Deleted per LA 12-15

State: **Louisiana**

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of **Louisiana** enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Native Americans (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
__X__ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

__X__ i. fee for service;
____ ii. capitation;
__X__ iii. a case management fee;
In addition to fee for service, Primary Care Providers (PCPs) are paid a management fee per member per month.
__*X__ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

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* **The Immunization Pay-for-Performance Initiative will be based on a published, three tier system of payment. The PCP must meet criteria of being enrolled in and utilizing Vaccines for Children Program (VFC) and the State Immunization Registry (LINKS) for the first level. Payment of the second and third levels will be based on HEDIS-like methodology for PCP linked CommunityCARE recipients who are up-to-date on immunizations. PCPs will only qualify for a single level of payment.**

* **Effective January 1, 2011, PCPs will receive pay-for-performance payments based on PCP compliance with the following performance standards.**

a. All Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings are performed in the PCP's office;

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b. National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Level 1 or higher status recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home Accreditation.

c. Extended office hours and the scheduling of routine, non-urgent and urgent appointments during these hours.

d. Decreased inappropriate utilization of emergency room (ER) and the need for ER services by linked recipients as determined through monthly reporting on paid claims.

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SUPERSEDES: NONE - NEW PAGE

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Citation	Condition or Requirement
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). __X__ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. __X__ ii. Incentives will be based upon specific activities and targets. __X__ iii. Incentives will be based upon a fixed period of time. __X__ iv. Incentives will not be renewed automatically. __X__ v. Incentives will be made available to both public and private PCCMs. __X__ vi. Incentives will not be conditioned on intergovernmental transfer agreements. ____ vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* **The CommunityCARE program has been operating as a 1915(b)(1) waiver since 1992 and was expanded from 20 parishes in July of 2001 to statewide in December of 2003. The statewide expansion was rolled out in regional increments and included several public meetings/presentations with area health care providers and professional medical organizations. Quarterly meetings are held with the Physicians Advisory Council. This Advisory Council consists of providers, Department officials, recipient advocates, and other interested parties. CommunityCARE is a standing topic on these meeting agendas.**

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1932(a)(1)(A)

5. The state plan program will _X_/will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) _____

ii. county/counties (voluntary)_____

iii. area/areas (mandatory)_____

iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. _X_ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. _X_ The state assures that all the applicable requirements of section 1932 including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. _X_ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)

5. _X_ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

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Citation	Condition or Requirement

1903(m)

1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)

6. ____The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

1932(a)(1)(A)

42 CFR 438.50(c)(6)

7. ____The state assures that all applicable requirements of 42 CFR 447.362 for 42 CFR 447.362 payments under any nonrisk contracts will be met.

45 CFR 74.40

8. ____The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.
   - **SSI & SSI-related (age 19 and older)**
   - **AFDC and AFDC-related**
   - **Poverty Level Eligibility Groups**

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

   Use a check mark to affirm if there is voluntary enrollment of any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment.
(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)

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

ii. __X__Native Americans who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

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Citation	Condition or Requirement
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. _X_ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. _ X _Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. _ X _Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. __ X _Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

The state defines the above referenced by receiving services at a specific clinic.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

__X__ i. program participation,
____ ii. special health care needs, or
____ iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

__X__ i. yes
____ ii. no

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Citation	Condition or Requirement
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1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; **These children are identified through an eligibility database.** ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; **These children are identified through an eligibility database.** iii. Children under 19 years of age who are in foster care or other out-of-home placement; **These children are identified through an eligibility database.** iv. Children under 19 years of age who are receiving foster care or adoption assistance. **These children are identified through an eligibility database.**
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* **Upon written request and submission of supporting medical documentation to the State, certain medically fragile eligibles may be exempt for a specified period of time, up to one year. The request for exemption must be submitted to the CommunityCARE Program by the beneficiary, specialist, or PCP along with the supporting documentation for consideration on a case-by-case basis. The State reviews the medical documentation and initiates discussions related to the beneficiary's needs with the PCP or specialist and the beneficiary and/or guardian as needed. If the beneficiary's health status (needs) is such that being linked to a PCP could place the recipient's health in jeopardy due to potential delays in seeking treatment, the request is approved. Written approval or denial notification is sent to the appropriate parties. If the request is denied the correspondence advises the recipient of their right to a fair hearing for reconsideration.**

Citation	Condition or Requirement Deleted per LA 12-15

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

   i. Recipients who are also eligible for Medicare.
   The above referenced group is identified by specific codes in the recipient Medicaid Management Information System (MMIS) file.

   ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

   The above reference group is identified by a self declared indicator on the recipient MMIS file.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Other beneficiary groups (not previously mentioned) are exempt from mandatory participation if they:

- **have medical insurance other than Medicaid that includes physician benefits;**
- **are residing in a nursing facility;**
- **are residing in an intermediate care facility for the mentally retarded (ICF/MR);**
- **are residing in psychiatric facilities;**
- **are refugees;**
- **are recipients in pregnant woman eligibility categories;**
- **have an eligibility period of less than 3 months;**
- **have only a retroactive eligibility period;**
- **are 65 years of age or older;**
- **are beneficiaries enrolled in Hospice; or**
- **are beneficiaries enrolled in PACE.**

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42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

N/A

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Enrollees are first given an opportunity to choose a participating provider. Each month a letter is mailed to new Medicaid eligibles notifying them to choose a PCP by a specific deadline and giving them a toll free number to call when they make their choice. If the potential enrollee does not choose a PCP by the stated deadline, they are then assigned a PCP by default using an electronic auto-assignment process. The auto-assignment process takes into consideration: a) previous linkage if within 90 days and the provider is still within an appropriate geographic area, b) the past one year of claims history for primary care office visits – if multiple providers have been visited during the year, the assignment is made to the provider with the most recent office visit.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Physician and physician groups who have traditionally served Medicaid recipients are enrolled in CommunityCARE as PCPs and are available for choice and default assignment.

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iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

If there is no history or prior linkage on which to base a linkage, the system then randomly auto-assigns enrollees on a rotation basis to each provider in the appropriate geographic area according to the providers' practice restrictions (e.g. no one over 16, females only over 16, new patients over 21 only).

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will **X** /will not____ use a lock-in for managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be **10 days**.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Each month following the assignment, the CommunityCARE/ KIDMED contractor, on behalf of the State, generates confirmation letters to all enrollees who chose a PCP, changed PCPs or were auto-assigned to a PCP. The letters are mailed to reach the enrollees by the 1st of the month that the linkage is effective, and it provides the linked PCP name, address, and telephone number.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The confirmation letter that is mailed to all enrollees that become linked by choice, change or auto-assignment states the enrollee may change PCPs within 90 days.

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v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*
Enrollees are auto-assigned on a rotation basis taking into consideration:
1) geographic parish of residence
2) provider capacity
3) provider practice restrictions/limits

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

At a minimum, monthly meetings between the State MMIS and CommunityCARE/KIDMED Subsystem programming staff are held to review reports generated during the monthly enrollment process.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. _X_ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

___This provision is not applicable to this 1932 State Plan Amendment.

4. ___The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of

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the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_X_ This provision is not applicable to this 1932 State Plan Amendment.

5. _X_ The state applies the automatic reenrollment provision in accordance with 42CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will_X_/will not___ use lock-in for managed care.

2. The lock-in will apply for _12_ months (up to 12 months).
NOTE: Or until the annual 60 day open enrollment period, which ever occurs first.

3. Place a check mark to affirm state compliance.

_X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).
N/A

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

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1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following services are excluded from requiring PCP authorization in Louisiana's PCCM model (There is no other Medicaid managed care model in Louisiana :

- **chiropractic services resulting from KIDMED referrals/authorizations, ages 0-21;**
- **dental services for children, ages 0-21 (billed on the ADA claim form);**
- **dental services for pregnant women, ages 21-59 (billed on the ADA claim form);**
- **dentures for adults;**
- **the three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization but do require POST authorization.); Refer to "Emergency Services" in the CommunityCARE Handbook;**
- **specific outpatient laboratory/radiology services;**
- **immunizations for children under age 21 (Office of Public Health and their affiliates) ;**
- **inpatient care that has been pre-certified: hospital, physician, and ancillary services;**
- **EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the Early Steps Program; Note: A referral/authorization from the PCP IS REQUIRED for "Children's Special Health Services" clinics (Handicapped Children's Services) operated by The Office of Public Health.**
- **family planning services;**
- **prenatal/obstetrical services;**
- **services provided through the Home and Community-Based Waiver programs;**
- **targeted case management;**
- **mental health services;**
- **neonatology services while in the hospital;**
- **ophthalmologist and optometrist services;**
- **pharmacy;**

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- **transportation services;**
- **hemodialysis;**
- **hospice services;**
- **WIC services (Office of Public Health WIC Clinics);**
- **services provided by School Based Health Centers to recipients age 10 and over; and**
- **services provided by urgent care facilities and retail convenience clinics.**

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not **X** intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. **X** The selective contracting provision in not applicable to this state plan.

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