and upper limb, except wrist and hand	T22.6* – T22.7*
Burn of second or third degree of wrist and hand	T23.2* – T23.3*
Corrosion of second or third degree of wrist and hand	T23.6* – T23.7*
Burn of second or third degree of lower limb, except ankle and foot	T24.2* – T24.3*
Corrosion of second or third degree of lower limb, except ankle and foot	T24.6* – T24.7*
Burn of second or third degree of ankle and foot	T25.2* – T25.3*
Corrosion of second or third degree of ankle and foot	T25.6* – T25.7*
Hb-SS disease with crisis	D57.0
Hb-SS disease with crisis, unspecified	D57.00
Hb-SS disease with acute chest syndrome	D57.01

Hb-SS disease with splenic sequestration	D57.02
Sickle-cell/Hb-C disease with crisis	D57.21
Sickle-cell/Hb-C disease with acute chest syndrome	D57.211
Sickle-cell/Hb-C disease with splenic sequestration	D57.212
Sickle-cell/Hb-C disease with splenic sequestration	D57.219
Sickle-cell thalassemia with crisis	D57.41
Sickle-cell thalassemia with acute chest syndrome	D57.411
Sickle-cell thalassemia with splenic sequestration	D57.412
Sickle-cell thalassemia with crisis, unspecified	D57.419
Other sickle-cell disorders with crisis	D57.81
Other sickle-cell disorders with acute chest syndrome	D57.811
Other sickle-cell disorders with splenic sequestration	D57.812
Other sickle-cell disorders with crisis, unspecified	D57.819

- Medication Therapy Management

- ❖ General Requirements

- Within 90 days of implementation, the MCO shall implement a Medication Therapy Management (MTM) program for targeted recipients enrolled in the plan. The MTM program shall include participation from community pharmacists, and include both in-person and telephonic interventions with trained clinical pharmacists, MTM providers and enrollees. If the MCO utilizes a contractor for MTM services, the MCO shall ensure all requirements are met. The MCO and/or contractor shall not limit MTM services to less than 1% of enrollees meeting MTM criteria. MTM shall be executed as specified herein.
- Reimbursement for MTM services with participating pharmacists shall be separate and above dispensing and ingredient cost reimbursement.
- The MCO shall have established an MTM program that:
 - is comprehensive and patient-centered;
 - is designed to increase medication adherence;
 - is designed to ensure that medications are appropriately used to optimize therapeutic outcomes through improved medication use;
 - is designed to reduce the risk of adverse events from medication therapy;
 - may be administered by a pharmacist or other qualified providers, such as physicians, nurse practitioners, physician assistants, or nurses;

- shall be developed in cooperation with licensed and practicing pharmacists and physicians; and
- shall include coordination between the MCO, the enrollee, the pharmacist and the prescriber using various means of communication.
- To assess the enrollee's medication therapy, the MTM program shall include an interactive comprehensive medication review (CMR), which includes recipient discussion and prescriber intervention if needed. This results in the creation of a written summary and is followed by frequent monitoring with further interventions as needed.

❖ Enrollment

- MCOs shall enroll targeted recipients in an opt-out method of enrollment only. The enrolled recipients may choose to opt-out of the program if desired at any time.
- MCOs shall auto-enroll the targeted recipients each year when they meet the eligibility criteria, and they are considered enrolled unless the recipient declines enrollment.
- MCOs shall use more than one approach to reach all eligible targeted recipients to offer MTM services versus only reaching out via passive offers.

❖ Targeted Recipients

- The MTM program may include recipients with multiple chronic diseases or any specific chronic disease may be targeted. If the MTM program is designed to target individual specific chronic diseases, then the program shall include at least three of the following:
 - Behavioral Health (such as Alzheimer's Disease, Bipolar Disorder, Depression, Schizophrenia, or Other Chronic/Disabling Mental Health Conditions);
 - Bone Disease-Arthritis (such as Osteoporosis, Osteoarthritis, or Rheumatoid Arthritis);
 - Cardiovascular Disease (such as Dyslipidemia, Heart Failure, or Hypertension);
 - Diabetes;
 - End-Stage Renal Disease (ESRD);

- Hepatitis C Infection;
- Respiratory Disease (such as Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disorders); and
- Substance Use Disorder.
- MCOs should also offer MTM services to an expanded population of recipients who do not meet the eligibility criteria but would benefit from MTM services. MCOs shall also leverage effective MTM to improve safety (e.g., increase adherence to medications, reduce the use of high-risk medications, and address issues of overutilization).
- ❖ Required MTM Services
 - MCOs shall offer a minimum level of MTM services to each recipient enrolled in the program that includes all of the following:
 - Interventions for both recipients and prescribers, as needed; and
 - An annual Comprehensive Medication Review (CMR) with written summaries created in a standardized format approved by the Louisiana Department of Health; and
 - Targeted Medication Reviews (TMRs), when needed, with follow-up interventions when necessary.
- ❖ Comprehensive Medication Review
 - CMR is a systematic process of:
 - Collecting patient-specific information;
 - Assessing medication therapies to identify medication-related problems;
 - Developing a prioritized list of medication-related problems; and
 - Creating a plan to resolve them with the patient, caregiver and/or prescriber.
 - MCOs shall offer a CMR to all recipients enrolled in the MTM program at least annually.
 - MCOs shall offer to provide a CMR to newly targeted recipients as soon as possible after enrollment into the MTM program, but no later than 60 days after

being enrolled in the MTM program.

- The recipient's CMR shall be conducted using an interactive, person-to-person review (including prescriptions, over-the-counter medications, herbal therapies and dietary supplements) performed by a pharmacist or other qualified provider, and may result in a recommended medication action plan.
- A written summary of the results of the review shall be provided to the targeted individual(s) in a standardized format approved by the Louisiana Department of Health and shall include the following:
 - Any concerns the recipient may have regarding their drug therapy; and
 - Purpose and instructions for use of the recipient's medications; and
 - Personal medication list (including prescription, non-prescription drugs, and supplements) which will aid in assessing medication therapy and engaging the recipient in management of their drug therapy.
- MCOs shall encourage recipients to take their action plan and personal medication list from their CMR to any medical encounter (such as physician visit, pharmacy, or hospital admission). This summary shall serve as a valuable tool to share information across providers and help reduce duplicate therapy and drug-drug interactions.

❖ Targeted Medication Review (TMR)

- The MCO shall perform TMRs when needed to address potential or specific medication-related problems, to assess any transition of care the recipient may have experienced, or to monitor new, unresolved, or continued medication therapies. The findings of the TMR shall then be reviewed to determine if a follow-up intervention is needed for the recipient or the prescriber. MCOs may determine how to tailor the follow-up intervention based on the specific needs or medication use issues of the recipient. For example, these interventions may be person-to-person or telephonic.

❖ Outcomes Measurement

- The MCO shall have a process in place to measure, analyze, and report the outcomes of their MTM program. This process shall include whether the goals of therapy have been reached and shall capture drug therapy recommendations and resolutions made as a result of MTM recommendations. A recommendation is

defined as a suggestion to take a specific course of action related to the recipient's drug therapy. Examples of drug therapy problem recommendations made as a result of MTM services and recommendations include, but are not limited to:

- Needs additional therapy;
- Unnecessary drug therapy;
- Dosage too high;
- Dosage too low;
- Adverse drug reaction;
- Medication non-adherence;
- Initiate drug;
- Change drug (such as product in different therapeutic class, dose, dosage form, quantity, or interval);
- Discontinue or substitute drug (such as discontinue drug, generic substitution, therapeutic substitution, or formulary substitution); or
- Medication adherence.

❖ Quarterly Reporting Requirements

- Reporting is an important factor in determining the effectiveness of an MTM program. MCOs shall document interventions, contact attempts, number of enrollees enrolled, and other associated parameters. Report requirements include, but are not limited to the following:
 - Enrollee enrollment parameters
 - Number of contact encounters and contact-related outcomes
 - Number of MTM interventions, both telephonic and face-to-face
 - Number of comprehensive medication reviews
 - Number of drug therapy problems identified, such as potential drug-drug interactions, adverse events, or the simplification of a complex regimen with the same therapeutic benefit

- Number of drug therapy problems resolved, such as modifications to drug dose, form, or frequency or changes in drug regimen due to identification of potential adverse event or interaction.
- If specific disease states are targeted, include the following:
 - Number of drug-related parameters improved, such as improved adherence in disease-specific medication regimen, modifications in drug therapy to reflect appropriate current treatment guidelines, or disease-related laboratory test monitoring.
 - Percentage of the MCO's recipient population with each targeted disease state that received MTM services
 - An example of a positive outcome demonstrated by MTM interventions for each targeted disease state. Examples include improvement in blood pressure measurements, A1C levels, LDL levels, etc.
 - This information shall be submitted to the Louisiana Department of Health on a quarterly basis, before the 30th of month following the end of the reporting period, using the Healthy Louisiana Medication Therapy Management (MTM) Report template, Rx 160.

2.5.17 Preconception/Inter-conception Care

For women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care, with special counseling on pregnancy prevention options for adolescent patients. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient in achieving her plan with optimization of health status in the interim. Use of long acting reversible contraceptives should be encouraged and barriers such as prior authorization shall not be required for approval.

2.5.18 Prenatal Care Services

Definitions:

Providers of basic prenatal care – Obstetricians, family physicians, certified nurse-midwives, and other advanced practice registered nurses with experience, training, and demonstrated competence

Providers of specialty prenatal care – Obstetricians

Providers of subspecialty prenatal care – Maternal fetal medicine specialists and reproductive geneticists with experience, training, and demonstrated competence

The Contractor shall ensure that enrollees who are pregnant begin receiving care within the first trimester or within seven (7) days after enrolling in the MCO. The Contractor shall provide available, accessible, and adequate numbers of prenatal care providers to provide prenatal services, including specialized behavioral health services that are incidental to a pregnancy (in accordance with 42 C.F.R. Part 440 Subpart B) to all enrollees. The pregnant enrollee shall be assured direct access within the Contractor's provider network to routine OB/GYN services, and the OB/GYN shall notify the PCP of his/her provision of such care and shall coordinate that care with the PCP.

The Contractor shall develop an outreach program to encourage women to seek prenatal services during the first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include issuance of brochures and/or periodic articles emphasizing the importance of such care to all enrollees.

The Contractor shall perform or require health providers to perform a risk assessment on all obstetrical patients, including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate providers of subspecialty prenatal care for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The Contractor shall provide case management for high-risk obstetrical patients, including, but not limited to, patients with a history of prior preterm birth.

The Contractor shall ensure that the prenatal care provider complies with the guidelines of the American College of Obstetricians and Gynecologists. The Contractor shall ensure that the provider counsels the pregnant enrollee about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child once the child is enrolled with the Contractor, as well as appropriate referrals to the WIC program for nutritional assistance and the Office of Public Health Title V breastfeeding resources (e.g., www.LABreastFeedingSupport.org).

The Contractor shall develop and promote patient engagement tools, including mobile applications and smartphone-based support to supplement existing pregnancy services. The Contractor shall provide details of its plan in the MCO Marketing and Outreach Plan submitted to LDH for approval. Some goals of this program would be to:

- Improve overall engagement in the maternity population and help women keep appointments and educate them about needed health screenings throughout pregnancy;
- Increase the appropriate identification and triage of high-risk pregnancies to evidence-based actions, including connection to maternity case managers or other public health resources; and

- Improve health decisions across the pregnant population based on available State-based and MCO-based programs and services.

2.5.19 Preventive Medicine Evaluation and Management Services (Adult)

Louisiana Medicaid reimburses preventive medicine services for adults, aged 21 years and older. One preventive medicine service will be reimbursed per enrollee per calendar year. The information gathered during the preventive medicine visit is to be forwarded to any requesting provider in order to communicate findings and prevent duplicative services.

Separately reported screening procedures performed by the physician, or referrals for those services, should be based on nationally recognized standards of care/best practices (e.g., screening mammography, prostate cancer screening, etc.).

The medical record documentation must include, but is not limited to:

- Physical examination;
- Medical and social history review;
- Counseling/anticipatory guidance/risk factor reduction intervention; and
- Screening test(s) and results.

In addition, one well-woman gynecological examination per calendar year for women aged 21 and over is covered, when performed by a primary care provider or gynecologist. The visit should include:

- Examination;
- Sexually Transmitted Infection (STI) screening and counseling;
- Breast and pelvic examination;
- Pap smear, if appropriate; and
- Contraceptive methods and counseling, as age appropriate.

2.5.20 Sterilization

Sterilization must be conducted in accordance with La. R.S. 40:1159.2, state Medicaid policy, federal regulations contained in 42 C.F.R. §441.250 - 441.259. All procedures must be documented with a completed Sterilization Consent Form OMB 0937-0166.

2.6 Population Health and Social Determinants of Health

The population health approach seeks to maintain and improve the health status of the entire population through prevention, while systematically identifying subpopulations with complex needs and implementing strategies to improve status and reduce health inequities among subpopulations.

The Contractor shall encourage and train providers to include Z codes in the ICD-10 CM on claims in order to track factors influencing health status and not for use in determining payment.

The Contractor shall not deny continuation of higher-level services (e.g., inpatient hospital) for failure to meet medical necessity unless the Contractor can provide the service through an in-network or out-of-network provider for a lower level of care.

As part of the Population Health Strategic Plan, the Contractor should ensure that CHWs, supervisors, and program directors successfully complete training on the following core competencies relevant to their roles.

- Community Health Worker
 - ❖ Adherence to intervention: Follows work practice manual for providing social support, care coordination, advocacy, etc. for patients
 - ❖ Organization: Utilizes tools to plan work and manage time (e.g. to-do list, calendar)
 - ❖ Explanation of role: Accurately describes CHW role to patients and other members of care team
 - ❖ Safety: Follows safety protocol set by organization (e.g. alerts supervisor when beginning/ending home visits)
- Supervisor
 - ❖ Adherence to intervention: Adheres to work practice manual for CHW Supervisors, including best practices for one-on-one CHW supervision (e.g. caseload review)
 - ❖ Organization: Utilizes tools to plan work and manage time
 - ❖ Explanation of program: Effectively describes the CHW role to care teams
 - ❖ Safety: Follows safety protocol set by organization (e.g. ensures CHWs check-out of home visits)
 - ❖ Performance assessments: Uses CHW performance reports to understand challenges

and coach to improve results

- ❖ Team leadership: Facilitates dynamic and engaging team meetings with ample CHW participation
- Program Director
 - ❖ Knowledge of intervention: Knowledge of work practice manuals for CHWs and CHW Supervisors
 - ❖ Organization: Utilizes tools to plan work and manage time
 - ❖ Explanation of program: Compellingly describes program design, goals, structure and results to partner organizations
 - ❖ Safety: Follows safety protocol set by organization (e.g. meets with CHWs who express safety concerns)
 - ❖ Performance assessment: Aggregates and analyzes CHW performance reports to ensure quality across the program
 - ❖ Enrollment targets: Sets and manages to quarterly patient enrollment goals; troubleshoots issues to stay on track
 - ❖ Organizational change: Manages process for revising work practice manuals and ensures uptake of changes across organization
 - ❖ CHW hiring: Articulates desired CHW characteristics and leads hiring process to assess for these elements

2.7 Care Management

A comprehensive care management program should be designed to support enrollees, regardless of age, based on individualized assessment of care needs.

2.7.1 Assessments for Mental Health Rehabilitation Services

The Contractor shall be responsible for providing assessment for mental health rehabilitation services per the requirements of the **Medicaid Behavioral Health Services Provider Manual**. LDH will establish process measures to monitor access to timely assessments

The Contractor shall ensure that its behavioral health providers conduct an assessment for eligibility based on level of care needed shall be completed within fourteen (14) calendar days of referral by a

provider or a case manager, based on the enrollee's potential need for community psychiatric support and treatment and psychosocial rehabilitation. Where individuals are in need of immediate emergency assessment and referral, the Contractor shall work with its behavioral health providers to ensure that the assessment is conducted as soon as possible.

The Contractor shall conduct annual reassessments for mental health rehabilitation services within 365 days of most recent certification in order to ensure that there is no lapse in service authorization or services to enrollees who remain qualified.

2.7.2 Independent Evaluations for PASRR Level II

The Contractor shall be responsible for conducting PASRR Level II evaluations of enrollees upon referral from LDH. Referrals will be based upon the need for an independent evaluation to determine the need for nursing facility services and/ or the need for specialized services to address mental health issues while the enrollee is in a nursing facility. This evaluation does not include individuals with an OCDD Statement of Approval; there is a separate determination process outside of this Contract for these evaluations.

In conducting the evaluation, the Contractor shall follow the criteria set forth in 42 C.F.R. §483.100 - 138 and shall utilize the PASRR Level II standardized evaluation form provided by LDH.

Evaluators may use relevant evaluative data, obtained prior to initiation of PASRR, if the data are considered valid and accurate and reflect the current functional status of the individual. However, if necessary to supplement and verify the currency and accuracy of existing data, the evaluator shall gather additional information necessary to assess proper placement and treatment. For those individuals without sufficient documentation to establish the validity of a primary dementia diagnosis, this may include authorizing additional professional evaluation to ensure appropriate diagnosis and differentiation.

In order to comply with federally mandated timelines, the Contractor shall submit the completed Level II evaluation report to OBH within four (4) business days of receipt of the referral from LDH.

In conducting Level II evaluations, the Contractor shall ensure that recommendations focus on ensuring the least restrictive setting appropriate with the appropriate services, including case management services as described in the Contract. The Contractor shall ensure that these recommended services are offered to the enrollee.

When LDH determines that nursing facility services are not appropriate, the Contractor shall assist eligible enrollees to obtain appropriate alternative behavioral health services available under this contract.

If at any time, the Contractor identifies or becomes aware of an enrollee with serious mental illness (SMI) that is residing in a nursing home who has an SMI but who has not received a Level II determination, the Contractor shall notify LDH, and shall conduct the evaluation upon request by LDH.

2.7.3 PASRR Tracking

The Contractor shall track enrollees in a nursing facility who went through the PASRR process, those identified with SMI and those receiving specialized services as per 42 C.F.R. §483.130.

The Contractor shall track and report quarterly to LDH the delivery of all PASRR specialized behavioral health services as defined and required under 42 C.F.R. §483.120 and the DOJ Settlement Agreement.

The Contractor shall advise OBH and Medicaid on any barriers to completing the PASRR evaluations or tracking process.

The Contractor shall notify OBH as outlined in the LDH-issue reporting template of any problems or issues with the PASRR process.

Contractor shall retain records of the PASRR process for 10 years in order to support OBH determinations, and to protect the individual's appeal rights as per 42 C.F.R. §483.130.

2.7.4 Services to Comply with the DOJ Agreement

The Contractor shall support LDH in its compliance with the Department's agreement with the United States Department of Justice (DOJ) to reduce reliance on nursing facility-based care for individuals with SMI. This includes, but is not limited to, providing assistance to LDH in executing the DOJ Agreement Implementation Plan, the development of a statewide crisis plan for individuals with SMI, and performing a service system gap analysis.

Contractor shall assist LDH to identify enrollees with SMI who are receiving facility-based care. The Contractor shall ensure that the enrollee is receiving all necessary behavioral health services within that nursing facility and to support the development of a care transition plan, where appropriate. Care transition plans shall include case management for the enrollees upon transition for at least a 12-month period.

The Contractor shall help identify and provide community based behavioral health services and service models to support reduction of use of facility-based care for individuals with SMI, by developing a robust provider network that can successfully serve enrollees in the community.

2.7.5 Women, Infant, and Children (WIC) Program Referral

The Contractor shall be responsible for ensuring that coordination exists between the WIC Program and its enrollees. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program. A sample referral/release of information form is found in the appendix.

2.8 Continuity of Care

The Contractor is responsible for developing and maintaining effective continuity of care and care transition activities to ensure a continuum of care approach to providing health care services to enrollees. This includes, but is not limited to:

- Care for pregnant women and enrollees with special health care needs;
- Pharmacy services;
- Behavioral health care;
- DME, prosthetics, orthotics, and certain supplies; and
- Transitioning between MCOs or to FFS Medicaid.

2.9 Provider Network, Contracts, and Related Responsibilities

The Contractor must develop, maintain, and monitor its provider network to ensure the availability and accessibility of MCO covered services as required by the Contract. This includes, but is not limited to, complying with geographic access, and appointment and wait times for enrollees.

2.9.1 Availability and Accessibility Requirements

The Contractor shall submit quarterly reports in the format specified by LDH documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in the MCO Contract and herein. The Contractor's network assessment shall compare the distribution of enrollees to the distribution of providers by region and parish, considering urban and rural standards as specified by LDH.

The Contractor shall submit reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed below.

Specialty	Louisiana Medicaid Provider Specialty	NPPEs Taxonomy Code
Primary Care Providers		
Family Practice	8	207Q00000X
FQHCs	42	261QF0400X
General Practice	1	208D00000X
Internal Medicine PCPs	41	207R00000X
Nurse Practitioners	79	363L00000X
OB/GYN PCPs	16	207V00000X
Pediatrics	37	208000000X
Rural Health Clinics	94	261QR1300X
Ancillary Services		
Ambulance Service Supplier	59	341600000X
Dialysis Centers	n/a	261QE0700X
Durable Medical Equipment	n/a	332B00000X
Home Health	n/a	251E00000X
Infusion Therapy	n/a	261QE0700X
NEMT - Non-profit	45	343900000X
NEMT – Profit	46	343900000X
Urgent Care Clinics	7N	261QU0200X
Hospitals		
Hospitals - General Acute Care	86	282N00000X
Hospitals - Children's	86	282NC2000X
Hospital - Rehabilitation	86	283X00000X
Pharmacies		
Pharmacies	n/a	333600000X
Specialty		
Adolescent Medicine	1A	2080A0000X
Allergy	3	207K00000X
Anesthesiology	5	207L00000X
Audiologist	64	231H00000X
Cardiac Electrophysiology	2A	207RC0001X
Cardiovascular Disease	6	207RC0000X
Cardiovascular Disease	2B	207RC0000X
Chiropractor	35	111N00000X
Clinic or Other Group Practice	70	261QM1300X
Critical Care Medicine	2C	207RC0200X

Specialty	Louisiana Medicaid Provider Specialty	NPES Taxonomy Code
Critical Care Medicine	3A	207RC0200X
Dermatology	7	207N00000X
Diagnostic Laboratory	72	293D00000X
Emergency Medicine	1T	207P00000X
Endocrinology & Metabolism	2E	207RE0101X
Family Practice	8	207Q00000X
Gastroenterology	10	207RG0100X
Gastroenterology	2F	207RG0100X
General Practice	1	208D00000X
General Surgery	2	208600000X
Geriatric Medicine	2G	207RG0300X
Geriatrics	38	207RG0300X
Gynecologic oncology	3B	207VX0201X
Hand Surgery	40	2086S0105X
Hematology	2H	207RH0000X
Independent Laboratory	69	291U00000X
Indiv Certified Prosthetist - Ortho	57	225000000X
Infectious Disease	2I	207RI0200X
Internal Medicine	41	207R00000X
Licensed Clinical Social Worker	73	1041C0700X
Maternal & Fetal Medicine	3C	207VM0101X
Med Supply / Certified Orthotist	51	222Z00000X
Med Supply / Certified Prosthetist	52	224P00000X
Medical Oncology	2J	207RX0202X
Neonatal Perinatal Medicine	1C	2080N0001X
Nephrology	39	207RN0300X
Nephrology	2K	207RN0300X
Neurological Surgery	14	207T00000X
Neurology	13	2084N0400X
Nuclear Medicine	2Q	207UN0903X
Nurse Practitioner	79	363L00000X
OB/GYN	16	207V00000X
Occupational Therapy	74	225X00000X
Ophthalmology	18	207W00000X
Optician / Optometrist	88	156FX1800X

Specialty	Louisiana Medicaid Provider Specialty	NPPES Taxonomy Code
Orthodontist	19	1223X0400X
Orthopedic Surgery	20	207X00000X
Otology, Laryngology, Rhinology	4	207W00000X
Pathology	22	207ZP0102X
Pediatric Cardiology	1D	2080P0202X
Pediatric Critical Care Medicine	1E	2080P0203X
Pediatric Day Health Care	1Z	261QM3000X
Pediatric Emergency Medicine	1F	2080P0204X
Pediatric Endocrinology	1G	2080P0205X
Pediatric Gastroenterology	1H	2080P0206X
Pediatric Hematology - Oncology	1I	2080P0207X
Pediatric Infectious Disease	1J	2080P0208X
Pediatric Nephrology	1K	2080P0210X
Pediatric Pulmonology	1L	2080P0214X
Pediatric Rheumatology	1M	2080P0216X
Pediatric Sports Medicine	1N	2080S0010X
Pediatric Surgery	1P	2086S0120X
Pediatrics	37	208000000X
Physical Medicine Rehabilitation	25	208100000X
Physician Assistant	2R	363A00000X
Plastic Surgery	24	208200000X
Podiatric Surgery	48	213ES0131X
Proctology	28	208C00000X
Psychiatry	26	2084P0800X
Pulmonary Disease	2L	207RP1001X
Pulmonary Diseases	29	207RP1001X
Radiology	30	2085R0202X
Rheumatology	2M	207RR0500X
Rural Health Clinic	94	261QR1300X
Speech Therapy	71	235Z00000X
Surgery - Critical Care	2N	2086S0102X
Surgery - General Vascular	2P	2086S0129X
Thoracic Surgery	33	208G00000X
Urology	34	208800000X
Specialized Behavioral Health		

Specialty	Louisiana Medicaid Provider Specialty	NPPEs Taxonomy Code
APRN – Clinical Nurse Specialist	26	364SP0808X
APRN – Nurse Practitioner	26	364SP0808X
Assertive Community Treatment	8E	261QM0850X
Behavioral Health Rehab Agency	8E	251S00000X
Center Based Respite	8E	385HR2055X
Crisis Receiving Center	8E	261QM0801X
Distinct Part Psychiatric Unit	86	273R00000X
Doctor of Osteopathic Medicine, Psychiatry	26	2084P0800X
Doctor of Osteopathic Medicine, Neurology	27	2084N0400X
Doctor of Osteopathic Medicine, Addiction Medicine	2W	2084A0401X
Federally Qualified Health Center	42	261QF0400X
Freestanding Psychiatric Hospital	86	283Q00000X
Licensed Addiction Counselor	8E	101YA0400X
Licensed Clinical Social Worker	73	1041C0700X
Licensed Marriage Family Therapist	8E	106H00000X
Licensed Professional Counselor	8E	101YP2500X
Medical Psychologist	6G	103TP0016X
Mental Health Clinic (LGEs)	70	261QM0801X
Mental Health Rehab Agency (Legacy)	78	251S00000X
Multi-Systemic Therapy Agency	5M	261QM0855X
Physician Assistant	26	364SP0808X
Psychiatric Residential Treatment Facility	9B	323P00000X
Psychiatric Residential Treatment Facility – Addiction Specialty	8U	323P00000X
Psychiatric Residential Treatment Facility – Other Specialty	8R	323P00000X
Psychiatrist	26	2084P0800X
Psychiatrist - Addictionologist	2W	2084P0802X
Psychologist – Clinical	6A	103TC0700X
Psychologist – Counseling	6B	103TC1900X
Psychologist – Developmental	6D	103TM1800X
Psychologist – Non-Declared	6E	103T00000X
Psychologist – Other	6F	103T00000X
Psychologist – School	6C	103TS0200X
Rural Health Clinic (Independent)	94	261QR1300X
Rural Health Clinic (Provider Based)	94	261QR1300X
School Based Health Center	70	261QH0100X

Specialty	Louisiana Medicaid Provider Specialty	NPPE Taxonomy Code
Substance Abuse & Alcohol Abuse Center (Outpatient)	70	261QR0800X
Substance Use Residential Treatment Facility	8U	324500000X
Therapeutic Foster Care Agency	9F	253J00000X
Therapeutic Group Home	5X	320800000X

The Contractor's network assessment shall compare the distribution of enrollees to the distribution of providers by region and parish, considering urban and rural standards as specified by LDH.

The data in the network adequacy reports shall be current, accurate, and consistent with the Contract and this Manual.

The Contractor's attestation included with geographic availability reports shall identify deficiencies in its provider network by parish and type of service as well as specific tasks that the Contractor will take to mitigate and work to eliminate each identified network deficiency by adding qualified, contracted network providers. The Contractor must also identify and address gaps in provider network accessibility in the Network Development and Management Plan along with the Contractor's approach to remedy such gaps.

2.9.2 Provider Network Monitoring Plan

The Contractor shall develop and implement a plan for monitoring providers and facilities, which incorporates onsite reviews and enrollee interviews. The Contractor shall submit as part of readiness reviews the plan to LDH and at least 60 days prior to revision. The Contractor's plan shall comply with all the requirements as specified in this manual and the Contract.

Note: This requirement is applicable to specialized behavioral health providers only at this time. LDH will provide advance notice if this requirement shall be expanded to other provider types in the future.

The Contractor's Provider Network Monitoring Plan shall be inclusive of the following requirements at a minimum:

- Review criteria for each applicable provider type and level of care;
- Sampling approach including number and percent of onsite audits by provider type, number and percent of administrative desk audits, and number and percent of enrollees interviewed;
- Enrollee interview criteria;
- Random audit selection criteria;

- Monitoring tools to be used;
- Frequency of review, including schedule of reviews by provider type;
- Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis;
- Plan for ensuring corrective actions are implemented appropriately and timely by providers; and
- Inter-rater reliability testing methods.

At a minimum, the Contractor's annual sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5% for each level of care. The sample shall be random and include providers who have served at least one enrollee during the review period. Levels of care shall include, at a minimum, outpatient, residential and inpatient.

The Contractor's review criteria shall address the following areas at a minimum:

- Adherence to minimum provider qualifications and requirements at the organizational level and the individual staff level as established by Louisiana law, rules, regulations, State Plan, waivers, and herein. This shall include but not be limited to requirements associated with licensure, accreditation, educational and professional experience, and training inclusive of utilization of LDH approved training curriculum in the delivery of services, if applicable, as established by this Manual. Verification shall include review of provider and staff personnel records and other administrative records;
- Adherence to clinical practice guidelines;
- Enrollee rights and confidentiality, including advance directives and informed consent;
- Cultural competency;
- Patient safety;
- Compliance with adverse incident reporting requirements;
- Accuracy of provider demographics associated with service location addresses, telephone numbers, languages spoken, current staff rosters and status of accepting new Medicaid referrals, as compared against the Contractor's credentialing files and the Contractor's provider directory listings;
- Treatment Planning components, including criteria to determine: the sufficiency of

assessments in the development of functional treatment recommendations; the treatment plan is individualized and appropriate for the enrollee and includes goals, Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective; individualized crisis plan; enrollees'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the enrollee changes; the treatment plan includes the involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the enrollee is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the enrollee; and

- Continuity and coordination of care, including adequate discharge planning.

Providers shall be reviewed based on the services for which they have received reimbursement.

The Contractor shall ensure that an appropriate corrective action is taken when a provider or staff fails to meet minimum provider qualifications or requirements, appointment availability standards, or is determined to be out of compliance with provisions of the Contract, federal and state regulations, law, rules, SPA, waivers, or this Manual. The Contractor shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.

2.9.3 Provider Enrollment

Exclusion from Participation

- The Contractor may access a list of providers excluded from federally funded health care programs using the following sources:
 - ❖ Office of Inspector General List of Excluded Individuals/Entities (<https://exclusions.oig.hhs.gov/>);
 - ❖ System for Award Management (<https://www.sam.gov/index.html>); and
 - ❖ Louisiana State Adverse Actions List Search (<https://adverseactions.dhh.la.gov/>).
- Other Enrollment and Disenrollment Requirements

The Contractor shall require unlicensed staff of provider organizations rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services to obtain and submit National Provider Identifier (NPI) numbers to the Contractor, as well as documentation verifying the unlicensed staff meets all qualifications and requirements for providing mental health rehabilitation (MHR) services established by State law, rules, regulations, State Plan, waivers,

and the Contract, inclusive of Evidence-Based Program (EBP) MHR services, prior to reimbursing agencies for services provided by these staff. 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 Contractor shall configure 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. The Contractor shall submit their policies, procedures and work plan associated with this requirement to LDH for approval within 30 days of contract execution. The Contractor's work plan shall include timelines associated with systems configuration, systems testing phases, education and outreach to providers, communication notices to providers, and the effective date the Contractor's unlicensed staff NPI requirement will go-live.

2.9.4 Primary Care

- **PCP Automatic Assignment**

The Contractor shall, at a minimum, determine whether the assigned enrollee has received services through the Contractor within the previous year and if the enrollee has a provider-beneficiary relationship with a network PCP.

If the assigned enrollee was previously enrolled with the Contractor, then the assignment shall be to the enrollee's most recent PCP if, in the Contractor's reasonable judgment, such assignment is appropriate.

If the assigned enrollee was not previously enrolled with the Contractor, then the Contractor shall make its best efforts to seek and obtain pertinent information from the enrollee to assign the enrollee to an appropriate PCP, considering all sources of information available to the Contractor, including but not limited to, information provided by LDH or its enrollment broker. The Contractor shall, based on such information that it is able to obtain in a timely manner, take into account factors that include, but are not limited to, the following:

- ❖ The enrollee's age and sex;
- ❖ Available information on the enrollee's health care needs, including behavioral health service needs;
- ❖ PCP training and expertise with demographic or special populations similar to the enrollee, including children in the care or custody of DCFS and homeless persons;
- ❖ Geographical proximity of PCP site(s) to the enrollee's residence;
- ❖ Whether the PCP site is accessible by public transportation;

- ❖ Whether the PCP site is accessible to people with disabilities;
- ❖ The enrollee's primary language and capabilities of the PCP to practice in that language and access to skilled medical interpreters who speak the enrollee's primary language at the PCP site; and
- ❖ Whether an immediate family member is enrolled in the MCO and has a designated PCP or a provider-beneficiary relationship that may be applicable to the enrollee.

If there is no enrollee or immediate family historical usage, enrollee shall be auto-assigned to a PCP using an algorithm developed by the Contractor, based on the age and sex of the enrollee, geographic proximity, and other information on the enrollee and PCP that is available, such as language or access for persons with disabilities as noted in this section.

The Contractor shall inform the enrollee of the name of the PCP to whom he or she is assigned and offer to assist the enrollee in scheduling an initial appointment with the PCP.

The Contractor shall routinely and promptly inform PCPs of newly assigned enrollees and shall require PCPs to make best efforts to schedule an initial appointment with new enrollees.

The Contractor shall submit to LDH for its review and prior approval a model assignment notification letter for enrollees and an assignment notice for PCPs.

- PCP Designation for Enrollees

The Contractor shall submit a roster for each PCP the individual enrollees that are designated to that PCP's panel to LDH weekly in accordance with the **Systems Companion Guide**. The Contractor shall also make the roster available to the PCP on the first day of each month via email or provider portal. The roster shall include an easily identifiable indicator if the enrollee is newly enrolled in the MCO and the method by which the enrollee was assigned (i.e., via section or automatic assignment).

The provider to enrollee linkage ratio should not exceed 1:2,500 across the MCOs. LDH will notify each MCO if a provider should be capped.

The Contractor shall perform a quarterly claims analysis based on the previous twelve (12) months of claims history to review correct enrollee designation. If an enrollee has been seeing another PCP, the enrollee may be reassigned.

- Referral System for Specialty Health Care

- ❖ The Contractor shall have a referral system for MCO enrollees requiring specialty health care services to ensure that services can be furnished to enrollees promptly and

without compromise to care. The Contractor shall provide the coordination necessary for referral of MCO enrollees to specialty providers. The Contractor shall assist a PCP or enrollee with getting an appointment with an the appropriate service provider. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services, and follow up are included in the PCP's enrollee medical record. The MCO must assist the PCP or enrollee with making an appointment.

- ❖ The Contractor shall submit referral system policies and procedures for review and approval within thirty (30) days from the date the MCO Contract is signed, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements:
 - When a referral from the enrollee's PCP is and is not required;
 - Process for enrollee referral to an out-of-network provider when there is no provider within the MCO's provider network who has the appropriate training or expertise to meet the particular health needs of the enrollee;
 - Process for providing a standing referral when an enrollee with a condition requires on-going care from a specialist;
 - Process for assisting PCPs find specialists when their attempts have been unsuccessful. This process shall include a form that can be faxed or securely emailed to the MCO, with a 72 hour turnaround to the provider;
 - Process for referral for specialty care for an enrollee with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time
 - Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or an enrollee of the provider's family has a financial relationship; and
 - Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's enrollee medical record.
- There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider; and

- Process for referral of enrollees for Medicaid State Plan services that are excluded from MCO covered services and that will continue to be provided through fee-for-service Medicaid.
- The Contractor shall develop electronic, web-based referral processes and systems.

2.9.5 Access to Medication Assisted Treatment

The Contractor shall refer to the *Reporting Requirements* section of this Manual for required MAT reporting.

2.9.6 Specialized Behavioral Health Providers

The Contractor shall ensure its provider network offers a range of basic and specialized behavioral health services as reflected herein and meets the network adequacy standards defined in this Contract. The provider network shall be adequate for the anticipated number of enrollees for the service area.

2.9.7 Integration of Primary Care and Behavioral Health Services

In recognizing that at least 70 percent of behavioral health can be and is treated in the primary care setting, the Contractor shall be responsible for the management and provision of all basic behavioral health services including but not limited to those with mild, moderate depression, ADHD, and generalized anxiety, that can be appropriately screened, diagnosed or treated in a primary care setting.

The Contractor's support shall include but not be limited to assistance to primary care providers in aligning their practices with best practice standards, such as those developed by the American Academy of Pediatrics, for the assessment, diagnosis, and treatment of ADHD, such as increasing the accuracy of ADHD diagnosis, increasing screening for other behavioral health concerns, and increasing the use of behavioral therapy as first-line treatment for children under age 6.

2.9.8 Services for Co-Occurring Behavioral Health and Developmental Disabilities

The MCO shall create a framework for delivery of services, staff development, and policies and procedures for providing effective care for enrollees with co-occurring developmental disabilities. This population should have the same reasonable access to behavioral health services as someone without a co-occurring developmental disability. If an enrollee qualifies for services through the Office for Citizens with Developmental Disabilities (OCDD), the MCO shall coordinate with Local Governing Entities, Support Coordination Agencies, and/or OCDD concerning the care of the enrollee. A statement of eligibility from OCDD shall not preclude services from the MCO.

2.9.9 Network Development and Management Plan

The Contractor shall submit its Network Development and Management Plan in accordance with this Manual annually, as amended, and as requested by LDH

The Contractor shall develop and implement specific strategies to promote the integration of physical and behavioral health service delivery and care integration activities and establish policies and procedures to facilitate integration. Specifically, the Contractor shall:

- Support PCPs who screen enrollees for behavioral health issues and treat mild to moderate cases, including educating and training practices on how to treat common behavioral health conditions and providing clinical consultations and guidance for issues that do not require specialty referrals;
- Encourage and support providers to co-locate primary care and behavioral health services, whether the co-located service is in a primary care or behavioral health setting;
- The MCO shall provide incentives to clinics to employ Licensed Mental Health Professionals (LMHP) in primary care settings to monitor the behavioral health of patients and to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients;
- Allow providers to bill for both primary care and behavioral health services on the same day;
- Develop, in coordination with LDH and other MCOs, a system to provide psychiatric prescribing support to primary care providers. Such support may be provided through consultation with psychiatrists regarding psychiatric prescribing practices;
- The MCO shall endorse real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications;
- Distribute Release of Information forms as per 42 C.F.R. §431.306, and provide training to providers on its use;
- Share necessary and integrated data with its network providers to promote clinical integration of physical and behavioral health; and
- Offer provider trainings on integrated care including but not limited to appropriate utilization of basic behavioral health screens in the primary care setting and basic physical health screenings in the behavioral health setting.

The Contractor shall work to integrate physical and behavioral health services through:

- Enhanced detection and treatment of behavioral health disorders in primary care settings;
- Coordination of care for enrollees with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for enrollees with co-existing medical-behavioral health disorders;
- Assisting enrollees without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder;
- Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled enrollees with co-existing medical and behavioral health disorders requiring co-management;
- Have enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients;
- Have enhanced rates or incentives for integrated care by providers;
- Distributing Release of Information forms as per 42 C.F.R. §431.306, and provide training to MCO providers on its use;
- Educating MCO enrollees and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;
- Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;
- Ensuring continuity and coordination of care for enrollees who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for enrollee(s) requiring behavioral health services;
- Documenting authorized referrals in the Contractor's clinical management system;
- Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;
- Conducting Case management rounds at least monthly with the Behavioral Health Case management team; and
- Participating in regular collaborative meetings at least yearly or as needed, with LDH

representatives for the purpose of coordination and communication.

The Contractor shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting.

- The Contractor shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards. The Contractor shall work to increase screening in primary care for developmental, behavioral, and social-emotional delays, as well as screening for child maltreatment risk factors, trauma, adverse childhood experiences (ACEs) and substance use. The Contractor may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.
- The Contractor shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, adverse childhood experiences (ACEs), and substance use. The Contractor shall work to increase the percentage of children with positive screens who 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.

Material Change to Provider Network

- The Contractor shall submit required information on material changes to its provider network in accordance with this manual, the MCO Contract, and in the time period specified by LDH.
- The Contractor's request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including:
 - ❖ Detailed information identifying the affected provider(s);
 - ❖ Demographic information and number of enrollee currently served and impacted by the event or material change, including the number of Medicaid enrollees affected by program category;
 - ❖ Location and identification of nearest providers offering similar services; and
 - ❖ For enrollees with special health care needs, a plan for clinical team meetings with the enrollee, his/her family/caregiver, and other persons requested by the enrollee and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.
 - If a provider loss results in a network deficiency, the Contractor shall submit to LDH a written plan with time frames and action steps for correcting the deficiency

within thirty (30) calendar days that includes the transitioning of enrollee to appropriate alternative providers in accordance with the network notification requirements.

- The Contractor shall track all enrollees transitioned due to a provider or material subcontractor's suspension, limitation, termination, or material change to ensure covered service continuity and provide enrollee information as requested by LDH.
- If LDH does not respond to the Contractor's request for approval of the material change in their provider network, including a copy of draft notification to affected enrollees, within thirty (30) days the notice is deemed approved. A material change in the Contractor's provider network requires thirty (30) days advance written notice to affected enrollees. For emergency situations, LDH shall expedite the approval process.
- The Contractor shall notify LDH within one (1) business day of the Contractor becoming aware of any unexpected changes (e.g., a provider becoming unable to care for enrollee due to provider illness, a provider death, the provider moves from the service area and fails to notify the Contractor, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network. The notification shall include:
 - ❖ Information about how the provider network change will affect the delivery of covered services, and
 - ❖ The Contractor's plan for maintaining the quality of enrollee care, if the provider network change is likely to affect the delivery of covered services.
- The Contractor shall give ninety (90) days' notice prior to a contract termination without cause.
- As it pertains to a material change in the network for behavioral health providers, the Contractor shall also:
 - ❖ Provide written notice to LDH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the Contractor's provider network, whether terminated by the Contractor or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in this section include:
 - A decrease in a behavioral health provider type by more than five percent (5%);
 - A loss of any participating behavioral health specialist which may impair or deny the enrollee's adequate access to providers; or

- A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by LDH.

2.9.10 Credentialing and Re-credentialing of Providers and Clinical Staff

The Contractor shall provide information to the State's provider management contractor on contracted providers in accordance with the Systems Companion Guide.

2.9.11 Pharmacy Network, Access Standards, and Reimbursement

- Pharmacy Claims Dispute Management
 - ❖ The MCO shall maintain an internal claims dispute process to permit local pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug. Reimbursement should be no less than the FFS rate on the date of service as required by Act 301 of the 2017 Louisiana Regular Session. Rates should be updated within 7 calendar days of MCO receipt of the Average Acquisition Cost (AAC) from LDH or its designee. MCOs shall be penalized \$1,000 per calendar day for each rate that is not updated within the 7 calendar day timeframe.
 - ❖ A local pharmacy is defined as any pharmacy domiciled in at least one Louisiana parish that: contracts directly with the MCO or the MCO's contractor in its own name or through a Pharmacy Services Administrative Organization (PSAO) and not under the authority of a group purchasing organization; and has fewer than ten retail outlets under the pharmacy's corporate umbrella.
 - ❖ The MCO shall permit pharmacies to submit claim disputes directly to the MCO or through a PSAO at the pharmacy's option.
 - ❖ The MCO may require pharmacies to submit claim disputes within a predetermined time limit. Such limit shall be no less than seven (7) business days after the latter of the fill date or the resolution date of any pending AAC rate update request.
 - ❖ The MCO shall provide written notification of the outcome of the internal claims dispute process to the pharmacy within seven (7) business days of the date that the dispute was received by the MCO.
- Specialty Drugs and Specialty Pharmacies
 - ❖ LDH recognizes the importance of providing adequate access to specialty drugs to Medicaid enrollees while ensuring proper management of handling and utilization. The Contractor shall comply with the specialty drug and specialty pharmacy requirements

specified herein and the MCO Contract.

- ❖ LDH recognizes the importance of providing adequate access to specialty drugs to Medicaid enrollees while ensuring proper management of handling and utilization.
- ❖ The MCO shall not limit distribution of specialty drugs or self-refer to a MCO or PBM-owned specialty pharmacy. Any qualified pharmacy that is able to procure specialty drugs from distributors, has any one of the nationally recognized accreditations and is willing to accept the terms of the MCO's contract shall be allowed to participate in the MCO/PBM's network (any willing provider). LDH reserves the right to deny specialty pharmacy contracts that include what LDH deems to be overly burdensome terms or requirements, including but not limited to requirements for excessive insurance coverage, unreasonable stocking requirements, or restrictive or duplicative accreditation requirements. The MCO shall accept any one of the nationally recognized accreditation programs to meet its specialty pharmacy network requirement.
- ❖ The MCO specialty pharmacy network shall be approved by LDH prior to MCO reimbursement for specialty drugs. MCO encounters may be denied until LDH has approved. Any subsequent addition or deletion to the specialty pharmacy network shall be approved by LDH prior to implementation.
- ❖ For the purposes of this contract, "specialty drugs" shall be determined by the definition below.
- ❖ A specialty drug is defined as a prescription drug which meets all of the following criteria:
 - ❖ The drug is not routinely dispensed at a majority of retail community pharmacies due to physical or administrative requirements that limit preparation and/or delivery in the retail community pharmacy environment. Such drugs may include but are not limited to chemotherapy, radiation drugs, intravenous therapy drugs, biologic prescription drugs approved for use by the federal Food and Drug Administration, and/or drugs that require physical facilities not typically found in a retail community pharmacy, such as a ventilation hood for preparation;
 - ❖ The drug is used to treat complex, chronic, or rare medical conditions:
 - That can be progressive; or
 - That can be debilitating or fatal if left untreated or undertreated; or
 - For which there is no known cure.

- ❖ The drug requires special handling, storage, and/or has distribution and/or inventory limitations;
- ❖ The drug has a complex dosing regimen or requires specialized administration;
- ❖ Any drug that is considered to have limited distribution by the federal Food and Drug Administration;
- ❖ The drug requires:
 - Complex and extended patient education or counseling; or
 - Intensive monitoring; or
 - Clinical oversight; and
 - The drug has significant side effects and/or risk profile.
- Access to Specialty Drugs

No entity shall establish definitions, or require accreditation or licensure, effectively limiting access to prescription drugs, including specialty drugs, other than the appropriate governmental or regulatory bodies.

- Internal Claims Dispute Process
 - ❖ The MCO shall maintain an internal claims dispute process to permit local pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug.
 - ❖ A local pharmacy is defined as any pharmacy domiciled in at least one Louisiana parish that: contracts directly with the MCO or the MCO's contractor in its own name or through a Pharmacy Services Administrative Organization (PSAO) and not under the authority of a group purchasing organization; and has fewer than ten retail outlets under the pharmacy's corporate umbrella.
 - ❖ The MCO shall permit pharmacies to submit claim disputes directly to the MCO or through a PSAO at the pharmacy's option
 - ❖ The MCO may require pharmacies to submit claim disputes within a predetermined time limit. Such limit shall be no less than seven (7) business days after the latter of the fill date or the resolution date of any pending AAC rate update request.
 - ❖ The MCO shall provide written notification of the outcome of the internal claims dispute process to the pharmacy within seven (7) business days of the date that the

dispute was received by the MCO.

- ❖ No entity shall establish definitions, or require accreditation or licensure, effectively limiting access to prescription drugs, including specialty drugs, other than the appropriate governmental or regulatory bodies.

2.10 Provider Services and Support

The Contractor must engage with its network providers to enhance service delivery, improve provider and enrollee satisfaction, promote data sharing and value-based payment strategies, and enable regular provider participation in clinical policy development and provider operations. This section provides additional information on ways in which the Contractor interacts and supports its providers to ensure that providers receive timely payment and appropriate support over the course of the Contract.

2.10.1 Provider Directory

The Contractor shall maintain a complete and accurate provider directory of PCPs, behavioral health providers, hospitals, specialists, sub-specialists, pharmacies, and ancillary service providers.

See additional requirements in the **Systems Companion Guide**.

2.10.2 Provider Website

The MCO provider website shall include general and up-to-date information about the MCO as it relates to the Louisiana Medicaid program. This shall include, but is not limited to:

- MCO provider manual;
- MCO-relevant LDH bulletins;
- Limitations on provider marketing;
- Information on upcoming provider trainings;
- A copy of the provider training manual;
- Information on the provider complaint/dispute system;
- Information on obtaining prior authorization and referrals;
- Enrollee scope of coverage;
- Information on how to contact the MCO Provider Relations; and

- General up-to-date information about all behavioral health programs and services. This shall include, but is not limited to information on requirements and reporting fraud, waste, and abuse.

2.10.3 Provider Handbook

At a minimum, the provider handbook shall include the following information:

- Description of the Medicaid managed care program and the MCO;
- All MCO Covered Services outlined in Attachment A, *MCO Covered Services*, of the Contract;
- Enrollee rights and responsibilities (42 C.F.R. 438.100)
- Emergency service responsibilities;
- Medical necessity standards as defined by LDH and practice guidelines;
- Description of where to obtain service-specific coverage requirements and medical necessity criteria;
- Description of how to obtain prior authorization and description of referral procedures, including required forms;
- Enrollee record standards for providers;
- Description of where to obtain claims submission protocols and standard including instructions and all information required for a clean or complete claim;
- Protocols for submitting claims data;
- Requirements regarding marketing activities and marketing prohibitions;
- Requirements regarding background screening for providers;
- Requirements regarding the provider enrollment, credentialing and re-credentialing processes;
- Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to: a) specific instructions regarding how to contact the Contractor to file a provider complaint, including complaints about claims issues, and b) the complaint review process, including the timeframes allowed for resolving claims payment issues, and the process a provider would take to escalate unresolved issues;

- Information about the Contractor's Enrollee Grievance and Appeal System, that with written permission from the enrollee, the provider may file a grievance or appeal on behalf of the enrollee, the required procedural steps, time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers, address and office hours of the grievance staff, the enrollee's right to request continuation of services while utilizing the Contractor's grievance and appeal system in accordance with 42 C.F.R. 438.414, and any additional information specified in 42 C.F.R. §438.10(g)(2)(xi);
- Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;
- PCP responsibilities;
- Other provider responsibilities under this Contract and as part of the provider's agreement with the Contractor;
- Prior authorization and referral procedures;
- Standards for record keeping;
- Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;
- MCO prompt pay requirements (see Attachment G, *Table of Monetary Penalties*);
- The Contractor's care management program;
- Quality performance requirements;
- Provider rights and responsibilities;
- Service authorization criteria to make medical necessity determinations;
- Information on reporting suspicion of provider or enrollee fraud, waste or abuse; and
- Information on obtaining Medicaid transportation services for enrollees.

2.10.4 Provider Training Requirements

All specialized behavioral health services training will be documented with agendas, written training materials, invited attendees, and sign-in sheets (including documentation of absent attendees). Training to be provided will include but not be limited to:

- Cultural Competency;

- Specialized Behavioral Health Services program requirements, rules, and regulations including but not limited to staff qualifications and requirements, approved training curricula, approved provider types and specialties, service definitions, clinical components, service limitations and exclusions, assessment, treatment planning and medical record requirements, quality management documentation;
- Adverse incident management and reporting requirements;
- Evidence-Based practices, promising practices, emerging best practices;
- Billing options and requirements and documentation requirements;
- Utilizing the LOCUS assessment tool for specialized behavioral health providers;
- Integrating physical and behavioral health;
- Assessing and treating individuals with co-occurring I/DD;
- Use of MCO systems and website; and
- Additional topics as determined through provider/enrollee surveys and/or as directed by LDH.

2.10.5 Provider Satisfaction Surveys

If LDH does not conduct the statewide survey, the Contractor shall conduct an annual provider survey to assess overall satisfaction, as well as satisfaction with the following functions:

- Access to linguistic assistance;
- Provider enrollment;
- Provider communication;
- Provider education and trainings (including cultural competency trainings);
- Resolution to provider complaints/disputes;
- Claims processing;
- Claims reimbursement;
- Network/coordination of care; and
- Utilization management processes(including medical reviews and support toward Patient Centered Medical Home implementation)

The Provider Satisfaction survey tool and methodology must be submitted to LDH for approval 90 days prior to administration.

All required components of the survey tool must be administered and reported to LDH annually within the provider satisfaction survey report. Survey response rates shall consider the population size and demographic category of providers with a minimum margin of error of +/- 5% and a confidence level of at least 95%. This shall be the minimum response rate for surveys completed and reported to LDH..

The Contractor shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.

2.10.6 Provider Complaint System

The Contractor is required to maintain a Provider Complaint System for in-network and out-of-network providers to dispute the MCO's policies, procedures, or any aspect of its administrative functions. Providers should first seek resolution with the MCO.

The Contractor shall provide its network providers with the following complaint and escalation contacts:

Formal Complaint	Phone number: E-mail address: Mailing address:
Management Level Contacts	Name: Title: E-mail address:
Executive Level Contacts	Name: Title: E-mail address:

If a provider is unable to reach satisfactory resolution or get a timely response through the MCO escalation process, the provider may contact LDH directly at ProviderRelations@la.gov.

Though there is a separate claim dispute procedure, the above options are available for resolution of all issue types, including claims.

2.11 Provider Reimbursement

The Contractor shall administer an effective, accurate and efficient claims processing system that adjudicates provider claims for covered services that are filled within timeframes specified in the Contract and the Manual.

2.11.1 FQHC/RHC Contracting and Reimbursement

Behavioral health services provided in a FQHC may be reimbursed via the Prospective Payment System (PPS) rate, when provided by approved practitioner types as established in the Medicaid FQHC Provider Manual, i.e., psychiatrists, licensed clinical psychologists and licensed clinical social workers, and in accordance with established FQHC Medicaid rules, policies and manuals.

Mental Health Rehabilitation (MHR) State Plan services may be provided by an FQHC under the following conditions:

- The FQHC has HRSA approval to provide ambulatory MHR services;
- Services are provided by a psychiatrist, licensed clinical psychologist or licensed clinical social worker;
- Services are delivered in accordance with the Louisiana Medicaid State Plan, as well as all federal and state laws; and
- Services are billed via the all-inclusive PPS rate.

FQHCs providing MHR services outside of the above established parameters may not be reimbursed with Medicaid funding for these services. Such entities desirous of providing MHR services must enroll separately with the MCO as an appropriate Behavioral Health Service Provider (BHSP) type with a unique National Provider Identifier (NPI), be licensed as a BHSP issued by LDH Health Standards, and bill in accordance with the SBHS Medicaid rules, policies and manuals.

2.11.2 Payment for Emergency Services and Post-Stabilization Services

- The Contractor shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The Contractor must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services is part of the Contractor's provider network. If an emergency medical condition exists, the Contractor is obligated to pay for the emergency service.
- The Contractor shall advise its enrollees of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.

- The Contractor shall not deny payment for treatment when a representative of the organization instructs the enrollee to seek emergency services.
- The Contractor shall not deny payment for treatment obtained when a enrollee had an emergency medical condition as defined in 42 C.F.R. §438.114(a).
- The attending emergency physician, or the provider actually treating the enrollee shall determine when the enrollee is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor for coverage and payment of emergency and post-stabilization services.
- The Contractor shall be responsible for educating enrollees and providers regarding appropriate utilization of ED services, including behavioral health emergencies.
- The Contractor shall monitor emergency services utilization by enrollees (by provider) and shall have routine means for redressing inappropriate emergency department utilization.
- For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.
- An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- As specified in 42 C.F.R. §438.114(e) and 42 C.F.R. §422.113(c)(2)(i), (ii) and (iii), the Contractor must cover and pay for post-stabilization care services obtained within or outside the Contractor's network that are:
 - ❖ Pre-approved by a network provider or other Contractor representative; or
 - ❖ Not preapproved by a network provider or other Contractor representative, but:
 - Administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further post-stabilization care services or
 - Administered to maintain, improve or resolve the enrollee's stabilized condition if the Contractor:
 - Does not respond to a request for pre-approval within one (1) hour;

- Cannot be contacted; or
- The Contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a network physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.
- The Contractor's financial responsibility for post-stabilization care services that it has not pre-approved ends when:
 - ❖ A network physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
 - ❖ A network physician assumes responsibility for the enrollee's care through transfer;
 - ❖ A representative of the Contractor and the treating physician reach an agreement concerning the enrollee's care; or
 - ❖ The enrollee is discharged.

2.11.3 Emergency Ancillary Services Provided at the Hospital

Emergency ancillary services which are provided in a hospital include, but are not limited to, radiology, laboratory, emergency medicine and anesthesiology. The Contractor shall reimburse the professional component of these services at a rate equal to or greater than the published Medicaid fee-for-service rate in effect on the date of service to in-network providers when an MCO authorizes these services (either in-patient or outpatient). Emergency ancillary services rendered by non-network providers in a hospital setting shall be reimbursed at the published Medicaid fee schedule in effect on the date of service.

2.11.4 Covered and Non-Covered Inpatient Hospital Days

The Contractor shall require hospitals to bill covered days and their associated ancillary charges. Covered days are days that have been approved through the precertification process.

The Contractor may permit hospitals to bill non-covered days and their associated ancillary charges but these must be billed separately from covered days and their associated ancillary charges. Non-covered days are days that are not certified or approved by the MCO. Even though these non-covered days and services will be denied by the Contractor, the Contractor must submit a denied encounter for these claims if billed by the provider.

When the Contractor receives an inpatient claim (electronic or paper) that includes dates of service that exceed approved days, the Contractor must deny the entire claim. The provider must resubmit the inpatient claim for covered days only. For example:

- If a provider obtains approval for a 10-day stay, and submits a claim for 12 days, the claim must be billed for the 10 approved days only.

2.12 Utilization Management

The Contractor shall develop and maintain policies and procedures for a Utilization Management (UM) program that incorporates utilization review and service authorization.

2.12.1 Medical Records

The Contractor shall ensure the medical record is:

- Accurate and legible;
- Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all enrollees evaluated or treated, and is accessible for review and audit; and
- Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.

The Contractor shall ensure the medical record includes, minimally, the following:

- Enrollee identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);
- Primary language spoken by the enrollee and any translation needs;
- Services provided, date of service, service site, and name of service provider;
- Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first enrollee visit with or by the Contractor;
- Referrals including follow-up and outcome of referrals;
- Documentation of emergency and/or after-hours encounters and follow-up;
- Signed and dated consent forms (as applicable);
- Documentation of immunization status;

- Documentation of advance directives, as appropriate;
- Documentation of each visit must include;
- Date and begin and end times of service;
- Chief complaint or purpose of the visit;
- Diagnoses or medical impression;
- Objective findings;
- Patient assessment findings;
- Studies ordered and results of those studies;
- Medications prescribed;
- Health education provided;
- Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and
- Initials of providers must be identified with correlating signatures.

2.12.2 Common Observation Policy

The Contractor shall utilize the following common observation policy, which has been developed collectively by MCO personnel with LDH approval. This policy shall be reviewed annually by LDH and the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation of any new or revised language. The purpose of the outpatient hospital services program is to provide outpatient services to eligible Medicaid enrollees and performed on an outpatient basis in a hospital setting. Hospital providers are to ensure that the services provided to Medicaid enrollees are medically necessary, appropriate and within the scope of current evidence-based medical practice and Medicaid guidelines.

Observation Time – the period beginning at the time the order is written to place an enrollee in observation status or the time a enrollee presents to the hospital with an order for observation, and ending with discharge of the enrollee, or an order for inpatient admission.

Observation Care – a well-defined set of specific, clinically appropriate services furnished while determining whether an enrollee will require formal inpatient admission or be discharged from the hospital. Observation is for a minimum of one (1) hour and up to 48 hours.

*The enrollee must be in the care of a physician during the period of observation, as documented in the medical record by an observation order, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

- Observation Procedure

- ❖ MCOs will reimburse up to 48 hours of medically necessary care for an enrollee to be in an observational status. This time frame is for the physician to observe the enrollee and to determine the need for further treatment, admission to an inpatient status, or for discharge. Observation and ancillary services do not require notification, precertification or authorization and will be covered up to 48 hours.
- ❖ Hospitals should bill the entire outpatient encounter, including emergency department, observation and any associated services on the same claim with the appropriate revenue codes, and all covered services are to be processed and paid separately.
- ❖ Any observation service over 48 hours requires MCO authorization. For observation services beyond 48 hours that are not authorized, MCOs shall only deny the non-covered hours.
- ❖ If an enrollee is anticipated to be in observation status beyond 48 hours, the hospital must notify the MCO as soon as reasonably possible for potential authorization of an extension of hours. The MCO and provider shall work together to coordinate the provision of additional medical services prior to discharge of the member as needed.

- Observation-to-Inpatient Procedure

- ❖ Length of stay alone should not be the determining factor in plan denial of inpatient stay/ downgrading to observation stay.
- ❖ Medicaid enrollees should not be automatically converted to inpatient status at the end of the 48 hours. Admission of an enrollee cannot be denied solely on the basis of the length of time the enrollee actually spends in the hospital.
- ❖ All hospital facility charges on hospital day one are included in the inpatient stay and billed accordingly inclusive of emergency department/observation facility charges. (Note: Professional charges should continue to be billed separately.)
- ❖ All observation status conversions to an inpatient hospital admission require notification to the MCO within one business day of the order to admit an enrollee. Acceptable notifications include the use of MCO provider portals, admit discharge

transfer notifications, and other mediums through which MCOs accept clinical communications.

- ❖ MCOs are prohibited from including any observation hours in the inpatient admission notification period.
- ❖ The MCO will notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the enrollee's health condition requires but within no more than one business day of making the initial determination. The MCO will subsequently provide written notification (i.e., via fax) to the provider within two business days of making the decision to approve or deny an authorization request.

2.12.3 Behavioral Health Services

The Contractor shall screen enrollees to determine level of need for the purpose of service authorization based on medical necessity. Based on this medical necessity determination, the Contractor shall authorize specialized behavioral health services as appropriate.

Services shall be managed to promote utilization of best, evidence-based and informed practices and to improve access and deliver efficient, high quality services.

Criteria for screening protocols and determining whether an individual meets the criteria for specialized behavioral health services may be determined by LDH and are based on factors relating to age, diagnosis, disability (acuity) and duration of the behavioral health condition.

Screening for services, including the Coordinated System of Care, shall take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care. The Contractor shall ensure (either using care management protocols or by ensuring appropriate, proactive discharge planning by contracted providers) the screening takes place while a youth resides in an out-of-home level of care (such as inpatient, PRTF, SUD residential treatment or TGH) and is prepared for discharge to a home and community-based setting. For settings such as PRTF and TGH with lengths of stay allowing sufficient time for comprehensive and deliberate discharge and aftercare planning, the Contractor shall ensure that screening for CSoc takes place at least 30 days and up to 90 days prior to the anticipated discharge date. If CSoc screening shows appropriateness, referral to CSoc up to 90 days prior to discharge from a residential setting shall occur, as it is expected to assist in comprehensive discharge and treatment planning, prevent disruption, and improve stabilization upon reentry to a home and community environment.

2.12.4 Prior Authorization of Non-Emergency Ambulance Services

The Contractor shall not require prior authorization of non-emergency ambulance services or emergency services, except for transportation by fixed-wing air ambulance or across state lines. Any claims for intrastate ground transportation services by an ambulance, including for patients being transported while under a physician's emergency certificate, shall not require a prior authorization but may be subject to post-service review. LDH reserves the right to specify a uniform transportation form should ambulance claim issues arise.

2.12.5 Prior Authorization for Pharmacy Benefits

- MCO prior authorization criteria shall align with FFS. The MCOs shall have input on PA criteria development and representation on the DUR board. The MCO shall have a Prior Authorization (PA) process that complies with 42 C.F.R. § 438.3(s)(6) and the following requirements.
 - ❖ The MCO shall allow prescribers and pharmacies to submit PA requests by phone, fax or automated process.
 - ❖ The MCO shall provide access to a toll-free call center for prescribers to call to request PA for non-preferred drugs or drugs that are subject to clinical edits. If the MCO or its pharmacy benefit manager operates a separate call center for PA requests, it will be subject to the provider call center standards and monetary penalties set forth in the Contract.
 - ❖ PA requests shall be approved or denied within 24 hours of receipt, seven (7) days a week. The MCO shall notify the requesting practitioner of the approval or disapproval of the request within 24 hours. Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and enrollee in writing. PA denials may be appealed in accordance with the Contract.
- Consistent with the requirements of Section 1927 of the Social Security Act, LDH will hold MCOs to a 99.5% compliance rate with the 24-hour resolution requirement. If a MCO is reporting less than 99.5% compliance on the RX055 report, justification shall be included with the report in the notes section.
- The MCO shall have an automated process that allows the pharmacy to dispense without PA up to a 72-hour emergency supply of a product or full unbreakable package. At a minimum, the MCO shall allow two emergency supply fills per prescription. The MCO shall reimburse the pharmacy for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post payment review to identify misuse.
- The MCO shall prior authorize drugs with a non-preferred status on the PDL.

- The MCO shall not prior authorize drugs with a preferred status on the PDL, except to align with FFS clinical edits.
- The MCO shall not prior authorize drugs not on the PDL, except to align with FFS clinical edits or otherwise directed by LDH.
- The MCO may prior authorize drugs when safety and utilization edits are exceeded when approved by LDH, except for drugs used for the treatment and prevention of HIV/AIDS.
- MCO prior authorization (PA) criteria and/or step therapy related to the preference of one agent over another agent within a therapeutic class listed on the PDL shall not be more restrictive than FFS. Application of PA and/or step therapy criteria more restrictive than FFS may result in daily monetary penalties of \$10,000 starting the day LDH is made aware of the violation and ending when the criteria change is implemented.
- PA and/or step therapy shall not be applied to preferred agents listed on the PDL in a manner that would disadvantage the selection of the preferred agents over other agents within the therapeutic class.
- PA and/or other safety edits are allowed on physician-administered drugs.
- If a PA is requested for a narrow therapeutic index (NTI) drug, every effort should be made to verify if the recipient is currently on a specific brand/generic, then the PA shall be approved for the corresponding product. NTI drugs include: Aminophylline, Carbamazepine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-Thyroxine, Lithium, Phenytoin, Theophylline, Thyroid, Valproic Acid, and Warfarin.
- PA shall not require more than two failures of preferred products.
- The MCO shall override PA for selected drug products or devices at LDH's discretion, including but not limited to certain DUR initiatives.
- The MCO shall not require PA for drugs with FDA indication for emergency contraception.
- The MCO shall not require PA for a dosage change for any medications (including long-acting injectable antipsychotics) and other medication assisted treatment (including dosages of buprenorphine or buprenorphine/naloxone) that have been previously authorized and/or approved by the MCO, as long as the newly prescribed dose is within established FDA guidelines for that medication.
- The MCO shall not penalize the prescriber or enrollee, financially or otherwise, for PA requests or other inquiries regarding prescribed medications.

- A enrollee receiving a prescription drug that was on the PDL and was removed from the PDL or changed from preferred to non-preferred status shall be allowed to continue to receive that prescription drug for at least sixty (60) days after notification. The MCO shall have 30 days after receipt of the NDC list to send out notifications of negative changes to prescribers and enrollees. Brand/generic preference changes of the same drug entity do not constitute a negative PDL change.
- When a prescriber is requesting brand name medication that has a generic equivalent, the MCO can encourage a prescriber to complete the FDA Medwatch form. A Medwatch form shall not be required or considered in the PA approval/denial determination of a brand drug.
- PA shall not be utilized to prefer a B-rated generic drug over an A-rated generic.
- The statewide universal prior authorization form shall be posted and utilized as specified in Act 423 of the 2018 Louisiana Regular Session. In order to obtain necessary information for prior authorization processing, the following therapeutic drug classes may be considered specialty for prior authorization purposes only: Hepatitis C Direct Acting Antiviral Agents, Synagis, Respiratory monoclonal antibody agents (benralizumab (Fasenra®), dupilumab (Dupixent®), mepolizumab (Nucala®), omalizumab (Xolair®), and reslizumab (Cinqair®), Growth Hormones, Multiple Sclerosis drugs, and Hemophilia agents.

2.12.6 Drug Utilization Review (DUR) Program

The MCO shall maintain a DUR program in accordance with LDH DUR initiatives, to ensure that outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results in accordance with Section 1927(g) of SSA. DUR (prospective, retrospective and educational) standards established by the MCO shall be consistent with those same standards established by LDH and the DUR board. MCO pharmacy directors shall participate in the DUR Board initiatives and meetings.

- The MCO shall include review of Mental Health drugs in its prospective, retrospective and educational DUR program.
- DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud and abuse, and take into consideration both the quality and cost of the pharmacy benefit.
- The MCO shall provide for a DUR program that contains the following components:
 - ❖ Prospective DUR program in accordance with DUR board initiatives
 - ❖ Retrospective DUR program in accordance with DUR board initiatives

❖ Educational DUR program

- The MCO shall provide for a review of drug therapy at Point of Sale (POS) before each prescription is dispensed to the recipient. Screening should be performed for potential drug problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, duration of therapy, and clinical misuse. The following parameters should be screened at POS. Inappropriate therapy should trigger edits and each edit should have its own separate denial code and description including, but not limited to: early refill, duration of therapy, therapeutic duplication, pregnancy precaution, quantity limit (excluding opioids), quantity limit for long-acting opioids, quantity limit for short-acting opioids, diagnosis code required on selected agents, drug interactions, age limit, and dose limits. Reporting capabilities shall exist for these denial codes. The MCOs shall report data on edits to the Department on a semi-annual basis prior to the submission date requirement of the DUR Annual Report.
- Pharmacy claims processing shall be capable of capturing diagnosis codes at the POS and utilizing codes in the adjudication process at POS. Denial of pharmacy claims could be triggered by an inappropriate diagnosis code or the absence of a diagnosis code.
- The MCO shall allow pharmacist overrides on selected POS denials as instructed by LDH. The pharmacist overrides shall utilize NCPDP established standards.
- The MCO shall ensure the pharmacist offers to counsel the patient or caregiver. A log of receipt of prescription and offer to counsel by the pharmacist shall be required of all pharmacy providers registered or enrolled with the MCO. The MCO shall periodically review for compliance.

• Retrospective DUR Program

- ❖ The MCO, in conjunction with LDH, shall provide for the ongoing periodic examination of claims data to identify patterns of gross overuse, abuse, potential fraud, and inappropriate or medically unnecessary care among prescribers, pharmacists, or recipients.
- ❖ Claims review must be assessed against predetermined standards while monitoring for therapeutic appropriateness. Prescribers and pharmacists should be contacted via an electronic portal or other electronic means if possible. Facsimile and mail will suffice in some instances. Each MCO shall follow retrospective criteria approved at the DUR Board meeting. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy. The MCO is not prohibited additional retrospective DUR

initiatives that are previously approved by LDH.

- Educational DUR Program

- ❖ The MCO shall provide active and ongoing educational outreach programs to educate and inform prescribers and pharmacists on common drug therapy programs with the aim of improving prescribing and/or dispensing practices. The frequency of patterns of abuse and gross overutilization or inappropriate or unnecessary care among prescribers, pharmacists and recipients should be identified.
- ❖ MCOs shall educate prescribers, pharmacists and recipients on therapeutic appropriateness when overutilization or underutilization occurs. LDH expects the MCOs to use current clinical guidelines and national recommendations to alert prescribers and pharmacists of pertinent clinical data. Clinical outcomes shall be monitored by the MCO and reported to LDH on a periodic basis established by the Department
- ❖ LDH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. At a minimum, the DUR program must include all LDH DUR initiatives and submit new initiatives to LDH for prior approval at least forty-five (45) days in advance of the proposed effective date.
- ❖ The MCO must provide a detailed description of its DUR program annually to LDH to reflect the FFS DUR annual report to CMS. The annual report shall ensure the requirements of 1927(g) of the Act are being met by the MCO DUR program. The annual report to the state will be due two (2) weeks after CMS provides the link.
- ❖ The MCOs shall recommend one Louisiana MCO Medical Director, one Louisiana MCO Behavioral Health Director, and one Louisiana MCO Pharmacy director to represent all Louisiana MCOs as voting members on the Medicaid DUR Board. The MCO representatives may not be employed by the same MCO plan.

2.12.7 Lock-In Program

- General Requirements

- ❖ Lock-In shall be utilized when LDH or the MCO finds that an enrollee has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines. The enrollee may be restricted for a reasonable period of time to obtain Medicaid services from designated providers only in accordance with 42 C.F.R. §431.54(e).

- ❖ Two types of Lock-In shall be utilized. An enrollee may be selected for Pharmacy-Prescriber Lock-In enrollment, where the enrollee will be allowed one primary care physician and specialist(s) if needed, and a single pharmacy provider; or Pharmacy-Only Lock-in where the enrollee is asked to choose only one pharmacy provider to fill all of his/her prescriptions. Providers shall be fully enrolled in the FFS Medicaid program. The lock-in mechanism does not prohibit the enrollee from receiving services from providers who offer services other than prescriber and pharmacy benefits.
 - ❖ The MCO shall implement and maintain a statewide Pharmacy-only and a Pharmacy-Prescriber Lock-In program, in which LDH will identify enrollees who are using pharmacy services at a frequency or amount that is excessive or not medically necessary, as determined in accordance with utilization guidelines established by LDH, in conformance with 42 C.F.R. §431.54(e). Lock-In shall be executed as specified in this manual.
- Enrollee selection
 - ❖ On a periodic basis, LDH will select and generate an enrollee list for the lock-in program based on established criteria. The MCO shall notify potential lock-in enrollees of its intent to lock enrollees into a limited number of providers. The MCO shall grant appeal rights to the enrollees.
 - ❖ Each MCO may lock-in additional enrollees based on their *own* independent review, *clinical criteria*, or referral.
 - ❖ The MCO shall conduct a second review to identify any enrollee that would not benefit from the program due to complex drug therapy or other case management needs. LDH shall be notified of those recommendations.
 - Lock-in Letters
 - ❖ LDH shall create template lock-in letters for the enrollee, pharmacy provider and/or prescribing provider.
 - ❖ The MCO shall be responsible for notifying the enrollee, chosen pharmacy provider, and/or chosen prescribing provider of the proposed lock-in status.
 - ❖ MCOs shall give the enrollee notice and an opportunity for a hearing, in accordance with procedures established by LDH and the CRF, before imposing the restrictions.
 - ❖ MCOs shall ensure the enrollee has reasonable access, taking into account geographical location and travel time, to quality Medicaid services.

- ❖ The initial enrollee notification letter shall be sent no later than sixty (60) days prior to the effective lock-in date. Letters shall include lock-in period of restriction (effective and termination dates), pharmacy choice selection, and details on the enrollee's appeal rights, and pharmacy and/or prescribing provider selection.
- ❖ MCOs shall restrict the enrollee as instructed no later than ninety (90) calendar days after receiving the enrollee list, as long as the enrollee does not file an appeal.
- ❖ Enrollees may change lock-in providers every year without cause. With good cause, they may change lock-in providers only with the MCO's approval. Enrollees may change providers for the following "good cause" reasons:
 - an enrollee relocates;
 - an enrollee's primary diagnosis changes;
 - the lock-in provider(s) request(s) that the enrollee be transferred; or
 - the lock-in provider(s) stop(s) participating in the Medicaid Program and does not accept Medicaid as reimbursement for services.
- ❖ MCOs shall have Point of Sale denials to restrict enrollees to the lock-in pharmacy and/or prescriber(s).
- ❖ In case of an emergency, the MCOs shall allow an emergency supply of medication to be filled by a pharmacy other than the lock-in pharmacy to ensure access to necessary medication. Emergency fills may be subject to audit.
- ❖ When the lock-in termination period has expired, the enrollee shall be reevaluated to determine future lock-in status.
- ❖ Regardless of the enrollee's movement between MCOs, the enrollee shall remain in lock-in status until the established termination lock-in period has expired.

2.13 Enrollee Services

The Contractor shall have written policies regarding enrollee rights and responsibilities.

2.13.1 Enrollees' Rights and Responsibilities

Each enrollee is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.

- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition. To receive all information — e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives — in a manner and format that may be easily understood as defined in the Contract between LDH and the MCO.
- To receive assistance from both LDH and the Enrollment Broker in understanding the requirements and benefits of the MCO.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- To receive information on the MCO's services, to include, but not limited to:
 - ❖ Benefits covered
 - ❖ Procedures for obtaining benefits, including any authorization requirements
 - ❖ Any cost sharing requirements
 - ❖ Service area
 - ❖ Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care dentist, specialists, and hospitals
 - ❖ Any restrictions on enrollee's freedom of choice among network providers

- ❖ Providers not accepting new patients
- ❖ Benefits not offered by the MCO but available to enrollees and how to obtain those benefits, including how transportation is provided
- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in core benefits and services at least 30 days before the intended effective date of the change.
- To receive information on grievance, appeal and State Fair Hearing procedures.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
 - ❖ What constitutes an emergency medical condition, emergency services, and post-stabilization services
 - ❖ That emergency services do not require prior authorization
 - ❖ The process and procedures for obtaining emergency services
 - ❖ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract
 - ❖ Enrollee's right to use any hospital or other setting for emergency care
 - ❖ Post-stabilization care services rules as detailed in 42 C.F.R. §422.113(c)
- To receive the MCO's policy on referrals for specialty care and other benefits not provided by the enrollee's PCP.
- To have his/her privacy protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 Subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way the MCO, its providers or LDH treat the enrollee.

2.13.2 Authorized Representatives

Medicaid enrollees may appoint an Authorized Representative (AR) to accompany, assist, and represent them in matters related to their Medicaid coverage. An enrollee may have an AR who is designated by operation of law or by the action of a court.

The case record maintained by the Louisiana Medicaid program is the definitive source of the identity of an enrollee's AR. The Contractor may contact Louisiana Medicaid to obtain verification of who is authorized to speak and act on behalf of the enrollee.

If the Contractor learns of an actual or potential change in an enrollee's AR, the Contractor should be proactive in educating the enrollee/caller to report changes to Louisiana Medicaid within 10 days and provide direction on contacting Louisiana Medicaid for assistance.

The Contractor shall not create a barrier to access to treatment for enrollees who are unable to speak for themselves. The Contractor should make a reasonable effort to contact the AR to obtain the appropriate consent for treatment; however, even if that attempt is unsuccessful, it is still legally possible for the provider to furnish necessary treatment, particularly in emergency situations.

This guidance does not affect the ability of a duly designated AR to sign an authorization permitting the disclosure of an enrollee's protected health information to a third person. Medicaid does not seek to dictate the precise authorization forms to be used by MCOs and their providers, other than to require that they be HIPAA compliant. Generally, Medicaid will honor any valid, HIPAA compliant authorization that permits it to disclose the requested information, but will no longer honor it when the person who signed it ceases to be the enrollee's AR. MCOs should follow the same policy.

A disclosure authorization of the type discussed in the preceding paragraph is not the same thing as a written consent for a provider to file a grievance or appeal or to request a state fair hearing on behalf of a enrollee.

2.14 Marketing and Education

Marketing is defined as communication from an MCO to a Medicaid beneficiary who is not enrolled in that MCO that can be reasonably be interpreted to influence the beneficiary to: 1) enroll in that MCO, or 2) either not enroll in, or disenroll from, another MCO.

Enrollee education is communication with an MCO's enrollee for the purpose of retaining enrollment and improving the health status of enrollees.

2.14.1 Events and Activities Approval Process

The Contractor shall provide written notice to LDH for all marketing and enrollee education events and activities for potential or current enrollees as well as any community/health education activities that are focused on health care benefits (health fairs or other health education and promotion activities). Notice to LDH may be made prior to the event in accordance with the **Marketing and Member Education Companion Guide**.

Any revisions to approved sponsorship, press, or media events and activities must be resubmitted for approval by LDH prior to the event or activity in accordance with the **Marketing and Member Education Companion Guide**.

LDH has no jurisdiction to approve or authorize any Health Insurance Exchange activities, including the review of marketing and member materials. It is the responsibility of the Contractor to ensure its Health Insurance Exchange products are approved by the proper authorities, including the Louisiana Department of Insurance and the United States Department of Health and Human Services. The Contractor shall ensure that marketing does not violate any of the terms and conditions of the Contract.

2.14.2 Focus Groups

LDH considers any focus group that includes non-enrollee participants to be a marketing effort.

- The Contractor shall obtain prior written approval from LDH for all focus group concepts. This includes, but is not limited to, focus group objectives, number of planned participants, cumulative number of non- enrollees who have participated in previous focus groups during the current contract year and methods for the recruitment of non- enrollees. Neither the Contractor nor its subcontractors may hold a focus group or begin focus group outreach without written consent of its focus group concept.
 - ❖ LDH will review the submitted focus group concept(s) and either approve, deny or request changes within ten (10) calendar days from the date of submission.
- The Contractor must obtain prior written approval from LDH for focus group materials, as it does for all marketing and member materials. Focus group materials include, but are not limited to, scripts and other materials used in the focus group. In the case of focus group materials, the layout or presentation must be approved as well as the text.
 - ❖ LDH will review the submitted focus group materials, and either approve, deny or request changes within 30 calendar days from the date of submission.
- The Contractor must obtain prior written approval from LDH for any focus group event. A focus group event is defined as an event where enrollees and/or potential enrollees are brought together in order to be questioned about their opinions about health insurance, Medicaid, MCOs, Medicaid Managed Care, or any related subject. The proposed focus group event should be submitted to LDH in accordance with the **Marketing and Member Education Companion Guide**. Required data elements include, but are not limited to, Event Date, Event Start Time, Event End Time, Street Address and City. Information as to whether or not inconspicuous observation is possible at the chosen venue should be included in the "Comments" field.

- ❖ Focus group events should not be submitted for LDH review until all materials for that focus group concept have been approved.
- ❖ LDH will review proposed focus group events and either approve or deny within seven (7) calendar days from the date of submission.
- The Contractor must limit total non-member participation to 50 individuals in any one (1) contract year.
- There is no limit placed on enrollee participation in focus groups.
- The maximum incentive that may be offered to each individual non-enrollee participant of a focus group is \$100 in an urban area (East Baton Rouge, Jefferson, Orleans and St. Bernard parishes) or \$125 in a rural area (parishes not specifically listed above).
- The Contractor shall provide LDH or its representatives access to any focus group event, where inconspicuous observation is possible, upon request.
- Data and its analysis resulting from all focus group events must be submitted to LDH for informational purposes upon request.

2.14.3 Marketing and Member Education Plan

The Contractor shall develop and implement a Marketing and Member Education Plan in accordance with the **Marketing and Member Education Companion Guide**. The detailed plan must be submitted as part of readiness reviews to LDH for review and approval within thirty (30) calendar days from the date the Contract is signed, and annually thereafter within thirty (30) calendar days of the end of the calendar year.

The Contractor shall not conduct enrollee education activities associated with this contract prior to the approval of the plan.

The plan shall take into consideration projected enrollment levels for equitable coverage of the entire MCO service area. The plan should clearly distinguish between marketing activities and materials and member education activities and materials.

The Contractor shall submit any changes to the Marketing and Member Education Plan or included materials or activities to LDH for approval at least thirty (30) days before implementation of the material or activity, unless the Contractor can demonstrate just cause for an abbreviated timeframe.

2.14.4 MCO Brand and Logo

The Contractor shall clearly distinguish between its Medicaid and commercial products in its branding and logo usage to ensure federal requirements against direct marketing to Medicaid enrollees are not compromised.

2.14.5 Steering

Patient steering is defined in Title 50 of the Louisiana Administrative Code as unsolicited advice or mass-marketing directed at Medicaid beneficiaries by MCOs, including any of the entity's employees, affiliated providers, agents, or contractors, that is intended to influence or can reasonably be concluded to influence the Medicaid beneficiary to enroll in, not enroll in, or disenroll from a particular MCO.

If the Contractor or its providers are found to have engaged in patient steering, they may be subject to non-compliance actions including, but not limited to, monetary penalties, loss of linked patients, and exclusion from enrollment in Medicaid/Medicaid managed care network opportunities.

The Contractor should ensure that its network providers adhere to the following:

- Providers may inform their patients of all MCO networks in which they participate, and may inform patients of the benefits, services, and specialty care services offered through the MCOs in which they participate.
- Providers are not allowed to disclose only some of the MCOs in which they participate. Disclosure of MCO participation must be all or nothing.
- Providers may display signage, provided by the MCO, at their locations indicating which MCOs are accepted there, but must include all MCOs in which they participate in this signage.
- Providers may not recommend one MCO over another MCO and may not offer patients incentives for selecting one MCO over another. Providers may allow use of office equipment (e.g., phones, computers, etc.) for enrollee-directed enrollment or disenrollment purposes.
- Providers may not assist a patient in the selection of a specific MCO. Additionally, patients may not use the provider's office equipment to make such a selection, except as required for the completion of a Medicaid application as a function of being an enrolled Medicaid Application Center.
- Patients who need assistance with their MCO services should call the member call center for the MCO in which they are enrolled, and those who wish to learn more about the different MCOs should contact the Healthy Louisiana Enrollment Broker at 1-855-229-6848 to receive assistance in making an MCO decision.

- Under no circumstances is a provider allowed to change a enrollee's MCO or request an MCO reassignment on an enrollee's behalf. Disenrollment requests must be initiated and approved by the enrollee. Enrollees who wish to change MCOs for cause must make this request to Medicaid themselves through the Enrollment Broker.

These prohibitions against patient steering apply to participation in the Medicaid managed care and the legacy Medicaid programs.

For pharmacies enrolled as Louisiana Medicaid providers, or contracted with any MCO's pharmacy benefit manager, the same steering prohibitions stated above apply to communications with Medicaid/Medicaid managed care patients.

2.14.6 Reporting Alleged Marketing Violations

Alleged marketing violations shall be reported to LDH in writing utilizing the **Marketing Complaint Form**.

2.15 Enrollee Grievances, Appeals and State Fair Hearings

The Contractor shall establish and maintain a system for receiving and resolving enrollee grievances and appeals. Components shall include a grievance process, an appeal process, and a process to access a state fair hearing.

2.15.1 Continuation of Benefits

An enrollee is only entitled to a continuation of benefits pending resolution of an appeal or state fair hearing when a previously authorized benefit is terminated, suspended, or reduced prior to the expiration of the current service authorization.

- Expiration of an approved number of visits does not constitute a termination for purposes of notice and continuation of benefits. The cessation of services because the authorization expired is not cause for a continuation of benefits, since the enrollee had no right to expect the services to continue beyond the "previously authorized" quantity, period, or duration.
- When a prescription, including refills, runs out and the enrollee requests another prescription, this is a new request, not a termination of benefits. In these circumstances, the Contractor is not required to send a notice or continue benefits pending the outcome of an appeal or State fair hearing. If the enrollee requests a reauthorization that the Contractor denied, the Contractor shall treat this request as a new request for service authorization and provide notice of the denial or limitation.

2.16 Quality Management and Quality Improvement

LDH's Medicaid Managed Care Quality Strategy ("Quality Strategy") defines and drives the overall vision for advancing health outcomes and quality of care provided to Louisiana Medicaid enrollees. The Contractor must have an overall quality management and quality improvement approach with specific strategies that advance the Quality Strategy and LDH's incentive-based quality measures.

2.16.1 Performance Improvement Projects

At LDH's request, prior to initiation for each LDH-directed PIP, the Contractor shall submit in writing a PIP proposal, in compliance with this manual and the MCO Contract, for LDH approval. The Proposal shall include:

- An overview explaining how and why the project was selected, the status of the PIP, and its relevance to the MCO enrollees and providers;
- The study question;
- The study population;
- The quantifiable measures to be used, including the baseline and goal for improvement;
- Baseline methodology;
- Data sources;
- Data collection methodology and plan;
- Data collection plan and cycle, which must be at least monthly;
- Results with quantifiable measures;
- Analysis with time period and the measures covered;
- Explanation of the methods to identify opportunities for improvement; and
- An explanation of the initial interventions to be taken.

Performance Improvement Projects Reporting Requirements

- The Contractor shall submit to LDH project data analysis quarterly or as determined by LDH.
- The Contractor shall submit project outcomes annually to LDH.

- Reporting specifications are detailed in the **MCO Quality Companion Guide**.
- LDH reserves the right to request additional reports as deemed necessary. LDH will notify the Contractor of additional required reports no less than thirty (30) days prior to due date of those reports.
- PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall:
 - ❖ Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation;
 - ❖ Use clinical care standards and/or practice guidelines to objectively evaluate the care the Contractor delivers or fails to deliver for the targeted clinical conditions;
 - ❖ Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered;
 - ❖ Implement system interventions to achieve improvement in quality, including a (PDSA) cycle;
 - ❖ Evaluate the effectiveness of the interventions;
 - ❖ Provide sufficient information to plan and initiate activities for increasing or sustaining improvement;
 - ❖ Monitor the quality and appropriateness of care furnished to enrollees with special health care needs;
 - ❖ Reflect the population served in terms of age groups, disease categories, and special risk status,
 - ❖ Ensure that multi-disciplinary teams will address system issues;
 - ❖ Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark;
 - ❖ Validate the design to ensure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and
 - ❖ Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

2.16.2 Enrollee Advisory Council

The Council is to be chaired by the Contractor's Administrator/CEO/COO or designee and will meet at least quarterly.

Every effort shall be made to include statewide broad representation of both enrollees/families/significant others, enrollee advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Enrollees/families/significant others and enrollee advocacy groups shall make up at least fifty percent (50%) of the membership.

The Contractor shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.

The Contractor shall develop and implement an Enrollee Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, enrollees' perspectives to improve quality of care. This plan shall be submitted to LDH within thirty (30) days of signing the Contract and annually thereafter.

LDH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any enrollee-identifying information redacted.

2.16.3 Adverse Incident and Quality of Care Concerns Management and Reporting

- The following are types of Critical Incidents:
 - ❖ Abuse (child/youth) - any one of the following acts that seriously endanger the physical, mental, or emotional health and safety of the child.
 - The infliction, attempted infliction, or, because of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person.
 - The exploitation or overwork of a child by a parent or any other person.
 - The involvement of a child in any sexual act with a parent or any other person.
 - The aiding or toleration by the parent of the caretaker of the child's sexual involvement with any other person or of the child's involvement in pornographic displays or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (La. Ch. Code art. 603(2))

- ❖ Abuse (adult) - the infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value. (La. R.S. 15:1503.2)
- ❖ Chemical restraint - consist of one time as needed medications which restricts the freedom of movement or causes incapacitation by sedation.
- ❖ Death - regardless of cause or the location where the death occurred.
- ❖ Exploitation (adult) - the illegal or improper use or management of the funds, assets, or property of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage. (La. R.S. 15:1503.7)
- ❖ Extortion (adult) - the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or Abuse of legal or official authority. (La. R.S. 15:503.8)
- ❖ Mechanical/Physical Restraint - Any physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
- ❖ Neglect (child/youth) - the refusal or unreasonable failure of a parent or caretaker to supply the child with the necessary food, clothing, shelter, care, treatment, of counseling for any illness, injury, or condition of the child, as a result of which the child's physical, mental or emotional health and safety are substantially threatened or impaired. This includes prenatal illegal drug exposure caused by the parent, resulting in the Newborn being affected by the drug exposure and withdrawal symptoms. (La. Ch. Code art. 603(18))
- ❖ Neglect (adult) - the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 15:1503.10)
- ❖ Protective Hold (Sometimes called "Personal Restraint") - the application of physical force using body pressure, without the use of any device, to an individual for the purpose of restraining the free movement of the individual's body.

- ❖ Seclusion - the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.

2.16.4 Outcome Assessment for Behavioral Health Services

Reserved.

2.17 Value-Based Payment

Value-based payment (VBP) is a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use.

2.17.1 VBP Strategic Plan

The Contractor shall develop its VBP Strategic Plan in accordance with the **VBP Requirements** appendix.

2.17.2 Minimum VBP Threshold and Qualifying VBP Arrangements

The Contractor shall demonstrate that it has met the minimum VBP threshold established as defined by LDH in accordance with the Contract and the **VBP Requirements** appendix.

2.17.3 Physician Incentive Plan

The Contractor's Physician Incentive Plans shall be in compliance with 42 C.F.R. §438.3(i), §422.208 and §422.210, the Contract, and the **Physician Incentive Plan Requirements** appendix.

2.18 Claims Management

2.18.1 Functionality

Required data elements are provided in the **Systems Companion Guide**.

2.18.2 Adjustments and Void

The Contractor may adjust or void incorrect claims payments.

The Contractor may adjust or void incorrect claims payments electronically or hard copy. Adjustments/voids must be submitted on the correct adjustment/void forms.

Only one internal control number (ICN) should be adjusted or voided on each form.

Only a paid claim can be adjusted or voided.

2.18.3 Rejected Claims

In the claims rejection letter, the Contractor shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, must include the following:

- The date the letter was generated;
- The enrollee's name;
- Provider identification, if available, such as provider ID number, TIN or NPI;
- The date of each service;
- The patient account number assigned by the provider;
- The total billed charges;
- The date the claim was received; and
- The reasons for rejection.

For purposes of Contractor reporting on payment to providers, an adjustment to a paid claim shall not be counted as a claim and electronic claims shall be treated as identical to paper based claims.

2.18.4 Payment to Providers

Interest owed to the provider must be reported on the encounter submission to the FI as defined in the **Systems Companion Guide**.

2.18.5 Claims Dispute Management

The Contractor shall have a claims dispute process for providers with the following elements:

Claim Reconsideration	
Time Requirements	Request for claim reconsideration review must be received from the provider within 180 calendar days of the Remittance Advice paid date or original denial date. A determination will be made by the MCO within 30 days of receipt.
How to Submit	Request may be submitted verbally, in writing or through the web portal (if applicable). The MCO shall provide a reference number for all requests for claim

	<p>reconsideration. This reference number can be used for claim appeals if necessary.</p> <p>Contact information, including phone number and mailing address.</p>
Links for More Information	[To be provided by MCO]
Claim Appeal	Include any documentation from prior claim reconsideration requests when submitting a claim appeal.
Time Requirements	<p>Must be received within [#] calendar days of the date on the determination letter from the original request for claim reconsideration.</p> <p>A determination will be made by the MCO within 30 calendar days of receipt.</p>
How to Submit	Claim appeals must be submitted in writing.
Address for Submission	[To be provided by MCO]
Arbitration	<p>Providers who have completed the MCO dispute process and remain dissatisfied with the MCO's determination may submit a written request for arbitration. The request should include decisions from all claim reconsideration requests and claim appeals.</p> <p>Note: Per House Bill No. 492 Act No. 349, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.</p>
	<p>Within 30 calendar days from the date of the appeal determination, submit written request to:</p> <p>[To be provided by MCO]</p>
Independent Review	<p>The Independent Review process may be initiated after claim denial.</p> <p>Note: Per House Bill No. 492 Act No. 349, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.</p>
	<ul style="list-style-type: none"> The Independent Review process was established by La-RS 46:460.81, et seq. to resolve claims disputes when a provider believes an MCO has partially or totally denied claims incorrectly. An MCO's failure to send a provider a remittance advice or other written or electronic notice either partially or totally

	<p>denying a claim within 60 days of the MCO's receipt of the claim is considered a claims denial.</p> <ul style="list-style-type: none"> • Independent Review is a two (2) step process which may be initiated by submitting an Independent Review Reconsideration Request Form to the MCO within 180 calendar days of the Remittance Advice paid, denial, or recoupment date. Request forms are available on MCO websites or at the link below. • If a provider remains dissatisfied with the outcome of an Independent Review Reconsideration Request, the provider may submit an Independent Review Request Form to LDH within 60 calendar days of the MCO's decision. Request form available at the link below. • There is a \$750 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCO is responsible for paying the fee. Conversely, if the independent reviewer finds in favor of the MCO, the provider is responsible for paying the fee. • Additional detailed information and copies of above referenced forms are available at: http://ldh.la.gov/index.cfm/page/2982.
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If the MCO or LDH or its subcontractors discover errors made by the MCO when a claim was adjudicated, the MCO shall make corrections and reprocess the claim within thirty (30) calendar days of discovery, or if circumstances exist that prevent the MCO from meeting this time frame, a specified date shall be approved by LDH. The MCO shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.

2.18.6 Encounter Data

The Contractor shall submit encounter data according to specifications, including data elements and reporting requirements, outlined in the **Systems Companion Guide**.

The Contractor shall submit paid, denied, adjusted, and voided claims with the appropriate identifiers established in the **Systems Companion Guide** to indicate these claims as encounters.

The Contractor should refer to the **Systems Companion Guide** for a list of encounter edit codes.

2.18.7 Claims Summary Report

The Contractor must submit monthly Claims Summary Reports of paid and denied claims to LDH by claim type per instructions in the **Systems Companion Guide**.

2.18.8 Pharmacy Encounters Claims Submission

The Contractor shall submit a weekly claim-level detail file of pharmacy encounters to LDH which includes individual claim-level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. See the **Systems Companion Guide** for a complete listing of claim fields required.

2.18.9 Disputed Pharmacy Encounter Submissions

Within 60 calendar days of receipt of the disputed encounter file from LDH, the Contractor shall, if needed, correct and resubmit any disputed encounters and send a response file that includes 1) corrected and resubmitted encounters as described in the Rebate Section of the **Systems Companion Guide** and/or 2) a detailed explanation of why the disputed encounters could not be corrected including documentation of all attempts to correct the disputed encounters at an encounter claim level detail, as described in the Rebate Section.

- 340B Claim Level Indicators
- Carve In Pharmacy Claims: On 340B claims, a value of "20" in NCPDP field 420-DK (Submission Clarification Code) and a value of "8" in NCPDP field 423-DN (Basis of Cost Determination) shall be submitted in the pharmacy claim segment of a billing transaction.
- Professional Services Claims (Physician- Administered Drug Claims): Physician-Administered drug claims shall use the UD modifier to identify 340B drugs on outpatient physician-administered drug claims.
- Carve-Out Claims: Covered entities who carve out Medicaid beneficiaries shall bill according to guidelines provided in each plan's provider manual.

2.18.10 Audit Requirements

Audit Coordination and Claims Reviews

- The Contractor shall coordinate audits with LDH in accordance with the audit coordination provisions.
- In the event LDH identifies an overpayment, the Contractor shall have ten (10) business days

from the date of notification of overpayments to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or designee. The Contractor shall not correct the claims upon notification by the Department or designee, unless directed to do so by LDH.

- LDH reserves the right to review any claim paid by the Contractor or designee. The Contractor has the right to collect or recoup any overpayments identified by the Contractor from providers of service in accordance with existing laws or regulations. If an overpayment is identified by the State or its designee and the provider fails to remit payment to the state, LDH may require the Contractor to collect and remit the overpayment to LDH. The Contractor shall refund the overpayment to the Department within thirty (30) calendar days. Failure by the Contractor to collect from the provider does not relieve the Contractor from remitting the identified overpayment to LDH.

2.19 Systems and Technical Requirements

The Contractor shall maintain an automated Management Information System (MIS), hereinafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data, and validates prior authorization and pre-certification that complies with LDH and federal reporting requirements.

2.19.1 General Requirements

The Contractor shall ensure that its System meets the requirements of the **Systems Companion Guide**.

2.19.2 HIPAA Standards and Code Sets

Data elements and file format requirements may be found in the **Systems Companion Guide**.

2.19.3 Connectivity

The System shall conform and adhere to the data and document management standards of LDH and its FI, inclusive of standard transaction code sets as outlined in the **Systems Companion Guide**.

2.19.4 Hardware and Software

The Contractor shall maintain hardware and software compatible with current LDH requirements which are as follows. This includes, but is not limited to, call center operations, claims EDI operations, authorized services operations, and enrollee services operations.

- Desktop Workstation Hardware:

- ❖ IBM-compatible, networked PC running Microsoft Windows 7 or later operating system.
- Desktop Workstation Software:
 - ❖ Operating system should be Microsoft Windows 7 or later,
 - ❖ Web browser that is equal to or surpasses Microsoft Internet Explorer v7.0 and is capable of resolving JavaScript and ActiveX scripts;
 - ❖ An e-mail application that is compatible with Microsoft Outlook 2007 or later. The e-mail application should have the ability to send secure messages in the case that Protected Health Information (PHI) is present. E-mail users should be periodically (at least annually) trained in the appropriate use of secure e-mail functionality with respect to PHI;
 - ❖ An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 or later;
 - ❖ Each workstation should be networked and have access to high speed Internet;
 - ❖ Each workstation connected to the Internet should have anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered;
 - ❖ A desktop compression/encryption application that is compatible with WinZIP v11.0;
 - ❖ All contractor-utilized workstations, laptops and portable communication devices shall be:
 - Protected by industry standard virus protection software which is automatically updated on a regular schedule;
 - Have installed all security patches which are relevant to the applicable operating system and any other system software; and
 - Have encryption protection enables at the Operating System level.
 - ❖ Compliant with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).

2.19.5 Network and Back-up Capabilities

The Contractor shall:

- Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs);
- Establish appropriate hardware firewalls, routers, and other security measures so that the MCO's computer network is not able to be breached by an external entity;
- Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval/recovery of mainframe (when applicable), network server data and desktop workstation data;
- Ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices; and
- Establish independent generator back-up power capable of supplying necessary power for a minimum of four (4) days.

2.19.6 Provider Enrollment

Provider enrollment systems shall include, at minimum, the following functionality:

- Audit trail and history of changes made to the provider file;
- Automated alerts when provider licenses are nearing expiration;
- Retention of NPI requirements;
- System generated letters to providers when their licenses are nearing expiration;
- Linkages of individual providers to groups;
- Credentialing information;
- Provider office hours; and
- Provider languages spoken.

2.20 Fraud, Waste, and Abuse Prevention

Preventing and detecting Medicaid fraud, waste, and abuse requires a collaborative effort by various parties.

LDH, the State Auditor's Office, and the Office of the Attorney General are responsible for identifying and reviewing suspected incidents of fraud, waste, and abuse. This includes the preliminary investigation of credible allegations of fraud, the preliminary and full investigation of fraud, waste, and/or abuse, and any other matters necessary to comply with federal and State regulations. The Office of the Attorney General conducts criminal investigation and prosecution of fraud and abuse by providers, via its Medicaid Fraud Control Unit (MFCU), and by recipients based on LDH and MCO referrals and complaints received from the public.

The Contractor is responsible for quality review, compliance, and fraud and abuse investigation. Subjects may be MCO employees, subcontractors, providers, and enrollees. The Contractor has no criminal review authority, although it may pursue civil damages, so the Contractor is required to report suspected and confirmed fraud and abuse to LDH and MFCU. Specific responsibilities include the following:

- Investigations
 - ❖ The Contractor and its subcontractors are responsible for investigating and reporting fraud, waste, and abuse for all services under this Contract.
 - ❖ All reviews shall be completed within eight months (240 calendar days) unless an extension is authorized.
- Referrals
 - ❖ All confirmed or suspected provider fraud and abuse shall be reported to LDH and MFCU.
 - ❖ Contact with a provider is prohibited when the MCO has submitted a fraud referral, until approved by LDH.
- Reporting
 - ❖ The Contractor shall report all audits, overpayments identified, and recoveries by the MCO and its subcontractors.
 - ❖ The Contractor shall adjust encounters when it discovers the data is incorrect, no longer valid, or some element of the claim needs to be changed.

PART 3: STATE RESPONSIBILITIES

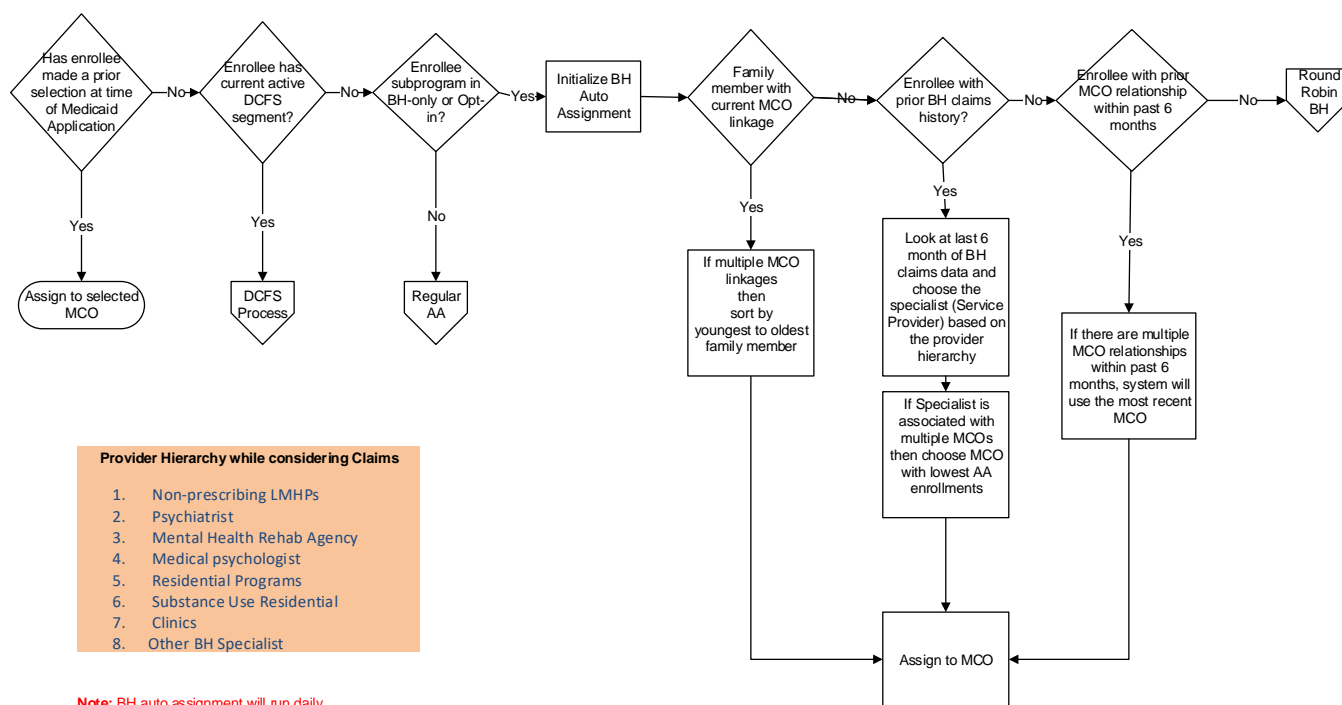
3.1 Contract Management

The mission of LDH is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. LDH is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner.

The LDH Bureau of Health Services Financing (BHSF) is the single state Medicaid agency which has primary oversight of the Contract, including Medicaid policy decision-making and Contract interpretation. As appropriate, BHSF shall provide clarification of Contract requirements and Medicaid policy, regulations and procedures and shall schedule meetings as necessary with the Contractor.

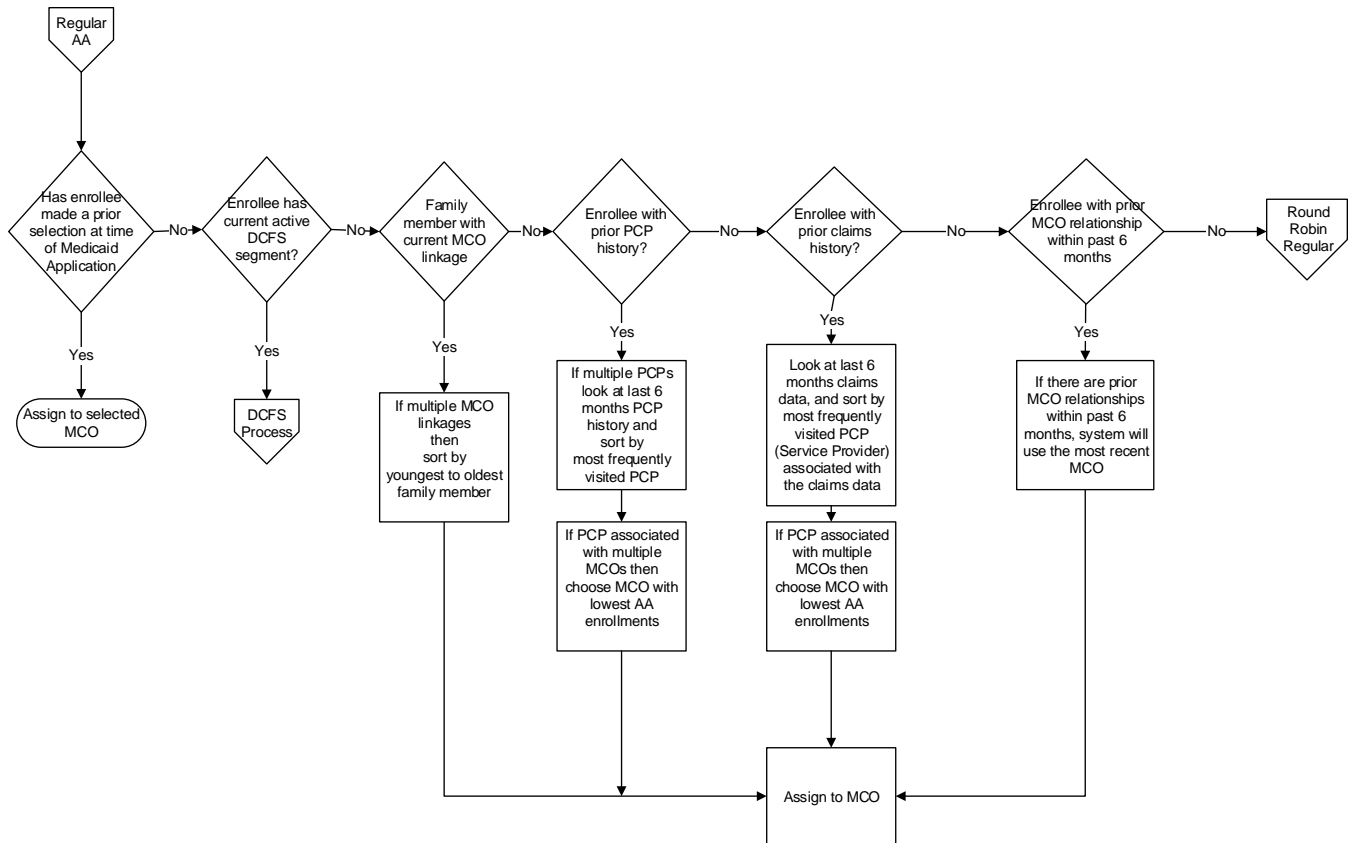
3.1.1 Automatic Assignment

LDH shall assign enrollees to MCOs in accordance with the methodology outlined in the Contract and as depicted in the following flowcharts.

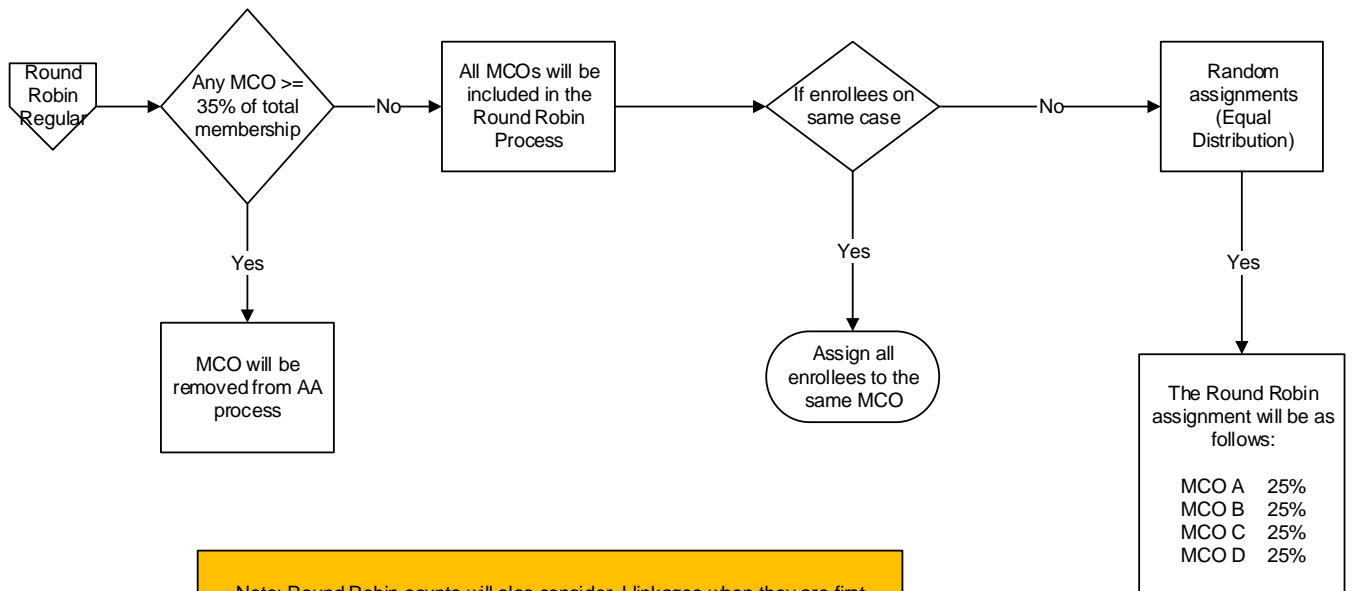


Note: BH auto assignment will run daily.

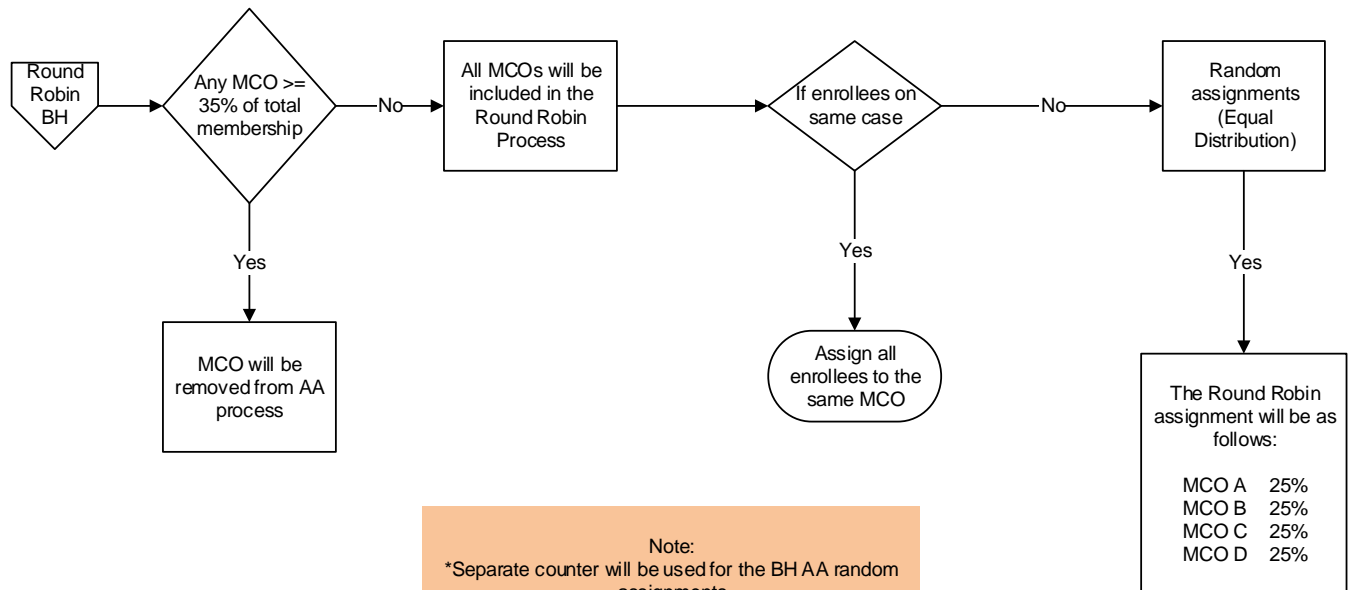
Note: The Behavioral Health process also applies to K linkages ("Pseudo linkages").



Note: These AA rules apply to J and P linkages alike.



Note: Round Robin counts will also consider J linkages when they are first created. When J linkages are converted to P linkages, they will not be counted again.



Note:
 *Separate counter will be used for the BH AA random assignments
 * Equal distribution of assignments to all plans
 *Round Robin counts will also consider K linkages when they are first created. When K linkages are converted to B linkages, they will not be counted again.

3.2 Contract Non-Compliance

When LDH identifies that the Contractor is not compliant with the terms of the Contract, LDH may pursue administrative actions, corrective action plans, and/or monetary penalties.

PART 4: PAYMENT AND FINANCIAL PROVISIONS

4.1 Capitated Payments

Capitated payments (also referred to as “PMPM payments”) are the fixed payments that LDH makes to the Contractor for each enrollee covered under the Contract for provision of MCO covered services. This payment is made regardless of whether the enrollee receives any MCO covered services during the period covered by the payment.

4.2 Maternity Kick Payments

Kick payments are one-time fixed payments, in addition to the capitated payment, that LDH reimburses the Contractor for specific services. For each obstetrical delivery, LDH reimburses a maternity kick payment to cover the cost of prenatal care, the delivery event, and post-partum care and uncomplicated newborn hospital costs. Kick payments may be differentiated between early elective delivery events and all other delivery events.

4.3 MCO Payment Schedule

The Contractor should refer to the payment schedule established by LDH and published on the Fiscal Intermediary website (www.lamedicaid.com).

4.4 Financial Incentives for MCO Performance

LDH withholds two percent (2%) of the Contractor’s monthly capitated payments to incentivize quality, health outcomes, and value-based payments.

- The Contractor may earn back the Quality Withhold for the measurement year based on its performance relative to incentive-based measures and targets as established by LDH and specified in the Contract, prior to the start of the measurement year.
- The Contractor may earn back the VBP Withhold based on its reporting and performance relative to VBP requirements and targets as established by the Contract. The Contractor shall report on its VBP use as specified in the **VBP Requirements** appendix.

4.5 Medical Loss Ratio

In accordance with the **Financial Reporting Guide**, the Contractor shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year.

4.6 Payment Adjustments

4.6.1 Medicaid Eligibility Determinations Based on SSI

When Supplemental Security Income (SSI) determinations are obtained by LDH from the Social Security Administration, they may be retroactive and LDH will alter eligibility periods with the appropriate aid category/type case information. This eligibility process may cause overlaps with existing eligibility periods for the impacted enrollees, resulting in a need for reconciliation between LDH, FI, enrollment broker, and the MCO.

The overlapping certification will be transmitted from LaMEDS to the MMIS (FI). The FI will send the overlapping eligibility information to the enrollment broker via daily member files and/or Weekly Full Recon files, and the enrollment broker will distribute to the MCOs via 834 Full Recon file in the 2700 Loop. All historical eligibility will be present for the MCOs.

The FI will conduct a retrospective SSI cleanup in accordance with the MCO Payment Schedule. MCOs can identify impacted enrollees by reviewing the associated 820 file.

4.7 Risk Sharing

The Medicaid managed care program is a full risk-bearing, MCO health care delivery system responsible for providing specified Medicaid covered services included in the Louisiana Medicaid State Plan to Medicaid enrollees.

An MCO assumes full risk for the cost of covered services under the Contract and incurs loss if the cost of furnishing these covered services exceeds the payment received for providing these services.

4.8 Determination of MCO Rates

LDH shall establish actuarially sound capitation rates for enrollees assigned to the Contractor to ensure that MCO covered services under this Contract are provided. Rates are set using available and appropriate sources, including FFS claims data, encounter data, and financial data and supplemental ad hoc data and analyses, and adjusted based on factors such as utilization trend, unit cost trend, TPL recoveries, and administrative costs.

4.9 Risk Adjustment

Capitated payments are risk adjusted, as deemed appropriate by LDH, to account for variation in health risks among participating MCOs.

4.10 Return of Funds

LDH may deduct from the monthly capitation payment amounts owed by the Contractor to LDH. LDH will provide written instruction to the Contractor if funds are to be returned in any other manner.

4.11 Other Payment Terms

Reserved.

4.12 Cost Sharing

In accordance with 42 C.F.R. §447.56(f)(1), Medicaid cost sharing incurred by all individuals in a Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a quarterly or monthly basis.

The Contractor and its subcontractors also may not impose copayments for the following:

- Family planning services and supplies;
- Emergency services;
- U.S. Preventive Services Task Force (USPSTF) A and B Recommendations;
- Services provided to:
 - ❖ Individuals younger than 21 years old;
 - ❖ Pregnant women;
 - ❖ Individuals who are inpatients in long-term care facilities or other institutions;
 - ❖ Native Americans;
 - ❖ Alaskan Eskimos;
 - ❖ Enrollees of an Home and Community Based Waiver;
 - ❖ Women whose basis of Medicaid eligibility is Breast or Cervical Cancer; and
 - ❖ Enrollees receiving hospice services.

The LDH FI will transmit a monthly file to the Contractor that contains enrollees who could be subject to copay, unless other copay exemptions exist. All current copay exemptions shall continue to be applied.

The Contractor shall introduce this file into its Pharmacy Benefit Manager/Point of Sale system and apply the existing copay exemptions.

4.13 Third Party Liability (TPL)

Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available Third Party Liability (TPL) resources must meet their legal obligation to pay claims before the Contractor pays for the care of an individual eligible for Medicaid.

4.13.1 General TPL Information

Specific payment mechanisms surrounding the TPL populations shall be determined by LDH in the **Systems Companion Guide**.

The Contractor must submit TPL related updates to update its system for TPL related daily TPL records sent from LDH (or its contractor) within one (1) business day of receipt. The Contractor must reconcile its system with weekly TPL reconciliation files sent from LDH within one (1) business day of receipt. If an enrollee is unable to access services or treatment until an update is made, the Contractor must verify and update its system within four (4) business hours of receipt of an update request. This includes updates on coverage, including removal of coverage that existed prior to the enrollee's linkage to the Contractor that impacts current provider adjudication or enrollee service access. Such updates must be submitted to LDH and/or its Third Party Liability vendor on the **Medicaid Recipient Insurance Information Update Form** the same day the update is made in the MCO system.

4.13.2 Cost Avoidance and Pay and Chase

The MCO shall "pay and chase" the full amount allowed under the MCO payment schedule for the claim and then seek reimbursement from the TPL insurer. The MCO shall within sixty (60) days after the end of the month in which the payment was made (or within sixty days after the end of the month the MCO learns of the existence of a liable third party) pursue recovery from said third party) for any liable of legal liability if:

- The claim is for prenatal care for pregnant women, who do not have private health insurance, as defined by HPA 16-17;
- If the provider submits a claim for prenatal services, the MCO is required to reject, but not deny the claim. The claim must be returned back to the provider noting the third party that LDH believes to be legally responsible for the payment.
- If after the provider bills the third party and a balance remains or if the claim is denied for a substantive reason, the provider can resubmit the claim to the MCO for payment of the balance, up to the maximum Medicaid payment amount established for the services provided.

- If a provider submits one bill (bundle) for all prenatal, labor and delivery services, the claim must be rejected. Since the State is now required to cost avoid prenatal claims, the option to pay and chase for the entire bundle of claims is no longer allowed.
- The claim is for preventive pediatric services as defined by HPA 16-17; or
- The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency.

4.13.3 Post-Payment Recoveries

Approval Guidelines for Lien Settlements Equal to or Greater Than \$25,000

The process for obtaining LDH approval for settlements on liens equal to or greater than \$25,000 is as follows:

- The LDH subject matter expert (SME)/business owner for the TPL Recovery process is the point of contact for these submissions. The Contractor should provide LDH with its contact for this process.
- The Contractor must submit these requests via email marked with High Importance, using the following subject format: "[MCO Name], Settlement Request, [Enrollee's Name]."
- At minimum, the Contractor must include the following in the body of the email and/or in the corresponding attachment(s):
 - ❖ Enrollee's identifying information (name, SSN, Medicaid ID#).
 - ❖ DOA/DOI (Date of Accident/Date of Incident).
 - ❖ Third party (i.e. liable party/insurance companies, defense and plaintiff attorneys), with contact information.
 - ❖ Contractor's lien amount.
 - ❖ Case settlement amount.
 - ❖ Requested settlement amount (suggested reduced amount).
 - ❖ Description of incident and injuries.
 - ❖ Reason for request and Contractor's recommendation.
 - ❖ Other liens to be considered.

- ❖ Attorney's fees and expenses.

- Once received, the LDH SME/business owner will consult with LDH Bureau of Legal Services and provide its decision to the MCO's contact via email.

4.13.4 TPL Reporting Requirements

The MCO shall provide LDH TPL information as specified in the Reporting Requirements.

4.13.5 TPL Payment Calculation

If a TPL insurer requires the enrollee to pay any co-payment, coinsurance or deductible, the MCO is responsible for making these payments under the method described below, even if the services are provided outside of the MCO network.

- Scenario 1 Professional Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
99212	55.00	0.00	24.10	36.00 (Ded)	24.10
83655-QW	30.00	0.00	11.37	28.20 (Ded)	11.37
Totals	85.00	0.00	35.47	64.20 (Ded)	35.47

- ❖ The Medicaid allowed amount minus the TPL paid amount is LESS than the patient responsibility; therefore, the Medicaid allowed amount is the payment.)

- Scenario 2 Outpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
HR270	99.25	74.44	22.04	0.00	0.00
HR450	316.25	137.19	70.24	100.00	0.00
Total	415.50	211.63	92.28	100.00	0.00

- ❖ (Medicaid "zero pays" the claim. When cost-compared, the private insurance paid more than Medicaid allowed amount for the procedure. When compared, the lesser of the Medicaid allowed amount minus the TPL payment AND the patient responsibility is the former; thus, no further payment is made by Medicaid. The claim is paid in full.)

- Scenario 3 Inpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
Multiple HR	12,253.00	2,450.00	5,052.00	300.00	300.00

- ❖ (The Medicaid allowed amount minus the TPL payment is greater than the patient responsibility; thus, the patient responsibility is paid on this covered service.)

- Scenario 4: FQHC/RHC/American Indian Clinic

Provider's PPS Rate (Medicaid allowable)	Procedure Code	Billed Charge	TPL Paid Amount	Patient Responsibility Amount	Medicaid Payment
150.00	T1015	150.00	50.00	40.00 (Ded)	100.00

- ❖ Provider's PPS rate is \$150.00. The third party paid \$50.00. Medicaid pays the difference from the PPS rate and third party payment making the provider whole.
- ❖ MCOs may not establish a cost-sharing payment methodology for enrollees with third party liability for FQHC, RHC and American Indian Clinic services at less than the Medicaid state plan rate (PPS). MCOs must pay the difference between the third party payment and the Medicaid state plan rate (PPS) for the service.
- ❖ $\text{MCO payment} = \text{Medicaid PPS Rate} - \text{TPL paid amount}$

- Scenario 5 Outpatient Pharmacy Claim

Amount Billed	TPL Paid Amount	Medicaid Maximum Allowable	Patient Responsibility Amount from Primary	Medicaid Pharmacy Co-Pay	Medicaid Payment
38.55	28.55	31.36	10.00 (Copay)	0.50	2.31
613.00	60.00	40.73	553.00 (Ded)	0.00	0.00
177.97	5.22	14.39	172.75 (Ded)	0.50	8.67

- ❖ If third party liability (TPL) is involved, the MCO as the secondary payer may not deny the claim for a high dollar amount billed for claims less than \$1,500. If the TPL pays \$0.00 or denies the claim, then the pharmacy claims should be treated as a straight Medicaid pharmacy claim. Taxes on the primary claim should be subtracted before calculating the Medicaid Maximum Allowable. Maximum Medicaid allowable is defined as professional dispensing fee plus ingredient cost (quantity * price per unit) or usual

and customary, whichever is less.

- ❖ The pricing calculation is ingredient cost (quantity * price per unit) + Dispensing Fee – TPL amount paid – copayment = Medicaid payment. If U&C is less than the Medicaid allowable, then the calculation is U&C – TPL amount paid – copayment = Medicaid payment. If there is other third party liability (TPL) payment greater than \$0.00, the MCO should electronically bypass prior authorization requirements and Point of Sale edits that would not be necessary as the secondary payer. Safety edits should still apply.
 - ❖ TPL claims should process with the same PCN and BIN number as primary claims.
- Scenario 6: LaHIPP enrollee claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
99213	70.00	40.00	36.13	10.00	10.00

- ❖ Because this is a LAHIPP recipient, Medicaid pays the co-pay even though the private insurance payment is more than the Medicaid allowable. Medicaid pays the patient responsibility on Medicaid covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.

4.14 Coordination of Benefits

4.14.1 Other Coverage Information

The Contractor shall provide TPL information it or its subcontractor discovers for each enrollee that is not included in the weekly reconciliation files received from LDH's FI. The Contractor shall submit a daily TPL file reporting verified additions and updates of TPL information in a format and medium specified by LDH. The Contractor shall review daily response files from LDH's FI and correct and resubmit rejected records until the record is correctly reported on weekly TPL reconciliation files received from LDH's FI.

4.14.2 Reporting and Tracking

The MCO's system shall identify and track potential collections. The system should produce reports indicating open receivables, closed receivables, amounts collected, amounts written off and amounts avoided.

4.15 Financial Disclosures for Pharmacy Services

Reserved.

4.16 Health Insurance Provider Fee (HIPF) Reimbursement

If the Contractor is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee ("Annual Fee") whose final calculation includes an applicable portion of the Contractor's net premiums written from LDH's Medicaid/CHIP lines of business, LDH shall, upon the Contractor satisfying completion of the requirements below, make an annual payment to the Contractor in each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by LDH (and its contracted actuary) as an adjustment to each MCO's capitation rates, in accordance with the **Financial Reporting Guide**, for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year"). The adjustment will be to the capitation rates in effect during the Data Year.

The Contractor should refer to the **Financial Reporting Guide** for the HIPF percentage calculation methodology and method or timing of payment for the Annual Fee.

4.17 Responsibility for Payment for Specialized Behavioral Health Services Provided to Coordinated System of Care (CSoc) Enrollees

Reserved.

4.18 Bond Requirements

Reserved.

PART 5: TURNOVER REQUIREMENTS

Turnover is defined as those activities that the Contractor is required to perform upon termination of the Contract in situations in which the Contractor must transition contract operations to LDH or a third party. Termination of the Contract may be initiated by the Contractor, initiated by LDH, or at the expiration of the Contract period and any extensions.

PART 6: APPENDICES

Note: The following draft appendices are provided to proposers for reference use only. Documentation will be finalized prior to contract negotiation.

6.1 Manuals and Guides

- [Chisholm Compliance Guide](#)
- [Emergency Management Plan](#)
- [Financial Reporting Guide](#)
- [Justice-Involved Pre-Release Enrollment Program Manual](#)
- [Marketing and Member Education Companion Guide](#)
- [Medicaid 834 Benefit and Enrollment Transaction Set Companion Guide](#)
- [Medicaid Behavioral Health Services Provider Manual](#)
- [Physician Incentive Plan Requirements](#)
- [Provider's Bill of Rights](#)
- [Quality Companion Guide](#)
- [Quality Strategy](#)
- [State Fair Hearing Companion Guide](#)
- Systems Companion Guide
 - [MCO System Companion Guide](#)
 - [Batch Pharmacy Encounter System Companion Guide](#)
- [VBP Requirements](#)

6.2 Forms and Templates

- [Material Subcontractor Checklist](#)
- [Marketing Complaint Submission Form](#)
- [WIC Referral Form](#)

Other forms referenced in the MCO Manual may be found at:

<https://www.lamedicaid.com/provweb1/Forms/forms.htm>.

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www.ldh.la.gov



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