

RULE

Department of Health and Hospitals Bureau of Health Services Financing

Coordinated Care Network (LAC 50:I.Chapters 31-40)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:I.Chapters 31-40 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part I. Administration

Subpart 3. Medicaid Coordinated Care

Chapter 31. Coordinated Care Network

§3101. Introduction

A. A coordinated care network (CCN) is an organized health care delivery system designed to improve access to care and the quality of services, as well as to promote healthier outcomes for Medicaid recipients through the establishment of a medical home system of care.

B. Coordinated care networks may be either a fee-for-service with shared savings model (CCN-S), a prepaid risk bearing managed care organization (MCO) model (CCN-P), or an alternative Medicaid managed care model that coordinates care and that the department makes available in accordance with the promulgation of administrative Rules.

1. A CCN-S is an entity that serves as a primary care case manager by providing enhanced primary care case management in addition to contracting with primary care providers (PCPs) for primary care management.

2. A CCN-P is a risk-bearing, MCO health care delivery system that is responsible for the provision of specified Medicaid State Plan services.

C. It is the department's goal to develop a health care delivery system that improves access to care and care coordination, promotes healthier outcomes, provides budget stability, and results in savings as compared to an unmanaged fee-for-service system.

D. It is the department's intent to:

1. procure the services of coordinated care networks statewide through the competitive bid process; and

a. The number of each type of coordinated care network model for each specified service area shall be no more than required to meet Medicaid enrollee capacity requirements and ensure choice for Medicaid recipients as required by federal statute.

2. provide the opportunity for an equal number of CCN-P and CCN-S models in each department designated service area, with the same minimum capacity requirements for both.

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 37:1573 (June 2011).

§3103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in coordinated care networks:

1. categorically needy individuals:

a. children up to 19 years of age and their parents who are eligible under §1931 of the Social Security Act (hereafter referred to as the Act) as poverty-level related groups or optional groups of older children and caretaker relatives;

b. qualified pregnant women and children who are eligible under §1902 and §1905 of the Act;

c. aged, blind and disabled adults over the age of 19 who are eligible under §1619, §1634, §1902 and §1905 of the Act. These individuals may be receiving cash payments through Supplemental Security Income (SSI) or have lost SSI eligibility due to a Social Security cost-of-living adjustment (COLA) or entitlement for, or an increase in Retirement, Survivors or Disability Insurance (RSDI) benefits;

d. uninsured women under the age of 65 who have been screened through the Centers for Disease Control National Breast and Cervical Cancer Early Detection Program and identified as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer, and are not otherwise eligible for Medicaid; and

e. uninsured women who are eligible through the Louisiana Children's Health Insurance Program (LaCHIP) Prenatal Option; and

2. medically needy individuals:

a. individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program.

B. Voluntary Participants

1. Participation in a CCN is voluntary for:

a. individuals who are Native Americans/Alaskan Natives and members of a federally recognized tribe except when the managed care organization or primary care case management entity is:

i. the Indian Health Service; or

ii. an Indian health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service; and

b. children under 19 years of age who are:

i. eligible under §1902(e)(3) of the Act and receiving Supplemental Security Income (SSI);

ii. in foster care or other out-of-home placement;

iii. receiving foster care or adoption assistance;

iv. receiving services through a family-centered, community-based coordinated care system that receives grant funds under §501(a)(1)(D) of Title V, and is defined by the department in terms of either program participation or special health care needs; or

v. enrolled in the Family Opportunity Act Medicaid Buy-In Program.

NOTE: These recipients will be enrolled in a CCN pursuant to the automatic assignment protocol if they do not choose a plan after a choice period of 30 days. They may request disenrollment at any time, without cause, during the first 90 days of enrollment.

C. The enrollment broker will ensure that all participants are notified at the time of enrollment that they may request disenrollment from the CCN at any time for cause.

D. Participation Exclusion

1. The following Medicaid and/or CHIP recipients are excluded from participation in a CCN and cannot voluntarily enroll in a CCN. Individuals who:

- a. receive hospice services;
- b. are both Medicare and Medicaid recipients;
- c. reside in a long-term care facility (nursing facility or intermediate care facility for persons with intellectual disabilities);
- d. receive home and community-based waiver services;
- e. are under 21 years of age and are listed on the New Opportunities Waiver Request for Services Registry (*Chisholm* class members);
- f. receive services through the Program of All-Inclusive Care for the Elderly (PACE);
- g. have a limited period of eligibility such as eligibility through the Spend-down Medically Needy Program or Emergency Services Only;
- h. are eligible through the Louisiana Children's Health Insurance Program (LaCHIP) Affordable Plan Program;
- i. are participants in the Take Charge Family Planning Waiver Program;
- j. are eligible through the Tuberculosis Infected Individual Program; or
- k. are enrolled in the Louisiana Health Premium Payment (LaHIPP) Program.

E. The department reserves the right to institute a medical exemption process for certain medically high risk recipients that may warrant the direct care and supervision of a non-primary care specialist on a case by case basis.

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 37:1573 (June 2011).

§3105. Enrollment Process

A. The CCN shall abide by all enrollment and disenrollment policy and procedures as outlined in the contract developed by the department.

B. The department will contract with an enrollment broker who will be responsible for the enrollment and disenrollment process for CCN participants. The enrollment broker shall be:

1. the primary contact for Medicaid recipients regarding the CCN and shall assist the recipient to enroll in a CCN;
2. the only authorized entity, other than the department, to assist a Medicaid recipient in the selection of a CCN; and
3. responsible for notifying all CCN members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in the contract.

C. Enrollment Period. The annual enrollment of a CCN member shall be for a period of up to 12 months contingent upon his/her continued Medicaid and CCN eligibility. A member shall remain enrolled in the CCN until:

1. DHH or its enrollment broker approves the member's written, electronic or oral request to disenroll or transfer to another CCN for cause; or

2. the annual open enrollment period or after the lock-in period; or

3. the member becomes ineligible for Medicaid and/or the CCN program.

D. Enrollment of Newborns. Newborns of Medicaid eligible mothers who are enrolled at the time of the newborn's birth will be automatically enrolled with the mother's CCN, retroactive to the month of the newborn's birth.

1. If there is an administrative delay in enrolling the newborn and costs are incurred during that period, the member shall be held harmless for those costs and the CCN shall pay for these services.

2. The CCN and its providers shall be required to register all births through the Louisiana Electronic Event Registration System (LEERS) administered by DHH/Vital Records Registry.

E. Selection of a CCN

1. As part of the eligibility determination process, Medicaid and LaCHIP applicants shall receive information and assistance with making informed choices about the CCNs in their area of residence and the availability of choice counseling. These individuals will have the opportunity to talk with an enrollment broker who shall provide additional information to assist in choosing the appropriate CCN.

2. Each new recipient shall be given no less than 30 calendar days from the postmark date of an enrollment form mailed by the enrollment broker to select a CCN and primary care provider (PCP).

a. Recipients who fail to choose a CCN shall be automatically assigned to a CCN by the enrollment broker and the CCN shall be responsible to assign the member to a PCP if a PCP is not selected at the time of enrollment into the CCN.

3. The following provisions will be applicable for recipients who are mandatory or voluntary participants.

a. If there are two or more CCNs in a department designated service area in which the recipient resides, they shall select one.

b. If there is only one CCN in a department designated service area where the recipient resides, the recipient must choose either the CCN, Medicaid fee-for-service or an alternative Medicaid managed care program that coordinates care and which the department makes available in accordance with the promulgation of administrative Rules.

c. Recipients who fail to make a selection will be automatically assigned to a participating CCN in their area.

d. Recipients may request to transfer out of the CCN for cause and the effective date of enrollment shall be no later than the first day of the second month following the calendar month that the request for disenrollment is filed.

F. Automatic Assignment Process

1. Mandatory CCN participants that fail to select a CCN and voluntary participants that do not exercise their option not to participate in the CCN program within the minimum 30 day window, shall be automatically assigned to

a CCN by the enrollment broker in accordance with the department's algorithm/formula and the provisions of §3105.E. CCN automatic assignments shall take into consideration factors including, but not limited to:

- a. the potential enrollee's geographic parish of residence;
- b. assigning members of family units to the same CCN;
- c. previous relationships with a Medicaid provider;
- d. CCN capacity; and
- e. CCN performance outcome indicators (when available).

2. Neither the MCO model nor the shared savings model will be given preference in making automatic assignments.

3. CCN automatic assignment methodology shall be available to recipients upon request to the enrollment broker prior to enrollment.

G. Selection or Automatic Assignment of a Primary Care Provider

1. As part of the Medicaid and LaCHIP application process, applicants may be given the option to indicate their preferred choice of a CCN and primary care provider.

a. If the choice of PCP is not indicated on the new enrollee file transmitted by the enrollment broker to the CCN, the CCN shall be responsible to assign the PCP.

2. The CCN is responsible to develop a PCP automatic assignment methodology in accordance with the department requirements for the assignment of a PCP to an enrollee who:

- a. does not make a PCP selection after making a voluntary selection of a CCN;
- b. selects a PCP within the CCN that has reached their maximum physician/patient ratio; or
- c. selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).

3. Members who do not proactively choose a PCP with a CCN will be automatically assigned to a PCP by the CCN. The PCP automatically assigned to the member shall be located within geographic access standards of the member's home and/or best meets the needs of the member.

4. If the enrollee does not select a PCP and is automatically assigned to a PCP by the CCN, the CCN shall allow the enrollee to change PCP, at least once, during the first 90 days from the date of assignment to the PCP. Effective the ninety-first day, a member may be locked into the PCP assignment for a period of up to nine months beginning from the original date that he/she was assigned to the CCN.

5. If a member requests to change his/her PCP for cause at any time during the enrollment period, the CCN must agree to grant the request.

H. Lock-In Period

1. Members have 90 days from the initial date of enrollment into a CCN in which they may change the CCN for any reason. Medicaid enrollees may only change CCNs without cause within the initial 90 days of enrollment in a CCN. After the initial 90-day period, Medicaid enrollees/members shall be locked into a CCN for nine additional months from the effective date of enrollment or until the annual open enrollment period, unless disenrolled under one of the conditions described in this Section.

I. Annual Open Enrollment

1. The department will provide an opportunity for all CCN members to retain or select a new CCN annually during the CCN member's open enrollment period. Prior to their annual open enrollment period, each CCN member shall receive information and the offer of assistance with making informed choices about CCNs in their area and the availability of choice counseling.

2. Members shall have the opportunity to talk with an enrollment broker representative who shall provide additional information to assist in choosing the appropriate CCN. The enrollment broker shall provide the individual with information on each CCN from which they may select.

3. During the open enrollment period, each Medicaid enrollee shall be given 60 calendar days to remain in their existing CCN or select a new CCN.

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 37:1574 (June 2011).

§3107. Disenrollment and Change of Coordinated Care Network

A. A member may request disenrollment from a CCN for cause at any time, effective the first day of the month following the month in which the member files the request.

B. A member may request disenrollment from a CCN without cause at the following times:

1. during the 90 days following the date of the member's initial enrollment with the CCN or the date the department sends the member notice of the enrollment, whichever is later;
2. at least once a year during the member's annual open enrollment period thereafter;
3. upon automatic re-enrollment if a temporary loss of Medicaid eligibility has caused the member to miss the annual open enrollment opportunity; or
4. if the department imposes the intermediate sanction against the CCN which grants enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to disenroll.

C. All member-initiated disenrollment requests must be made to the enrollment broker.

1. Oral requests to disenroll shall be confirmed by the enrollment broker by return call with written documentation, or in writing to the requestor.

2. A member's oral or written request to disenroll must be acted on no later than the first day of the second month following the month in which the member filed the request. If not, the request shall be considered approved.

3. If the disenrollment request is denied, the member may access the state's fair hearing process as outlined in the contract.

4. The effective date of disenrollment shall be no later than the first day of the second month following the calendar month the request for disenrollment is filed.

D. Disenrollment for Cause

1. A member may initiate disenrollment or transfer from their assigned CCN after the first 90 days of enrollment for cause at any time. The following circumstances are cause for disenrollment:

- a. the member moves out of the CCN's designated service area;

b. the CCN does not, because of moral or religious objections, cover the service that the member seeks;

c. the member needs related services to be performed at the same time, not all related services are available within the CCN and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;

d. the contract between the CCN and the department is terminated;

e. the member loses Medicaid eligibility;

f. the member is placed in a nursing facility or intermediate care facility for individuals with intellectual disabilities;

g. the member's eligibility changes to an excluded eligibility group;

h. to implement the decision of a hearing officer in an appeal proceeding by the member against the CCN or as ordered by a court of law; and

i. other reasons including, but not limited to:

i. poor quality of care;

ii. lack of access to services covered under the contract; or

iii. documented lack of access to providers experienced in dealing with the enrollee's health care needs.

E. Involuntary Disenrollment

1. The CCN may submit an involuntary disenrollment request to the enrollment broker, with proper documentation, for the following reasons:

a. fraudulent use of the CCN identification card. In such cases, the CCN shall report the incident to the Medicaid Program Integrity Section; or

b. the member's behavior is disruptive, unruly, abusive or uncooperative to the extent that his/her enrollment seriously impairs the CCN's ability to furnish services to either the member or other members.

2. The CCN shall promptly submit such disenrollment requests to the enrollment broker. The effective date of an involuntary disenrollment shall not be earlier than 45 calendar days after the occurrence of the event that prompted the request for involuntary disenrollment. The CCN shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.

3. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the department. All decisions are final and are not subject to CCN dispute or appeal.

4. The CCN may not request disenrollment because of a member's:

a. health diagnosis;

b. adverse change in health status;

c. utilization of medical services;

d. diminished mental capacity;

e. pre-existing medical condition;

f. refusal of medical care or diagnostic testing;

g. uncooperative or disruptive behavior resulting from his or her special needs, unless it seriously impairs the CCN's ability to furnish services to either this particular member or other members as defined in this Subsection;

h. attempt to exercise his/her rights under the CCN's grievance system; or

i. attempt to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned.

F. Department Initiated Disenrollment

1. The department will notify the CCN of the member's disenrollment due to the following reasons:

a. loss of Medicaid eligibility or loss of CCN enrollment eligibility;

b. death of a member;

c. member's intentional submission of fraudulent information;

d. member becomes an inmate of a public institution;

e. member moves out of state;

f. member becomes Medicare eligible;

g. member is placed in a long term care facility (nursing facility or intermediate care facility for persons with intellectual disabilities);

h. member becomes a participant in a home and community-based services waiver;

i. member elects to receive hospice services;

j. loss of CCN's participation; or

k. member enrolls in a managed care plan through third party coverage.

G. If the CCN ceases participation in a geographic service area or in the CCN Program, the CCN shall notify the department in accordance with the termination procedures described in the contract.

1. The enrollment broker will notify CCN members of the choices of CCNs in their geographic area. If there is no other CCN or other options for which they may be eligible, they will be placed in fee-for-service.

2. The CCN shall assist the department in transitioning the CCN members to another CCN or to the Medicaid fee-for-service delivery system or other program the recipient may be eligible for to ensure access to needed health care services.

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 37:1575 (June 2011).

§3109. Member Rights and Responsibilities

A. The CCN member's rights shall include, but are not limited to the right to:

1. receive information in accordance with federal regulations and as described in the contract and department issued guides;

2. receive courteous, considerate and respectful treatment provided with due consideration for the member's dignity and privacy;

3. receive information on available treatment options and alternatives in a manner appropriate to the member's condition and ability to understand;

4. participate in treatment decisions, including the right to:

a. refuse treatment;

b. complete information about their specific condition and treatment options including, but not limited to the right to receive services in a home or community setting or in an institutional setting if desired;

- c. seek second opinions;
- d. information about available experimental treatments and clinical trials and how such research can be accessed; and

e. assistance with care coordination from the PCP's office;

5. be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience;

6. express a concern about their CCN or the care it provides, or appeal a CCN decision, and receive a response in a reasonable period of time;

7. receive a copy of their medical records, including, if the HIPAA privacy rule applies, the right to request that the records be amended or corrected as allowed in federal regulations;

8. be furnished health care services in accordance with federal regulations governing access standards;

9. implement an advance directive as required in federal regulations (applicable for CCN-P only):

a. the CCN must provide adult enrollees with written information on advanced directive policies and include a description of applicable state law. The written information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of change;

b. members have the right to file a grievance concerning noncompliance with the advance directive requirements to the department or other appropriate licensing or certification agency as allowed in federal regulations;

10. choose his/her health professional to the extent possible and appropriate in accordance with federal regulations; and

11. be furnished health care services in accordance with federal regulations.

B. Members shall have the freedom to exercise the rights described herein without any adverse affect on the member's treatment by the department or the CCN, or its contractors or providers.

C. The CCN member's responsibilities shall include, but are not limited to:

1. informing the CCN of the loss or theft of their CCN identification card;

2. presenting their identification card when using health care services;

3. being familiar with the CCN procedures to the best of his/her abilities;

4. contacting the CCN, by telephone or in writing (formal letter or electronically, including email), to obtain information and have questions clarified;

5. providing participating network providers with accurate and complete medical information;

6. following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;

7. making every effort to keep any agreed upon appointments and follow-up appointments and contacting the provider in advance if they are unable to do so; and

8. accessing preventive care services.

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 37:1576 (June 2011).

Chapter 33. Coordinated Care Network Shared Savings Model

§3301. Participation Requirements

A. In order to participate in the Medicaid Program, a coordinated care network shared savings model (CCN-S) must be a successful bidder, awarded a contract, and pass the readiness review. A CCN-S is required to comply with all of the terms and conditions set forth in the contract.

B. A CCN-S must:

1. meet the definition of a primary care case manager (PCCM) in accordance with federal regulations;

2. be a legal entity domiciled in Louisiana and registered with the Louisiana Secretary of State's Office to do business in the state;

3. have the capability to pre-process claims (with the exception of carved-out services) and transfer data to the department's fiscal intermediary or have a contract with an entity to perform these functions;

4. provide financial reports as requested by the department;

5. post a surety bond for an amount specified by the department for the at-risk portion of the enhanced care management fee;

6. post a performance bond for an amount specified by the department;

7. not have an actual or perceived conflict of interest that, in the discretion of the department, would interfere or give the appearance of possibly interfering with its duties and obligations under this Rule, the contract and any and all appropriate guides. Conflict of interest shall include, but is not limited to, being the fiscal intermediary contractor for the department; and

8. have network capacity to enroll a minimum of 75,000 Medicaid and LaCHIP eligibles into the network in each DHH designated geographic service area.

C. A CCN-S shall provide enhanced primary care case management services to recipients in specified geographic service area(s).

1. Enhanced primary care case management services shall be provided to all Medicaid recipients enrolled in the CCN-S throughout the designated geographic service area as defined by the department.

D. Upon request by the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG), the Government Accounting Office (GAO) and/or the department or its designee, a CCN-S shall make all of its records pertaining to its contract (services provided there under and payment for service) with the department available for review, evaluation and audit. The records shall include, but are not limited to the following:

1. pertinent books and documents;

2. financial records;

3. medical records and documents; and

4. provider records and documents involving financial transactions related to the contract.

E. A CCN-S shall maintain an automated management information system that collects, analyzes, integrates and reports data that complies with department and federal reporting requirements.

1. The CCN-S shall submit its emergency/contingency plan to the department for approval if the CCN-S is unable to provide the data reporting specified in the contract and department issued guides.

F. A CCN-S shall obtain insurance coverage(s) including, but not limited to, workman's compensation, commercial liability, and errors and omissions as specified in the terms of the contract. CCN-S subcontractors, if any, shall be covered under these policies or have insurance comparable to the CCN-S's required coverage.

G. A CCN-S shall maintain a minimum net worth amount as specified in the terms of the contract.

H. A CCN-S shall provide all financial reporting as specified in the terms of the contract.

I. A CCN-S shall secure and maintain performance and fidelity bonds as specified in the terms of the contract during the life of the contract.

J. In the event of noncompliance with the contract and the department's guidelines, a CCN-S shall be subject to the sanctions specified in the terms of the contract including, but not limited to:

1. corrective action plans;
2. monetary penalties;
3. temporary management; or
4. suspension and/or termination of the CCN-S' 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 37:1577 (June 2011).

§3303. Shared Savings Model Responsibilities

A. The CCN-S shall be responsible for the administration and management of its requirements and responsibilities under the terms of the contract, and any and all department issued guides. This includes all subcontracts, employees, agents and anyone acting for or on behalf of the CCN-S.

1. No subcontract or delegation of responsibility shall terminate the legal responsibility of the CCN-S to the department to assure that all requirements are carried out.

B. A CCN-S shall possess the expertise and resources to ensure the delivery of enhanced primary care case management services to CCN-S members as specified in the terms of the contract.

1. A CCN-S shall have written policies and procedures governing its operation. A CCN-S shall also have a written provider network development plan which describes how the network will assure the department that the provision of services will occur according to the terms and conditions of the contract. These documents shall be furnished to the department upon request.

C. A CCN-S shall accept enrollees in the order in which they apply without restriction, up to the enrollment capacity limits set under the contract. The CCN-S shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status or need for health care services, and shall not use any policy or practice that has the effect of discriminating on any such basis.

D. A CCN-S shall provide enhanced primary care management services and PCP care management services as defined in the Medicaid State Plan and as specified in the terms of the contract.

E. A CCN-S shall provide a chronic care management program as specified in the terms of the contract.

F. A CCN-S shall establish and implement a quality assessment and performance improvement program as specified in the terms of the contract.

G. A CCN-S shall develop and maintain a utilization management program including policies and procedures with defined structures and processes as specified in the terms of the contract.

H. A CCN-S shall develop and maintain effective continuity of care activities which ensure a continuum of care approach to providing health care services to members.

I. A CCN-S shall promote and facilitate the capacity of all participating PCP practices to meet the recognition requirements of a National Committee for Quality Assurance (NCQA) PPC®-PCMH™ as jointly defined by NCQA or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home Accreditation and the department.

1. Participating PCPs shall be provided with technical support and appropriate incentives to assist the practices with their transition to a patient-centered medical home as specified in the terms of the contract.

J. A CCN-S shall facilitate the data interchange between practices and the network as well as data interchange between the network and the department.

K. A CCN-S shall be responsible for conducting routine provider monitoring to ensure:

1. continued access to care for Medicaid recipients;
2. compliance with CCN-S policies and procedures; and
3. that the participating providers' practices meet or exceed the department's guidelines and timelines for implementation of patient-centered medical homes.

L. A CCN-S shall not engage the services of a provider who is in non-payment status with the department or is excluded from participation in federal health care programs (i.e., Medicare, Medicaid, or the Children's Health Insurance Program).

M. Medical records shall be maintained in accordance with the terms and conditions of the contract. These records shall be safeguarded in such a manner as to protect confidentiality and avoid inappropriate disclosure according to federal and state law.

N. A CCN-S shall provide referrals to the Women, Infants and Children (WIC) Program.

O. A CCN-S shall maintain staffing that is capable of fulfilling the requirements as specified in the terms of the contract and department issued guides.

P. A CCN-S shall participate in the department's established committees for administrative simplification and quality improvement, which will include physicians, other healthcare providers as appropriate, and at least one member of the Senate and House Health and Welfare Committees or their designees.

Q. The CCN-S shall provide both member and provider services in accordance with the terms of the contract and department issued guides.

1. The CCN-S shall submit member handbooks, provider manuals, and provider directory to the department for approval prior to distribution, annually and subsequent to any revisions.

a. The CCN-S must provide a minimum of 30 days notice to the department of any proposed material changes to the member handbooks and/or provider manuals.

b. After approval has been received from the department, the CCN-S must provide a minimum of 30 days notice to the members and/or providers of any proposed material changes to the member handbooks and/or provider manuals.

R. The member handbook shall include, but not be limited to:

1. a table of contents;
2. a general description regarding:
 - a. how a coordinated care network operates;
 - b. member rights and responsibilities;
 - c. appropriate utilization of services including emergency room visits for non-emergent conditions;
 - d. the PCP selection process; and
 - e. the PCP's role as coordinator of services;
3. member rights and protections as specified in the CCN-S's contract with the department including:
 - a. a member's right to disenroll from the CCN-S;
 - b. a member's right to change providers within the CCN-S;
 - c. any restrictions on the member's freedom of choice among CCN-S providers; and
 - d. a member's right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the CCN-S if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;
4. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CCN or the department including, but not limited to:
 - a. immediately notifying the department if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;
 - b. reporting to the department's Medicaid Customer Service Unit if the member has or obtains another health insurance policy, including employer sponsored insurance; and
 - c. a statement that the member is responsible for protecting his/her identification card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;
5. the amount, duration, and scope of benefits available under the CCN-S's contract with the department in sufficient detail to ensure that members understand the benefits to which they are entitled including, but not limited to:
 - a. information about health education and promotion programs, including chronic care management;
 - b. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;
 - c. how members may obtain benefits, including family planning services and specialized behavioral health services, from out-of-network providers;
 - d. how and where to access any benefits that are available under the Louisiana Medicaid State Plan, including

information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

e. the policy on referrals for specialty care, including behavioral health services and other benefits not furnished by the member's primary care provider;

f. for counseling or referral services that the CCN-S does not cover because of moral or religious objections, the CCN-S is required to furnish information on how or where to obtain the service;

g. how to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show"; and

h. the extent to which and how after-hour services are provided;

6. information to call the Medicaid Customer Service Unit toll free telephone number or visit a local Medicaid eligibility office to report changes in parish of residence, mailing address or family size changes;

7. a description of the CCN-S' member services and the toll-free telephone number, fax telephone number, e-mail address and mailing address to contact CCN-S' Member Services Unit;

8. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English, Spanish and Vietnamese; and

9. grievance, appeal and state fair hearing procedures and time frames, as described in the CCN-S' contract with the department and department issued guide.

S. The provider manual shall include but not be limited to:

1. billing guidelines;
2. medical management/utilization review guidelines;
3. case management guidelines;
4. claims pre-processing guidelines and edits;
5. enrollee and provider grievance and appeals procedures and processes; and
6. other policies, procedures, guidelines, or manuals containing pertinent information related to operations and pre-processing claims.

T. The provider directory for members shall be developed in the following three formats:

1. a hard copy directory for members and, upon request, potential members;
2. a web-based online directory for members and the public; and
3. an electronic file of the directory for the enrollment broker.

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 37:1578 (June 2011).

§3305. Coordination of Medicaid State Plan Services

A. Core benefits and services shall be defined as those health care services and benefits required to be provided to Medicaid CCN members enrolled in the CCN-S as specified under the terms of the contract. Covered services shall be defined as those health care services and benefits to which an individual eligible for Medicaid is entitled under the Louisiana Medicaid State Plan.

B. The CCN-S shall be required to pre-process and provide service authorization, referrals, coordination, and/or assistance in scheduling medically necessary Medicaid covered services described in this Chapter, consistent with the standards as defined in the Louisiana Medicaid State Plan and the contract regarding service limits and service authorization requirements.

1. The CCN shall have policies and processes to authorize physician visits in excess of the service cap for these services as specified in the State Plan.

C. Covered services will be billed fee-for-service to the fiscal intermediary.

D. The following is a summary listing of the covered services for which the CCN-S shall pre-process and provide service authorization, referrals, coordination, and/or assistance in scheduling. These services include, but are not limited to:

1. inpatient hospital services;
2. outpatient hospital services;
3. ancillary medical services;
4. organ transplant-related services;
5. EPSDT/Well Child visits;
6. emergency medical services;
7. communicable disease services;
8. emergency medical transportation;
9. home health services;
10. family planning services as specified in 42 CFR §431.51(b)(2);
11. basic behavioral health services;
12. school-based health clinic services;
13. physician services;
14. maternity services;
15. chiropractic services; and
16. rehabilitation therapy services (physical, occupational, and speech therapies).

E. The CCN-S will be responsible for coordinating State Plan services that are medically necessary.

1. Claims will be paid fee-for-service through the Medicaid Management Information System (MMIS).

2. The CCN-S shall not implement hard limits for EPSDT services.

F. The CCN-S will not be responsible for pre-processing or providing service authorization for the following services, but shall provide any required referrals and coordination for these services:

1. EarlySteps services (specified);
2. dental services;
3. hospice services;
4. personal care services (EPSDT and long-term);
5. intermediate care facility services for persons with intellectual disabilities;
6. home and community-based waiver services;
7. behavioral health drugs;
8. school-based Individualized Education Plan (IEP) services;
9. non-emergency medical transportation;
10. nursing facility services;
11. specialized behavioral health services;
12. targeted case management;
13. durable medical equipment and certain supplies;
14. prosthetics and orthotics; and
15. non-behavioral health drugs.

G. The CCN shall implement mechanisms, as specified in the contract, to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

1. The assessment mechanisms must use appropriate health care professionals.

2. The CCN shall have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

H. Utilization Management

1. The CCN-S shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review. The program shall include service authorization and medical necessity review and comply with the requirements set forth in this Section, the contract and department issued guides.

a. The CCN-S shall submit UM policies and procedures to the department for written approval, annually and subsequent to any revisions.

2. The UM Program policies and procedures shall, at a minimum, include the following requirements:

a. the individual(s) who is responsible for determining medical necessity, appropriateness of care, level of care needed, and denying a service authorization request or authorizing a service in amount, duration or scope that is less than requested, must meet the following requirements. The individual shall:

i. be a licensed clinical professional with appropriate clinical expertise in the treatment of a member's condition or disease;

ii. have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions that have been taken or are pending such action by any hospital, governmental agency or unit, or regulatory body, that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character; and

iii. attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise;

b. the methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;

c. the data sources and clinical review criteria used in decision making;

d. the appropriateness of clinical review shall be fully documented;

e. the process for conducting informal reconsiderations for adverse determinations;

f. mechanisms to ensure consistent application of review criteria and compatible decisions;

g. data collection processes and analytical methods used in assessing utilization of healthcare services; and

h. provisions for assuring confidentiality of clinical and proprietary information;

3. The UM program's medical management and medical necessity review criteria and practice guidelines shall be reviewed annually and updated periodically as appropriate. The CCN-S shall use the medical necessity

definition as set forth in LAC 50:I.1101 for medical necessity determinations.

a. Medical management and medical necessity review criteria and practice guidelines shall:

i. be objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

ii. consider the needs of the members;

iii. be adopted in consultation with contracting health care professionals; and

iv. be disseminated to all affected providers, members, and potential members upon request.

b. The CCN-S must identify the source of the medical management criteria used for the review of medical necessity and for service authorization requests.

i. The vendor must be identified if the criteria are purchased.

ii. The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society.

iii. The guideline source must be identified if the criteria are based on national best practice guidelines.

iv. The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the CCN medical director or other qualified and trained professionals.

4. The CCN-S shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

5. The CCN-S shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

I. Claims Management

1. The CCN-S must accept and pre-process claims within two business days of receipt in accordance to the requirements in the contract and department issued guides.

2. The CCN-S shall maintain a claims management system that, at a minimum, will:

a. provide service authorization approval to providers utilizing a unique authorization number as defined in the department issued guides;

b. confirm CCN-S membership as service authorization requests are submitted on the basis of the eligibility information provided by the department;

c. verify medical necessity as defined by the department;

d. identify the date that the CCN-S receives the claim;

e. provide on-line and telephone based capabilities to providers for obtaining status information;

f. obtain a submitter identification number from the department's fiscal intermediary (FI) prior to submitting claims; and

g. submit paper claims in batch form or electronic claims to the FI within two business days of receipt from providers.

3. If a claim is partially or totally denied on the basis that the provider did not submit required information or documentation with the claim, then a remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation.

a. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the timeframe for claims pre-processing.

4. Pre-processed approved claims will be paid on a fee-for-service (FFS) basis by the department subject to prompt pay requirements for fee-for-service Medicaid claims.

a. The department shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP program pursuant to §1128 or §1156 of the Social Security Act or is otherwise not in good standing with the department.

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 37:1579 (June 2011).

§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 shall reimburse the PCP a monthly base case management fee for each enrollee assigned to the PCP. The CCN-S may reimburse an amount greater than the base case management fee, but not less than that amount.

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.

3. The CCN-S shall be subject to sanctions if it is determined that the CCN-S did not pay the base management fee to the PCPs.

a. The CCN-S shall be sanctioned an amount equal to the amount the CCN was responsible to reimburse the PCPs, plus an additional amount up to \$25,000 for each event the department determines the PCP care management fee is not reimbursed.

b. The CCN-S shall be liable to reimburse the PMPM PCP care management fee owed to the PCP(s) and all costs incurred to issue payments to the PCP within the timelines specified by the department for such reimbursement or be subject to additional sanctions.

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). The PCPB will not include the PCP care management fees.

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.

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 (excluding the PCP care management fee) 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. The enhanced primary care case management fee will be reduced by the base case management fee during the reconciliation process.

b. 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).

Chapter 35. Coordinated Care Network Managed Care Organization Model

§3501. Participation Requirements

A. In order to participate in the Medicaid Program, a coordinated care network managed care organization model (CCN-P) must be a successful bidder, be awarded a contract with the department, and complete the readiness review.

B. A CCN-P must:

1. meet the federal definition of an managed care organization as defined in federal regulations;
2. meet the requirements of R.S. 22:2016 and be licensed or have a certificate of authority from the Louisiana Department of Insurance (DOI) pursuant to Title 22 of the Louisiana Revised Statutes;
3. be certified by the Louisiana Secretary of State to conduct business in the state;
4. meet solvency standards as specified in federal regulations and Title 22 of the Louisiana Revised Statutes;
5. meet NCQA or URAC Health Plan Accreditation or agree to submit an application for accreditation at the earliest possible date as allowed by NCQA or URAC and once achieved, maintains accreditation through the life of this agreement;
6. have a network capacity to enroll a minimum of 75,000 Medicaid and LaCHIP eligibles into the network in each department designated geographic service area; and
7. not have an actual or perceived conflict of interest that, in the discretion of the department, would interfere or give the appearance of possibly interfering with its duties and obligations under this Rule, the contract and any and all appropriate guides. Conflict of interest shall include, but is not limited to, being the fiscal intermediary contractor for the department.

C. A CCN-P shall ensure the provision of core benefits and services to Medicaid enrollees in a department designated geographic service area as specified in the terms of the contract.

D. Upon request by the Centers for Medicare and Medicaid Services, the Office of Inspector General, the Government Accounting Office, the department or its designee, a CCN-P shall make all of its records pertaining to its contract (services provided there under and payment for services) with the department available for review, evaluation and audit. The records shall include, but are not limited to the following:

1. pertinent books and documents;
2. financial records;
3. medical records and documents; and
4. provider records and documents involving financial transactions related to the contract.

E. A CCN-P shall maintain an automated management information system that collects, analyzes, integrates and reports data that complies with department and federal reporting requirements.

1. The CCN-P shall submit to the department for approval the CCN-P's emergency/contingency plan if the CCN-P is unable to provide the data reporting specified in the contract and department issued guides.

F. A CCN-P shall obtain insurance coverage(s) including, but not limited to, workman's compensation, commercial liability, errors and omissions, and reinsurance as specified in the terms of the contract. Subcontractors, if

any, shall be covered under these policies or have insurance comparable to the CCN-P's required coverage.

G. A CCN-P shall provide all financial reporting as specified in the terms of the contract.

H. A CCN-P shall secure and maintain a performance and fidelity bond as specified in the terms of the contract during the life of the contract.

I. In the event of noncompliance with the contract and the department's guidelines, a CCN-P shall be subject to the sanctions specified in the terms of the contract including, but not limited to:

1. corrective action plans;
2. monetary penalties;
3. temporary management; or
4. suspension and/or termination of the CCN-P's 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 37:1583 (June 2011).

§3503. Managed Care Organization Model Responsibilities

A. The CCN-P shall be responsible for the administration and management of its requirements and responsibilities under the contract with the department and any and all department issued guides. This includes all subcontracts, employees, agents and anyone acting for or on behalf of the CCN-P.

1. No subcontract or delegation of responsibility shall terminate the legal obligation of the CCN-P to the department to assure that all requirements are carried out.

B. A CCN-P shall possess the expertise and resources to ensure the delivery of core benefits and services to members and to assist in the coordination of covered services, as specified in the terms of the contract.

1. A CCN-P shall have written policies and procedures governing its operation as specified in the contract and department issued guides.

C. A CCN-P shall accept enrollees in the order in which they apply without restriction, up to the enrollment capacity limits set under the contract.

1. A CCN-P shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status or need for health care services, and shall not use any policy or practice that has the effect of discriminating on any such basis.

D. A CCN-P shall be required to provide service authorization, referrals, coordination, and/or assistance in scheduling the covered services consistent with standards as defined in the Louisiana Medicaid State Plan and as specified in the terms of the contract.

E. A CCN-P shall provide a chronic care management program as specified in the contract.

F. The CCN-P shall establish and implement a quality assessment and performance improvement program as specified in the terms of the contract and department issued guides.

G. A CCN-P shall develop and maintain a utilization management program including policies and procedures with defined structures and processes as specified in the terms of the contract and department issued guides.

H. A CCN-P shall develop and maintain effective continuity of care activities which ensure a continuum of care approach to providing health care services to members.

I. The CCN-P must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

1. The CCN-P shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP program as well all requirements set forth in the contract and department issued guides.

J. A CCN-P shall maintain a health information system that collects, analyzes, integrates and reports data as specified in the terms of the contract and all department issued guides.

1. A CCN-P shall collect data on enrollees and provider characteristics and on services furnished to members through an encounter data system as specified in the contract and all department issued guides.

K. A CCN-P shall be responsible for conducting routine provider monitoring to ensure:

1. continued access to care for Medicaid recipients; and

2. compliance with departmental and contract requirements.

L. A CCN-P shall not engage the services of a provider who is in non-payment status with the department or is excluded from participation in federal health care programs (i.e., Medicare, Medicaid, CHIP, etc.).

M. Medical records shall be maintained in accordance with the terms and conditions of the contract. These records shall be safeguarded in such a manner as to protect confidentiality and avoid inappropriate disclosure according to federal and state law.

N. A CCN-P shall participate on the department's quality committee to provide recommendations to Medicaid on areas of standardized business process for the Coordinated Care Network Program.

O. A CCN-P shall participate on the department's established committees for administrative simplification and quality improvement, which will include physicians, hospitals, other healthcare providers as appropriate, and at least one member of the Senate and House Health and Welfare Committees or their designees.

P. The CCN-P shall provide both member and provider services in accordance with the terms of the contract and department issued guides.

1. The CCN-P shall submit member handbooks, provider manuals, and provider directory to the department for approval prior to distribution, annually and subsequent to any revisions.

a. The CCN-P must provide a minimum of 30 days notice to the department of any proposed material changes to the member handbooks and/or provider manuals.

b. After approval has been received from the department, the CCN-P must provide a minimum of 30 days notice to the members and/or providers of any proposed material changes to the member handbooks and/or provider manuals.

Q. The member handbook shall include, but not be limited to:

1. a table of contents;

2. a general description regarding:

a. how a coordinated care network operates;

b. member rights and responsibilities;

c. appropriate utilization of services including emergency room visits for non-emergent conditions;

d. the PCP selection process; and

e. the PCP's role as coordinator of services;

3. member rights and protections as specified in 42 CFR §438.100 and the CCN-P's contract with the department including, but not limited to:

a. a member's right to disenroll from the CCN-P;

b. a member's right to change providers within the CCN-P;

c. any restrictions on the member's freedom of choice among CCN-P providers; and

d. a member's right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the CCN-P if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;

4. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CCN-P or the department including, but not limited to:

a. immediately notifying the CCN-P if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;

b. reporting to the department's Medicaid Customer Service Unit if the member has or obtains another health insurance policy, including employer sponsored insurance; and

c. a statement that the member is responsible for protecting his/her identification card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;

5. the amount, duration, and scope of benefits available under the CCN-P's contract with the department in sufficient detail to ensure that members understand the benefits to which they are entitled including, but not limited to:

a. information about health education and promotion programs, including chronic care management;

b. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;

c. how members may obtain benefits, including family planning services and specialized behavioral health services, from out-of-network providers;

d. how and where to access any benefits that are available under the Louisiana Medicaid State Plan, but are not covered under the CCN-P's contract with department;

e. information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

f. how transportation is provided, including how to obtain emergency and non-emergency medical transportation;

g. the post-stabilization care services rules set forth in 42 CFR 422.113(c);

h. the policy on referrals for specialty care, including behavioral health services and other benefits not furnished by the member's primary care provider;

i. for counseling or referral services that the CCN-P does not cover because of moral or religious objections, the CCN-P is required to furnish information on how or where to obtain the service;

j. how to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a “no show”; and

k. the extent to which and how after-hour services are provided;

6. information to call the Medicaid Customer Service Unit toll free telephone number or visit a local Medicaid eligibility office to report changes in parish of residence, mailing address or family size changes;

7. a description of the CCN-P’s member services and the toll-free telephone number, fax telephone number, e-mail address and mailing address to contact CCN-P’s Member Services Unit;

8. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English, Spanish and Vietnamese; and

9. grievance, appeal and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and the CCN-P’s contract with the department.

R. The provider manual shall include but not be limited to:

1. billing guidelines;
2. medical management/utilization review guidelines;
3. case management guidelines;
4. claims processing guidelines and edits;
5. grievance and appeals procedures and processes;

and
6. other policies, procedures, guidelines, or manuals containing pertinent information related to operations and pre-processing claims.

S. The provider directory for members shall be developed in three formats:

1. a hard copy directory for members and, upon request, potential members;
2. a web-based online directory for members and the public; and
3. an electronic file of the directory for the enrollment broker.

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 37:1583 (June 2011).

§3505 Network Access Standards and Guidelines

A. The CCN-P must maintain and monitor a provider network that is supported by written agreements and is sufficient to provide adequate access of healthcare to enrollees as required by federal law and the terms as set forth in the contract. The CCN-P shall adhere to the federal regulations governing access standards as well as the specific requirements of the contract and all department issued guides.

B. The CCN-P must provide for service delivery out-of-network for any core benefit or service not available in network for which the CCN-P does not have an executed contract for the provision of such medically necessary

services. Further, the CCN-P must arrange for payment so that the Medicaid enrollee is not billed for this service.

C. The CCN shall cover all medically necessary services to treat an emergency medical condition in the same amount, duration and scope as stipulated in the Medicaid State Plan.

1. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- b. serious impairment to bodily functions; or
- c. serious dysfunction of any bodily organ or part.

2. Emergency services means covered inpatient and outpatient services that are as follows:

- a. furnished by a provider that is qualified to furnish these services under this Section; and
- b. needed to evaluate or stabilize an emergency medical condition.

3. Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an member is stabilized in order to maintain the stabilized condition or, under the circumstances described in 42 CFR §438.114, to improve or resolve the member's condition.

D. The CCN-P must maintain a provider network and in-area referral providers in sufficient numbers, as determined by the department, to ensure that all of the required core benefits and services are available and accessible in a timely manner within the CCN-P’s designated geographic service area(s) as approved by the department, in accordance with the terms and conditions in the contract and department issued guide.

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 37:1585 (June 2011).

§3507. Benefits and Services

A. Core benefits and services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to enrollees under Louisiana Medicaid State Plan.

1. Core benefits and services shall be defined as those health care services and benefits required to be provided to Medicaid CCN members enrolled in the CCN-P as specified under the terms of the contract and department issued guides.

2. Covered services shall be defined as those health care services and benefits to which a Medicaid and LaCHIP eligible individual is entitled to under the Louisiana Medicaid State Plan.

B. The CCN-P:

1. shall ensure that medically necessary services, defined in LAC 50:I.1101, are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are being furnished;

2. may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member;

3. may place appropriate limits on a service:
 - a. on the basis of certain criteria, such as medical necessity; or
 - b. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;
 4. shall provide core benefits and services as outlined and defined in the contract and shall provide medically necessary and appropriate care to Medicaid CCN Program members;
 5. shall provide all of the core benefits and services consistent with, and in accordance with, the standards as defined in the Title XIX Louisiana Medicaid State Plan:
 - a. the CCN may exceed the limits as specified in the minimum service requirements outlined in the contract;
 - b. no medical service limitation can be more restrictive than those that currently exist under the Title XIX Louisiana Medicaid State Plan; and
 6. shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes, but is not limited to prenatal care, delivery, postpartum care, and family planning/interconception care services for pregnant women in accordance with federal regulations.
- C. If the CCN-P elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the CCN-P must furnish information about the services it does not cover in accordance with §1932(b)(3)(B)(ii) of the Social Security Act and federal regulations by notifying:
1. the department in its response to the department's request for proposals (RFP) or whenever it adopts the policy during the term of the contract;
 2. the potential enrollees before and during enrollment in the CCN-P;
 3. enrollees within 90 days after adopting the policy with respect to any particular service; and
 4. members through the inclusion of the information in the member handbook.
- D. The following is a summary listing of the core benefits and services that a CCN-P is required to provide:
1. inpatient hospital services;
 2. outpatient hospital services;
 3. ancillary medical services;
 4. organ transplant-related services;
 5. family planning services as specified in 42 CFR §431.51(b)(2) (not applicable to CCN operating under a moral and religious objection as specified in the contract);
 6. EPSDT/Well Child visits;
 7. emergency medical services;
 8. communicable disease services;
 9. durable medical equipment and certain supplies;
 10. prosthetics and orthotics;
 11. emergency and non-emergency medical transportation;
 12. home health services;
 13. basic behavioral health services;
 14. school-based health clinic services provided by the Office of Public Health certified school-based health clinics;
 15. physician services;
 16. maternity services;

17. chiropractic services; and
18. rehabilitation therapy services (physical, occupational, and speech therapies).

NOTE: This overview is not all inclusive. The contract, policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, published fee schedules, and guides issued by the department are the final authority regarding services.

E. Transition Provision. In the event a member transitions from CCN included status to a CCN excluded status before being discharged from a hospital and/or rehabilitation facility, the cost of the entire admission will be the responsibility of the CCN entity. This is only one example and does not represent all situations in which the CCN is responsible for cost of services during a transition.

F. The core benefits and services provided to the members shall include, but are not limited to, those services specified in the contract.

1. Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

G. Excluded Services

1. The following services will continue to be reimbursed by the Medicaid Program on a fee-for-service basis. The CCN shall provide any appropriate referral that is medically necessary. The department shall have the right to incorporate these services at a later date if the PMPM rates have been adjusted to incorporate the cost of such service. Excluded services include:

- a. services provided through the Early-Steps Program (IDEA Part C Program services);
- b. dental services;
- c. intermediate care facility services for persons with intellectual disabilities;
- d. hospice services;
- e. personal care services (EPSDT and Long-Term);
- f. nursing facility services;
- g. pharmacy services (prescription drugs);
- h. school-based Individualized Education Plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures;
 - i. home and community-based waiver services;
 - j. specialized behavioral health; and
 - k. targeted case management services.

H. Utilization Management

1. The CCN-P shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review. The program shall include service authorization and medical necessity review and comply with the requirements set forth in this Section, the contract and department issued guides.

a. The CCN-P shall submit UM policies and procedures to the department for written approval, annually and subsequent to any revisions.

2. The UM Program policies and procedures shall, at a minimum, include the following requirements:

a. the individual(s) who is responsible for determining medical necessity, appropriateness of care, level of care needed, and denying a service authorization request or authorizing a service in amount, duration or scope that is

less than requested, must meet the following requirements. The individual shall:

i. be a licensed clinical professional with appropriate clinical expertise in the treatment of a member's condition or disease;

ii. have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions that have been taken or are pending such action by any hospital, governmental agency or unit, or regulatory body, that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character; and

iii. attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise;

b. the methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;

c. the data sources and clinical review criteria used in decision making;

d. the appropriateness of clinical review shall be fully documented;

e. the process for conducting informal reconsiderations for adverse determinations;

f. mechanisms to ensure consistent application of review criteria and compatible decisions;

g. data collection processes and analytical methods used in assessing utilization of healthcare services; and

h. provisions for assuring confidentiality of clinical and proprietary information.

3. The UM Program's medical management and medical necessity review criteria and practice guidelines shall be reviewed annually and updated periodically as appropriate. The CCN-P shall use the medical necessity definition as set forth in LAC 50:I.1101 for medical necessity determinations.

a. Medical management and medical necessity review criteria and practice guidelines shall:

i. be objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

ii. consider the needs of the members;

iii. be adopted in consultation with contracting health care professionals; and

iv. be disseminated to all affected providers, members, and potential members upon request.

b. The CCN-P must identify the source of the medical management criteria used for the review of medical necessity and for service authorization requests.

i. The vendor must be identified if the criteria are purchased.

ii. The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society.

iii. The guideline source must be identified if the criteria are based on national best practice guidelines.

iv. The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the CCN medical director or other qualified and trained professionals.

4. The CCN shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

5. The CCN-P shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

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 37:1585 (June 2011).

§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.

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.

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 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 its 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.

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 CCN-P shall reimburse the provider the published Medicaid fee-for-service rate in effect on the date of service.

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).

§3511 Prompt Pay of Claims

A. Network Providers. All subcontracts executed by the CCN-P shall comply with the terms in the contract. Requirements shall include at a minimum:

1. the name and address of the official payee to whom payment shall be made;
2. the full disclosure of the method and amount of compensation or other consideration to be received from the CCN-P; and
3. the standards for the receipt and processing of claims are as specified by the department in the CCN's contract with the department and department issued guides.

B. Network and Out-of-Network Providers

1. The CCN-P shall make payments to its network providers, and out-of-network providers, subject to conditions outlined in the contract and department issued guides.

a. The CCN-P shall pay 90 percent of all clean claims, as defined by the department, received from each provider type within 15 business days of the date of receipt.

b. The CCN-P shall pay 99 percent of all clean claims within 30 calendar days of the date of receipt.

2. The provider must submit all claims for payment no later than 12 months from the date of service.

3. The CCN-P and all providers shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws.

a. Any such documents shall be retained for a period of at least six years or until the final resolution of all litigation, claims, financial management reviews, or audits pertaining to the contract.

4. There shall not be any restrictions on the right of the state and federal government to conduct inspections and/or audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of costs.

C. Claims Management

1. The CCN shall process a provider's claims for covered services provided to members in compliance with all applicable state and federal laws, rules and regulations as well as all applicable CCN policies and procedures including, but not limited to:

- a. claims format requirements;
- b. claims processing methodology requirements;
- c. explanation of benefits and related function requirements;
- d. processing of payment errors;
- e. notification to providers requirements; and
- f. timely filing.

D. Provider Claims Dispute

1. The CCN shall:
 - a. have an internal claims dispute procedure that is in compliance with the contract and department issued guide and approved by the department;
 - b. contract with independent reviewers to review disputed claims;

c. systematically capture the status and resolution of all claim disputes as well as all associate documentation; and

d. Report the status of all disputes and their resolution to the department on a monthly basis as specified in the contract and department issued guides.

E. Claims Payment Accuracy Report

1. The CCN shall submit an audited claims payment accuracy percentage report to the department on a monthly basis as specified in the contract and department issued CCN-P guides.

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 37:1589 (June 2011).

Chapter 37. Enrollee Grievance and Appeal Process

Subchapter A. Coordinated Care Network Shared Savings Model

§3701. Introduction

A. A coordinated care network shared savings model (CCN-S) shall establish and maintain a procedure for the receipt and prompt internal resolution of all Medicaid enrollee grievances pursuant to applicable state and federal laws as well as the terms and conditions of the contract and all department issued guides.

1. All appeals received by the CCN-S must be logged in and directly forwarded to the state agency responsible for conducting the fair hearing process. The CCN-S must assist the department in handling appeals submitted by its members through the state fair hearing process.

2. The CCN-S shall not have any processes that impede the start of the state fair hearing process. The CCN-S shall work with the department toward simultaneous resolution of any appeals brought to their attention.

3. The CCN-S shall not create barriers to timely due process. If it is determined by the department that the CCN-S has created barriers to timely due process, the CCN-S shall be subject to sanctions for each incident and/or grievance. If the number of appeals reversed by the state fair hearing process exceeds 10 percent of the appeals received within a 12 month period, the CCN shall be subject to sanctions.

B. The CCN-S's grievance procedures and any changes thereto must be approved in writing by the department prior to their implementation and must include, at a minimum, the requirements set forth herein.

1. The CCN-S shall refer all members who are dissatisfied, in any respect, with the CCN-S or its subcontractor to the CCN-S's designee who is authorized to review and respond to grievances and to require corrective action.

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 37:1589 (June 2011).

§3703. Definitions

Action—a termination, suspension, or reduction (which includes denial of a service as specified in federal regulations) of Medicaid eligibility or covered services.

Appeal—a request for review of an action as defined in this Section.

Grievance—an expression of dissatisfaction about any matter other than an action as that term is defined in this

Section. The term is also used to refer to the overall system that includes CCN-S level grievances and access to a fair hearing. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

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 37:1589 (June 2011).

§3705. General Provisions

A. The CCN-S must have a system in place for members that include a grievance process and access to the fair hearing process as described in federal regulations and state laws.

B. Authority to File. A member or a representative of his/her choice may file a grievance and/or request a state fair hearing in response to an action. A CCN-S provider, acting on behalf of the member with the member's written consent, may file a grievance or request a state fair hearing on behalf of a member in response to an action.

1. Filing Timeframe. The member must be allowed 30 calendar days from the date on the CCN-S's notice of action to request a state fair hearing. Within this timeframe, the member, or a representative or provider acting on their behalf, may request a state fair hearing.

2. Filing Procedures

a. The member may file a grievance either orally or in writing with the CCN-S.

b. The member, or a representative or provider acting on the member's behalf and with the member's written consent, may file for a state fair hearing with the designated state entity either orally or in writing, unless an expedited resolution is requested. An oral request for a state fair hearing must be followed up with a written, signed appeal request in order to initiate an expedited resolution.

C. Grievance Notice and Fair Hearing Procedures

1. The CCN-S shall ensure that all members are informed of the state fair hearing process and of the CCN-S's grievance procedures.

a. The CCN-S shall provide a member handbook to each member that shall include descriptions of the CCN-S's grievance procedures.

b. Forms to file grievances, concerns or recommendations to the CCN-S shall be available through the CCN-S, and must be provided to the member upon request. The CCN-S shall make all forms easily available on its website.

D. Grievance Records

1. A copy of an oral grievance log shall be retained for six years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six-year period, whichever is later.

E. Grievance Reports

1. The CCN-S shall provide an electronic report of the grievances it has received to the department on a monthly basis in accordance with the requirements outlined in the contract, which will include, but is not limited to:

- a. the member's name and Medicaid identification number;
- b. summary of grievances;
- c. date of filing;
- d. current status;
- e. resolutions; and
- f. resulting corrective action.

F. All state fair hearing requests shall be sent directly to the state designated entity. However, if the CCN-S receives a request for a state fair hearing, the CCN-S will be responsible for promptly forwarding the request to the designated state fair hearing entity.

G. The department has the right to make final decisions regarding the resolution of any grievance.

H. Information to Providers and Subcontractors

1. The CCN-S must provide the information about the grievance procedures for Medicaid enrollees to all providers and subcontractors at the time that they enter into a contract with the CCN-S as specified in the contract and the department issued guides.

I. Recordkeeping and Reporting Requirements

1. Reports of grievances and resolutions shall be submitted to the department as specified by the department. The CCN-S shall not modify its grievance procedures without the prior written approval of the department.

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 37:1590 (June 2011).

§3707. Enrollee Handling of Grievances and Fair Hearings

A. In handling grievances, the CCN must meet the following requirements:

1. give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free telephone numbers that have adequate TTY/TTD and interpreter capability; and

2. acknowledge receipt of each grievance and appeal.

B. Resolution and Notification. The CCN must dispose of a grievance and provide notice, as expeditiously as the member's health conditions require, within the timeframes established in the contract and department issued guides.

1. For standard disposition of a grievance and notice to the affected parties, the established timeframe is 90 days from the day the CCN receives the grievance.

C. Extension of Timeframes. The CCN-S may extend the timeframes for disposition of a grievance up to 14 calendars days under the following circumstances:

1. the member request the extension; or

2. the CCN-S shows (to the satisfaction of the department or its designee, upon request) that there is need for additional information and how the delay is in the member's interest.

D. If the CCN-S extends the timeframes for any extension not requested by the member, it must give the member written notice of the reason for the delay.

1. The CCN shall use the method and format specified in the contract for notifying a member of the disposition of a grievance.

E. Requirements for State Fair Hearings

1. The member may request a state fair hearing within 30 days from the date of the notice of action following the resolution of the grievance.

2. The parties to the state fair hearing include the CCN-S as well as the member and his/her representative or the representative of a deceased member's estate.

F. Concurrent Appeal Review

1. The CCN-S shall conduct an internal concurrent review for each appeal for which a state fair hearing is requested. The purpose of the concurrent appeal review is to expedite the resolution of the appeal to the satisfaction of the member, if possible, prior to the state fair hearing.

2. The CCN-S shall notify the state fair hearing designated entity of concurrent appeal reviews resulting in a resolution in favor of the member.

3. The concurrent appeal review shall not delay the CCN's submission of an appeal to the state fair hearing entity, nor shall it not delay the review of the appeal in the state fair hearing.

G. Special Requirements for Appeals

1. All appeals by members or on their behalf shall be filed with the state designated entity. However, if the CCN-S receives a state fair hearing request, the request shall be forwarded directly to the designated entity that will conduct the state fair hearing.

2. The CCN-S's staff shall be educated concerning the importance of the appeal procedures and the rights of the member and providers.

3. The appropriate individual or body within the CCN-S that made the decision that is being appealed shall be identified. This individual shall prepare the summary of evidence and be available for the appeal, either in person or by telephone.

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 37:1590 (June 2011).

§3709. Notice of Action

A. Language and Format Requirements

1. The notice of action will only be sent by the CCN-S in certain circumstances as specified by the department.

2. The notice must be in writing and must meet the language and format requirements of federal regulations in order to ensure ease of understanding.

B. Content of Notice. The notice must explain the following:

1. the action the CCN-S or its subcontractor has taken or intends to take;

2. the reasons for the action;

3. the member's right to request a state fair hearing and a telephone number to call for free legal advice;

4. the procedures for exercising the rights specified in this Section;

5. the circumstances under which expedited resolution is available and how to request it;

6. the member's right to have services continue pending resolution of the appeal, the procedures to make such a request, and the circumstances under which the member may be required to pay for the costs of these services; and

7. a statement in Spanish and Vietnamese that translation assistance is available at no cost and the toll free telephone number to call to receive translation of the notice.

C. Notice Timeframes. The CCN-S must mail the notice within the following timeframes:

1. for termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action (except as permitted under federal regulations);

2. for standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service. A possible extension of up to 14 additional calendar days may be granted under the following circumstances:

a. the member, his/her representative or a provider acting on his/her behalf, requests an extension; or

b. the CCN-S justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest;

3. on the date that the timeframe for service authorization expires.

D. If the CCN-S extends the timeframe in accordance with this Section, it must:

1. give the member written notice of the reason for the decision to extend the timeframe;

2. inform the member of the right to file a grievance if he/she disagrees with that decision; and

3. issue and carry out its determination as expeditiously as the member's health condition requires, but no later than the date that the extension expires.

E. For expedited service authorization decisions where a provider indicates, or the CCN-S determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN-S must make an expedited authorization decision.

1. A notice must be furnished as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request for service.

2. The CCN-S may extend the 72 hours time period by up to 14 calendar days if the member, or provider acting on behalf of the member with the member's written consent, requests an extension or if the CCN-S justifies (to the department upon request) a need for additional information and how the extension is in the member's interest.

F. The department shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

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 37:1591 (June 2011).

§3711. Continuation of Services during the State Fair Hearing Process

A. If the member requests a hearing before the date of action or within 10 days from the postmark of the notice, the department may not terminate or reduce services until a decision is rendered after the hearing unless:

1. it is determined that the sole issue is one of federal or state law or policy; and

2. the department or its designee promptly informs the member in writing that services are to be terminated or reduced pending the hearing decision.

B. Member Liability for Services

1. If the final resolution of the appeal is adverse to the member, the department may recover the cost of the services furnished to the member during the pending appeal process in accordance with federal regulations.

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 37:1591 (June 2011).

§3713. Effectuation of Reversed Appeal Resolutions

A. Discontinuation of Services during the State Fair Hearing Process

1. If the CCN-S or the state fair hearing entity reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCN must authorize the disputed services promptly and as expeditiously as the member's health condition requires.

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 37:1592 (June 2011).

Subchapter B. Coordinated Care Network Managed Care Organization Model

§3721. Introduction

A. A Coordinated Care Network Managed Care Organization (MCO) Model (CCN-P) must have a grievance system for Medicaid enrollees that complies with federal regulations. The CCN-P shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws and as specified in the contract and all department issued guides.

B. The CCN-P's grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation and must include, at a minimum, the requirements set forth herein.

1. The CCN-P shall refer all members who are dissatisfied, in any respect, with the CCN-P or its subcontractor to the CCN-P's designee authorized to review and respond to grievances and require corrective action.

2. The member must exhaust the CCN-P's internal grievance/appeal procedures prior to accessing the state fair hearing process or filing a grievance with the department or its designee.

C. The CCN shall not create barriers to timely due process. If the number of appeals reversed by the state fair hearing process exceeds 10 percent of appeals received within a 12 month period, the CCN shall be subject to sanctions.

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 37:1592 (June 2011).

§3723. Definitions

Action—the denial or limited authorization of a requested service, including:

1. the type or level of service;

2. reduction, suspension, or termination of a previously authorized service;

3. denial, in whole or in part, of payment for a service;

4. failure to provide services in a timely manner as specified in the contract; or

5. failure of the CCN-P to act within the timeframes provided in this Subchapter.

Appeal—a request for review of an action as the term is defined in this Section.

Grievance—an expression of dissatisfaction about any matter other than an action as that term is defined in this Section. The term is also used to refer to the overall system that includes grievances and appeals handled at the CCN-P level. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

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 37:1592 (June 2011).

§3725. General Provisions

A. The CCN-P must have a system in place for members that include a grievance process, an appeal process, and access to the state fair hearing process once the CCN-P's appeal process has been exhausted.

B. Filing Requirements

1. Authority to file. A member or a representative of his/her choice may file a grievance and a CCN-P level appeal. Once the CCN-P's appeals process has been exhausted, a member or his/her representative may request a state fair hearing.

a. A CCN-P provider, acting on behalf of the member and with his/her written consent, may file an appeal. A CCN-P provider may file a grievance or request a state fair hearing on behalf of a member.

2. Filing Timeframes. The member, or a representative or provider acting on the member's behalf and with his/her written consent, may file an appeal within 30 calendar days from the date on the CCN-P's notice of action.

3. Filing Procedures

a. The member may file a grievance either orally or in writing with the CCN-P.

b. The member, or a representative or provider acting on the member's behalf, may file an appeal either orally or in writing, unless an expedited resolution is requested, which must follow an oral filing with a written, signed appeal.

C. Grievance Notice and Appeal Procedures

1. The CCN-P shall ensure that all members are informed of the state fair hearing process and of the CCN-P's grievance procedures.

a. The CCN-P shall provide a member handbook to each member that shall include descriptions of the CCN-P's grievance procedures.

b. Forms to file grievances, appeals, concerns or recommendations to the CCN-P shall be available through the CCN-P, and must be provided to the member upon request. The CCN shall make all forms easily available on the CCN's website.

D. Grievance and Appeals Records

1. The CCN-P must maintain records of grievances and appeals. A copy of the grievance logs and records of the disposition of appeals shall be retained for six years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six-year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six-year period, whichever is later.

E. Grievance and Appeal Reports

1. The CCN-P shall provide an electronic report of the grievances and appeals to the department on a monthly basis in accordance with the requirements specified by the department, which will include, but is not limited to:

- a. the member's name and Medicaid identification number;
- b. summary of grievances and appeals;
- c. date of filing;
- d. current status;
- e. resolutions; and
- f. resulting corrective action.

F. The CCN-P will be responsible for promptly forwarding any adverse decisions to the department for further review and/or action upon request by the department or the CCN-P member.

G. The department may submit recommendations to the CCN-P regarding the merits or suggested resolution of any grievance or appeal.

H. Information to Providers and Subcontractors

1. The CCN-P must provide the information about the grievance system as specified in federal regulations to all providers and subcontractors at the time they enter into a contract.

I. Recordkeeping and Reporting Requirements

1. Reports of grievances and resolutions shall be submitted to the department as specified in the contract. The CCN-P shall not modify the grievance system without the prior written approval of the department.

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 37:1592 (June 2011).

§3727. Handling of Enrollee Grievances and Appeals

A. In handling grievances and appeals, the CCN-P must meet the following requirements:

1. give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free telephone numbers that have adequate TTY/TTD and interpreter capability;
2. acknowledge receipt of each grievance and appeal;
3. ensure that the individuals who make decisions on grievances and appeals are individuals who:
 - a. were not involved in any previous level of review or decision-making; and
 - b. if deciding on any of the following issues, are health care professionals who have the appropriate clinical expertise, as determined by the department, in treating the member's condition or disease:
 - i. an appeal of a denial that is based on lack of medical necessity;

- ii. a grievance regarding denial of expedited resolution of an appeal; or

- iii. a grievance or appeal that involves clinical issues.

B. Special Requirements for Appeals

1. The process for appeals must:

- a. provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution;

- b. provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The CCN-P must inform the member of the limited time available for this in the case of expedited resolution;

- c. provide the member and his/her representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents and records considered during the appeals process; and

- d. include, as parties to the appeal:

- i. the member and his/her representative; or
- ii. the legal representative of a deceased member's estate.

2. The CCN-P's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

3. The appropriate individual or body within the CCN-P having decision making authority as part of the grievance and appeal procedures shall be identified.

4. Failure to Make a Timely Decision

- a. Appeals shall be resolved no later than the stated time frames and all parties shall be informed of the CCN-P's decision.

- b. If a determination is not made by the above time frames, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

5. The CCN shall inform the member that he/she may seek a state fair hearing if the member is not satisfied with the CCN-P's decision in response to an appeal.

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 37:1593 (June 2011).

§3729. Notice of Action

A. Language and Format Requirements. The notice must be in writing and must meet the language and format requirements of federal regulations in order to ensure ease of understanding.

B. Content of Notice. The notice must explain the following:

1. the action the CCN-P or its subcontractor has taken or intends to take;
2. the reasons for the action;
3. the member's or the provider's right to file an appeal with the CCN;
4. the member's right to request a state fair hearing after the CCN-P's appeal process has been exhausted;
5. the procedures for exercising the rights specified in this Section;

6. the circumstances under which expedited resolution is available and the procedure to request it; and

7. the member's right to have services continue pending resolution of the appeal, the procedure to make such a request, and the circumstances under which the member may be required to pay the costs of these services.

C. Notice Timeframes. The CCN-P must mail the notice within the following timeframes:

1. for termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action except as permitted under federal regulations;

2. for denial of payment, at the time of any action taken that affects the claim; or

3. for standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service. A possible extension of up to 14 additional calendar days may be granted under the following circumstances:

a. the member, or his/her representative or a provider acting on the member's behalf, requests an extension; or

b. the CCN-P justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

D. If the CCN-P extends the timeframe in accordance with this Section, it must:

1. give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with that decision; and

2. issue and carry out its determination as expeditiously as the member's health condition requires, but no later than the date the extension expires.

E. For service authorization decisions not reached within the timeframes specified in this Section, this constitutes a denial and is thus an adverse action on the date that the timeframes expire.

F. For expedited service authorization decisions where a provider indicates, or the CCN-P determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN-P must make an expedited authorization decision.

1. A notice must be furnished as expeditiously as the member's health condition requires, but no later than 72 hours or as expeditiously as the member's health requires after receipt of the request for service.

2. The CCN-P may extend the 72 hour time period by up to 14 calendar days if the member or provider acting on behalf of the member requests an extension or if the CCN-P justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

G. The department shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

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 37:1593 (June 2011).

§3731. Resolution and Notification

A. The CCN-P must dispose of a grievance, resolve each appeal, and provide notice as expeditiously as the member's health condition requires, within the timeframes established in this Section.

B. Specific Timeframes

1. For standard disposition of a grievance and notice to the affected parties, the timeframe is established as 90 days from the day the CCN-P receives the grievance.

2. For standard resolution of an appeal and notice to the affected parties, the timeframe is established as 30 calendar days from the day the CCN-P receives the appeal.

3. For expedited resolution of an appeal and notice to affected parties, the timeframe is established as 72 hours or as expeditiously as the member's health requires after the CCN-P receives the appeal.

C. Extension of Timeframes

1. The CCN-P may extend the timeframes by up to 14 calendar days under the following circumstances:

a. the member requests the extension; or

b. the CCN-P shows to the satisfaction of the department, upon its request, that there is need for additional information and that the delay is in the member's interest.

D. If the CCN-P extends the timeframes for any extension not requested by the member, it must give the member written notice of the reason for the delay.

E. Format of Notice

1. The CCN-P shall follow the method specified in the department issued guide to notify a member of the disposition of a grievance.

2. For all appeals, the CCN-P must provide written notice of disposition.

3. For notice of an expedited resolution, the CCN-P must also make reasonable efforts to provide oral notice.

F. Content of Notice of Appeal Resolution. The written notice of the resolution must include, at a minimum, the following information:

1. the results of the resolution process and the date it was completed;

2. for appeals not resolved wholly in favor of the members:

a. the right to request a state fair hearing and the procedure to make the request;

b. the right to request to receive services during the hearing process and the procedure to make such a request; and

c. that the member may be held liable for the cost of those services if the hearing decision upholds the CCN-P's action.

G. Requirements for State Fair Hearings

1. The department shall comply with the federal regulations governing fair hearings. The CCN-P shall comply with all requirements as outlined in the contract and department issued guides.

2. If the member has exhausted the CCN-P level appeal procedures, the member may request a state fair hearing within 30 days from the date of the CCN-P's notice of resolution.

3. The parties to the state fair hearing include the CCN-P as well as the member and his/her representative or the representative of a deceased member's estate.

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 37:1594 (June 2011).

§3733. Expedited Resolution of Appeals

A. The CCN-P must establish and maintain an expedited review process for appeals when the CCN-P determines (either from a member's request or indication from the provider making the request on the member's behalf or in support of the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

B. Punitive Action. The CCN-P must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

C. If the CCN-P denies a request for expedited resolution of an appeal, it must:

1. transfer the appeal to the timeframe for standard resolution in accordance with the provisions of this Subchapter; and

2. make reasonable efforts to give the member prompt oral notice of the denial and follow up within two calendar days with a written notice.

D. This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an action or require a notice of action. The member may file a grievance in response to this decision.

E. Failure to Make a Timely Decision

1. Appeals shall be resolved no later than the established timeframes and all parties shall be informed of the CCN-P's decision. If a determination is not made by the established timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

F. The CCN-P is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution.

1. The member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required.

2. The CCN-P shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

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 37:1595 (June 2011).

§3735. Continuation of Services during the Pending CCN-P Appeal or State Fair Hearing

A. As used in this Section, the term "timely filing" means filing on or before the later of the following:

1. within 10 calendar days of the CCN-P's mailing of the notice of action; or

2. the intended effective date of the CCN-P's proposed action.

B. Continuation of Benefits. The CCN-P must continue the member's benefits if:

1. the member or the provider files the appeal timely;

2. the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. the services were ordered by an authorized provider;

4. the original period covered by the original authorization has not expired; and

5. the member requests extension of benefits.

C. Duration of Continued or Reinstated Benefits

1. If, at the member's request, the CCN-P continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

a. the member withdraws the appeal;

b. 10 calendar days pass after the CCN-P mails the notice providing the resolution of the appeal against the member, unless the member has requested a state fair hearing with continuation of benefits, within the 10-day timeframe, until a state fair hearing decision is reached;

c. a state fair hearing entity issues a hearing decision adverse to the member; or

d. the time period or service limits of a previously authorized service has been met.

D. Member Liability for Services

1. If the final resolution of the appeal is adverse to the member, the CCN-P may recover from the member the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with federal regulations.

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 37:1595 (June 2011).

§3737. Effectuation of Reversed Appeal Resolutions

A. Provision of Services during the Appeal Process

1. If the CCN-P or the state fair hearing entity reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCN-P must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

B. If the CCN-P or the state fair hearing entity reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CCN-P must pay for those services in accordance with the contract.

C. At the discretion of the secretary, the department may overrule a decision made by the Division of Administration, Division of Administrative Law (the state fair hearing entity).

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 37:1595 (June 2011).

Subchapter C. Grievance and Appeals Procedures for Providers

§3743. General Provisions

A. If the provider is filing a grievance or appeal on behalf of the member, the provider shall adhere to the requirements outlined in Subchapter B of this Chapter.

B. A Coordinated Care Network must have a grievance and appeals process for claims and medical necessity and

contract disputes for providers in accordance with the contract and department issued guides.

1. The CCN shall establish and maintain a procedure for the receipt and prompt internal resolution of all provider initiated grievances and appeals as specified in the contract and all department issued guides.

2. The CCN's grievance and appeals procedures and any changes thereto, must be approved in writing by the department prior to their implementation.

3. Notwithstanding any CCN or department grievance and appeal process, nothing contained in any document, including, but not limited to Rule or contract, shall preclude a CCN provider's right to pursue relief through a court of appropriate jurisdiction.

4. The CCN shall report on a monthly basis all grievance and appeals filed and resolutions in accordance to the terms of the contract and department issued guide.

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 37:1595 (June 2011).

Chapter 39. Sanctions for Coordinated Care Networks **§3901. Sanctions**

A. The CCN agrees to be subject to the sanctions specified in the terms and conditions of the contract and all department issued guides. The specific grounds for sanctions and respective sanctions shall be set forth within the contract.

1. Sanctions may include, but are not limited to:

- a. corrective action plans;
- b. monetary penalties;
- c. temporary management; and
- d. suspension and/or termination of the CCN's

contract.

B. It shall be at the department's sole discretion as to the proper administrative sanction that will be imposed.

C. The department will notify the CCN through a notice of corrective action when the department or its designee determines that the CCN is deficient or non-compliant with requirements (excluding causes for intermediate sanctions and termination) of the contract.

D. The determination of deficiency and/or non-compliance with such requirements is at the sole discretion of the department.

E. The CCN shall submit a corrective action plan (CAP) to the department, within the timeframe specified in the notice, for approval. The CAP shall delineate the steps and timeline for correcting deficiencies and/or non-compliance issues identified in the notice.

F. The department shall impose monetary penalties and/or sanctions on the CCN for a deficient CAP. A CAP is deficient when it is not submitted within the notice of corrective action timeline requirements and/or when the CCN and/or its subcontractor(s) fail to implement and/or follow the CAP at the discretion of the department.

G. The department, as specified in the contract, has the right to enforce monetary penalties against the CCN for certain conduct.

1. Any and all fines collected as a result of sanctions against a CCN or any of its subcontractors, or any recoupment(s)/repayment(s) received from the CCN or any

of its subcontractors, shall be placed into the Louisiana Medical Assistance Trust Fund established by R.S. 46:2623.

H. Monetary Penalties

1. The CCN may be required to pay monetary penalties to the department in the amounts specified in the contract for failure to timely and accurately comply with reporting requirements and for deficient deliverables as set forth in the contract and all department issued guides.

I. Intermediate Sanctions

1. The department may impose any of the following sanctions if it determines that the CCN has violated any provision of the contract, or the applicable statutes or Rules governing CCNs.

2. The department shall notify the CCN and CMS in writing of its intent to impose sanctions and explain the process for the CCN to employ the dispute resolution process as described in the contract. Sanctions shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and federal regulations and may include any of the following:

a. suspension of payment for members enrolled in the CCN after the effective date of the sanction and until CMS and/or the department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. This violation may result in recoupment of payments;

b. imposition of a fine of up to \$25,000 for each marketing/enrollment violation, in connection with any one audit or investigation;

c. termination pursuant to the terms of the contract;

d. non-renewal of the contract;

e. suspension of auto-enrollment;

f. appointment of temporary management;

g. civil money penalties in accordance with §1932 of the Social Security Act (42 USC § 1396u-2);

h. withholding up to 30 percent of a CCN's monthly PMPM payment;

i. permitting individuals enrolled in the CCN to disenroll without cause;

j. suspension or default of all enrollment after the date that CMS or the department notifies the CCN of an occurrence under §§1903(m) or 1932(e) of the Social Security Act;

k. termination of the contract if the CCN has failed to meet requirements of §§1903(m), 1905(t)(3) or 1932(e) of the Social Security Act and offer the CCN-P's Medicaid members an opportunity to enroll with other CCNs;

l. imposition of sanctions pursuant to §1932(e)(B) of the Social Security Act if the CCN does not provide abortion services as provided under the contract;

m. imposition of a fine of up to \$25,000 for each occurrence of the CCN's failure to substantially provide medically necessary items and services that are required to be provided to a member covered under the contract;

n. imposition of a fine of up to \$15,000 per individual not enrolled and up to a total of \$100,000 per each occurrence, when the CCN acts to discriminate among members on the basis of their health status or their requirements for health care services;

o. imposition of a fine of up to \$25,000 or double the amount of the excess charges, whichever is greater, for

charging premiums/co-payments in excess of the amounts permitted under the Medicaid Program;

p. imposition of sanctions as outlined in the contract if the CCN fails to comply with the physician incentive plan requirements or other sanctions set forth in the contract or department issued guides;

q. imposition of sanctions as outlined above if the CCN misrepresents or falsifies information that it furnishes to CMS, to the state or to a member, potential member or health care provider;

r. imposition of sanctions as outlined in the contract if the CCN fails to comply with prompt payment requirements;

s. imposition of fines up to \$10,000 per incident as outlined in the contract if the CCN:

i. does not maintain network adequacy for mandatory provider types included in the contract and department issued guide;

ii. does not document the required three attempts to contract with the mandatory provider type prior to the delivery of the service; and

iii. is required to provide medically necessary services through an out-of-network providers;

t. imposition of sanctions if the percentage specified in the contract of grievance decisions appealed for medical necessity to a State Fair Hearing level of recipient appeals have been reversed or otherwise resolved in favor of the member.

J. Duration of Sanction

1. Unless the duration of a sanction is specified, a sanction will remain in effect until the department is satisfied that the basis for imposing the sanction has been corrected. The department will notify CMS when a sanction has been lifted.

K. Termination for Cause

1. Issuance of Notice of Termination

a. The department may terminate the contract when it determines the CCN has failed to perform, or violates, substantive terms of the contract or the department issued guides or fails to meet applicable requirements in §§1903(m), 1905(t) or 1932 of the Social Security Act in accordance with the provisions of the contract.

b. The department will provide the CCN with a timely written Notice of Intent to Terminate notice. In accordance with federal regulations, the notice will state:

i. the nature and basis of the sanction;

ii. pre-termination hearing and dispute resolution conference rights, if applicable; and

iii. the time and place of the hearing.

c. The termination will be effective no less than 30 calendar days from the date of the notice.

d. The CCN may, at the discretion of the department, be allowed to correct the deficiencies within 30 calendar days of the date that the notice was issued, unless other provisions in this Section demand otherwise, prior to the issue of a Notice of Termination.

L. Termination Due to Serious Threat to Health of Members

1. The department may terminate the contract immediately if it is determined that actions by the CCN or its subcontractor(s) pose a serious threat to the health of members enrolled in the CCN.

2. The CCN members will be given an opportunity to enroll in another CCN (if there is capacity) or move to fee-for-service.

M. Termination for Insolvency, Bankruptcy, Instability of Funds

1. The CCN's insolvency or the filing of a bankruptcy petition by or against the CCN shall constitute grounds for termination for cause.

N. Termination for Ownership Violations

1. The CCN is subject to termination unless the CCN can demonstrate changes of ownership or control when a person with a direct or indirect ownership interest in the CCN (as defined in the contract and PE-50) has:

a. been convicted of a criminal offense as cited in §1128(a), (b)(1) or (b)(3) of the Social Security Act, in accordance with federal regulations;

b. had civil monetary penalties or assessment imposed under §1128(A) of the Social Security Act; or

c. been excluded from participation in Medicare or any state health care program.

O. CCN Requirements Prior to Termination for Cause.

The CCN shall comply with all of the terms and conditions stipulated in the contract and department issued guides during the period prior to the effective date of termination. The CCN is required to meet the requirements as specified in the contract if terminated for cause.

P. Other Sanctions. The department may impose additional sanctions allowed under state statute or regulation that address areas of noncompliance.

Q. Denial of Payment While Under Sanction by CMS. Payments provided for under the contract will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in federal regulations.

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 37:1596 (June 2011).

Chapter 40. Audit Requirements for Coordinated Care Networks

§4001. Audit of Services

A. The CCN and its subcontracts shall comply with all audit requirements specified in the contract and department issued guides.

B. The CCN and its subcontractor shall maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of claims.

1. Such documents, including all original claim forms, shall be maintained and retained by the CCN and or its subcontractors for a period of six years after the contract expiration date or until the resolution of all litigation, claim, financial management review or audit pertaining to the contract, whichever is longer.

2. The CCN or its subcontractors shall provide any assistance that such auditors and inspectors reasonably may require to complete with such audits or inspections.

C. There shall be no restrictions on the right of the state and federal government to conduct inspections and audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

D. Upon reasonable notice, the CCN and its subcontractors shall provide the officials and entities identified in the contract and department issued guides with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of 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 37:1597 (June 2011).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Bruce D. Greenstein
Secretary

1106#074

RULE

Department of Health and Hospitals Bureau of Health Services Financing

Early and Periodic Screening, Diagnosis and Treatment—Dental Program—Covered Services and Reimbursement Rate Reduction (LAC 50:XV.6903 and 6905)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:XV.6903 and §6905 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 5. Early and Periodic Screening, Diagnosis and Treatment

Chapter 69. Dental Services

§6903. Covered Services

A. - D. ...

E. Effective August 1, 2010, the prefabricated esthetic coated stainless steel crown-primary tooth dental procedure shall be included in the service package for coverage under the EPSDT Dental Program.

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, Office of the Secretary, Bureau of Health Services Financing, LR 29:175 (February 2003), amended LR 30:252 (February 2004), LR 31:667 (March 2005), LR 33:1138 (June 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1889 (September 2009), amended LR 37:1598 (June 2011).

§6905. Reimbursement

A. - D.3. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement fees for EPSDT dental services shall be reduced to the following percentages of the 2009

National Dental Advisory Service Comprehensive Fee Report seventieth percentile, unless otherwise stated in this Chapter:

1. 69 percent for the following oral evaluation services:

- a. periodic oral examination;
- b. oral examination—patients under three years of age; and
- c. comprehensive oral examination—new patient;

2. 65 percent for the following annual and periodic diagnostic and preventive services:

- a. radiographs—periapical, first film;
- b. radiograph—periapical, each additional film;
- c. radiograph—panoramic film;
- d. prophylaxis—adult and child;
- e. topical application of fluoride—adult and child

(prophylaxis not included); and

f. topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age);

3. 50 percent for the following diagnostic and adjunctive general services:

- a. oral/facial images;
- b. non-intravenous conscious sedation; and
- c. hospital call; and

4. 58 percent for the remainder of the dental services.

F. Removable prosthodontics and orthodontic services are excluded from the August 1, 2010 rate reduction.

G. Effective for dates of service on and after January 1, 2011, the reimbursement fees for EPSDT dental services shall be reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report seventieth percentile, unless otherwise stated in this Chapter:

1. 67.5 percent for the following oral evaluation services:

- a. periodic oral examination;
- b. oral Examination-patients under 3 years of age;

and

- c. comprehensive oral examination-new patients;

2. 63.5 percent for the following annual and periodic diagnostic and preventive services:

- a. radiographs-periapical, first film;
- b. radiographs-periapical, each additional film;
- c. radiographs-panoramic film;
- d. diagnostic casts;
- e. prophylaxis-adult and child;
- f. topical application of fluoride, adult and child

(prophylaxis not included); and

g. topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age);

3. 73.5 percent for accession of tissue, gross and microscopic examination, preparation and transmission of written report;

4. 70.9 percent for accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report;

5. 50 percent for the following diagnostic and adjunctive general services:

- a. oral/facial image;