§3307. Reimbursement Methodology

A. The department or its fiscal intermediary shall make monthly enhanced primary care case management fee

payments to the CCN-S and lump sum savings payments to the CCN-S, if eligible.

B. The enhanced primary care case management fee shall be based on the enrollee's Medicaid eligibility category as specified in the contract and paid on a per member per month (PMPM) basis.

C. The enhanced primary care case management fee comprises reimbursement for enhanced primary care case management functions as specified in the terms of the contract and includes funding for the CCN-S to pay the PCPs for care management (e.g. care coordination, referrals) to Medicaid enrollees linked to each PCP as specified in the terms and conditions of the contract and department issued guides.

1. The CCN-S may reimburse the PCP a monthly base case management fee for each enrollee assigned to the PCP.

2. In order to be eligible to receive these payments, the PCP must enter into a subcontract with the CCN-S, meet the performance measures goals, and remain in compliance with all of the provisions contained in the subcontract.

D. The department reserves the right to adjust these enhanced primary care case management fees on an as needed basis.

E. The CCN-S shall have limited risk for returning up to 50 percent of enhanced primary care case management fees advanced to the network when savings are not realized.

F. The department shall conduct a periodic reconciliation as specified in the contract to determine savings realized or refunds due to the department.

1. The reconciliation shall compare the actual aggregate cost of authorized/preprocessed services as specified in the contract and include the enhanced primary care case management fee for dates of services in the reconciliation period, to the aggregate Per Capita Prepaid Benchmark (PCPB).

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

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

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

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

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

a. nursing facilities;

b. dental services;

c. personal care services (EPSDT and Long-Term);

d. hospice;

e. specialized behavioral health drugs;

f. school-based Individualized Education Plan services provided by a school district and billed through the intermediate school district;

g. specified EarlySteps Program services;

h. specialized behavioral health services (e.g. mental health rehabilitation);

i. targeted case management;

j. non-emergency medical transportation;

k. intermediate care facilities for persons with intellectual disabilities;

l. home and community-based waiver services;

m. durable medical equipment and supplies; and

n. orthotics and prosthetics.

o. Reserved.

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

a. Application of the individual member total cost shall include:

i. when a member transitions between aid categories, claims will accumulate from zero under the new aid category;

ii. maternity claims that fall into the kick payment bucket will not be included in determining whether the catastrophic limit has been reached; and

iii. while no actual maternity kick payment is paid, a "benchmark maternity kick payment" has been calculated. This is a mechanism to protect plans with a disproportionate share of pregnant women in that the benchmark cost will increase for each additional delivery.

5. The department will perform interim and final reconciliations as of June 30 and December 31 of each year with provisions for incurred-but-not-reported (IBNR) claims included in the actual cost.

a. The department reserves the right to make interim payments of any savings for any dates of service with more than six months elapsed time.

b. A final reconciliation will be performed for any periods for which there are dates of service with more than 12 months elapsed time, at which point there should be sufficient completion of paid claims to determine total medical cost incurred by the CCN-S without the need to

consider additional claims that have been incurred, but are still outstanding.

c. Final reconciliations will not be for less than 12 months of service unless determined appropriate by the department. In the first year of a CCN-S's operations, the department will exclude claims from the first 30 days of operations when calculating the reconciliation.

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

7. The CCN-S will be eligible to receive up to 60 percent of savings if the actual aggregate costs of authorized services, including enhanced primary care case management fees advanced, are less than the aggregate PCPB (for the entire CCN-S enrollment).

a. Due to federally mandated limitations under the Medicaid State Plan, shared savings will be limited to five percent of the actual aggregate costs including the enhanced primary care case management fees paid. Such amounts shall be determined in the aggregate and not for separate enrollment types.

8. During the CCN Program's first two years of implementation, any distribution of CCN-S savings will be contingent upon the CCN meeting the established "early warning system" administrative performance measures and compliance under the contract. After the second year of implementation, distribution of savings will be contingent upon the CCN-S meeting department established clinical quality performance measure benchmarks and compliance with the contract.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1581 (June 2011), amended LR 40:311 (February 2014).

c. PMPM rate risk adjustments will begin three months after the implementation date for each phase of program implementation.

d. The health risk of the members and associated CCN-P risk scores will be updated periodically to reflect changes in risk over time.

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

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

b. The hospital shall accurately input the delivery event into the Louisiana Electronic Event Registration System (LEERS) as evidence that a delivery event has taken place in order for a maternity kick payment request to be initiated to the department's fiscal intermediary for payment to the CCN-P.

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

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

5. PMPM payments related to pharmacy services will be adjusted to account for pharmacy rebates.

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

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

D. A CCN-P shall assume 100 percent liability for any expenditure above the prepaid premium.

E. The CCN-P shall meet all financial reporting requirements specified in the terms of the contract.

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

1. A CCN-P shall provide an annual MLR report, in a format as determined by the department, by June 1 following the MLR reporting year that separately reports the CCN-P's medical loss ratio for services provided to Medicaid enrollees and payment received under the contract with the

§3509. Reimbursement Methodology

A. Payments to CCN-P. The department, or its fiscal intermediary, shall make monthly capitation payments to the CCN-P based on a per member, per month rate.

1. Actuarially sound rates will be determined by the department acting on the advice of its actuaries. It is intended that rates will initially be set using historical fee-for-service data, with appropriate adjustments for the expected impact of managed care on the utilization of the various types of services (some increases and some reductions) and for the expected cost of CCN-P administration and overhead.

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

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

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

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

department from any other products the CCN-P may offer in the state of Louisiana.

2. If the medical loss ratio is less than 85 percent, the CCN-P will be subject to refund of the difference, within the timeframe specified, to the department by August 1. The portion of any refund due the department that has not been paid by August 1 will be subject to interest in the amount of ten percent per annum.

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

G. Any cost sharing imposed on Medicaid members must be in accordance with the federal regulations governing cost sharing and cannot exceed the amounts reflected in the Louisiana Medicaid State Plan, but the amounts can be less than the cost sharing levels in the State Plan.

H. The department may adjust the PMPM rate, during the term of the contract, based on:

1. the health status-risk adjustment as determined by the department acting on the advice of its actuaries;

2. the inclusion of covered Medicaid services not incorporated in the applicable PMPM;

3. the implementation of federal requirements; and/or

4. legislative appropriations and budgetary constraints.

I. Any adjusted rates must continue to be actuarially sound and will require an amendment to the contract. The department will provide the CCN with three months advance notice of any major revision to the risk-adjustment methodology.

J. The CCN-P shall not assign its rights to receive the PMPM payment, or it obligation to pay, to any other entity.

1. At its option, the department may, at the request of the CCN-P, make payment to a third party administrator.

K. In the event that an incorrect payment is made to the CCN-P, all parties agree that reconciliation will occur.

1. If an error or overcharge is discovered by the department, it will be handled in accordance with the terms and conditions of the contract.

L. Network Provider Reimbursement

1. Reimbursement for covered services shall be equal to or greater than the published Medicaid fee-for-service rate in effect on the date of service. Notwithstanding, upon request by a network provider, or potential network provider, and with the prior approval of the department, exceptions may be granted.

a. The CCN-P shall pay a pharmacy dispensing fee, as defined in the contract, at a rate no less than the minimum specified in the terms of the contract.

2. The CCN-P's subcontract with the network provider shall specify that the provider shall accept payment made by the CCN as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from the department or the member.

a. The term "member" shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served.

3. The CCN-P may enter into alternative payment arrangements with its network providers or potential providers with prior approval by the department.

a. The CCN-P shall not enter into alternative payment arrangements with federally qualified health centers or rural health clinics as the CCN-P is required to reimburse these providers according to the published FQHC/RHC Medicaid prospective payment schedule rate in effect on the date of service, whichever is applicable.

M. Out-of-Network Provider Reimbursement

1. The CCN-P is not required to reimburse more than 90 percent of the published Medicaid fee-for-service rate in effect on the date of service to out-of-network providers to whom they have made at least three documented attempts to include the provider in their network as per the terms of the contract and department issued guide.

2. If three attempts to contract with the provider prior to the delivery of the medically necessary service have not been documented, the CNN-P shall reimburse the provider the published Medicaid fee-for-service rate in effect on the date of service.

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

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

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

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

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

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

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