



**State of Louisiana**  
Department of Health and Hospitals  
Bureau of Health Services Financing

VIA E-MAIL

November 1, 2011

Mr. John Matessino  
Louisiana Hospital Association  
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Dear John and Paul:

On behalf of Secretary Greenstein, thank you for your letter of October 28<sup>th</sup> in which you provided, on behalf of your member hospitals, a third set of written questions regarding BAYOU HEALTH. We appreciate the forum you provide to make available important information to your members. Our responses to your questions are as follows:

*Programmatic/Budget/Rating*

- a. In DHH's response letter dated October 24, 2011, triage fees were mentioned as a possibility for CCNs to address ER services that may not have initially met the prudent layperson standard. Can DHH confirm that this type payment mechanism would have to be mutually agreed upon by both the CCN and provider? **Yes**
- b. Would such an arrangement require the alternative payment request process be completed since a triage fee would be a deviation from the expected fee-for-service payment for ER services? **Health Plans may offer services that are different than those services listed in the Medicaid State Plan, such as establishment of a triage service, and these services do not fall under those that require alternative payment arrangement approval. Note however that reimbursement to non-contract providers of emergency services—whether in state or out-of-state—cannot be more than that provider would have received from the Louisiana Medicaid fee-for-service program. (Refer to Section 9.3.1 of the CCN-Prepaid**

**Model RFP and the State Medicaid Director's Letter # 06-10 dated March 31, 2006 ,issued by the CMS Center for Medicaid and State Operations).**

*Operational Issues*

- a. The deadline for member enrollment in GSA A is January 26, 2012 (Thursday) and the go-live date is February 1, 2012 (the following Wednesday). For GSA B, those dates are March 28, 2012 and April 1, 2012 respectively. For GSA C, those days are May 29, 2012 and June 1, 2012 respectively. With the steps that need to be taken by DHH, the communication that will need to take place between DHH/CCN and CCN/member, and that in the aforementioned timelines, there are very few business days for all of that to occur, there will likely be instances of late enrollees presenting to incorrect or out-of-network providers. What steps has DHH taken to limit these situations?
  1. **Choice letters will be mailed to GSA A recipients over a seven to ten day period beginning December 15<sup>th</sup>.**
  2. **If a potential member has not selected a Health Plan by the 30<sup>th</sup> day from the date the Choice Letter is postmarked, they will be auto-assigned to a Health Plan. This means that the process of auto-assignments will begin January 14<sup>th</sup> and extend seven to ten days.**
  3. **A Confirmation Letter indicating the name of the Health Plan will be mailed by the Enrollment Center to the member immediately after a choice is made or the member is assigned to a Health Plan.**
  4. **Enrollment files with assigned members will be sent to Health Plans daily beginning December 16<sup>th</sup>.**
  5. **Members who have chosen or been assigned to a Health Plan have until the third to last working day of the month (January 27, 2012 for GSA A) to change Health Plans with an effective date of February 1<sup>st</sup>.**
  6. **The February 2012 Enrollment File of a Health Plan's assigned members will be created on the night of the third to last working day of the month and forward to them.**
  7. **DHH anticipates that the vast majority of Health Plan members will have received a Confirmation Letter with the name of their Health Plan prior to their "go live" date. Many will have already received their Member Welcome Packet and ID card from their Health Plan.**
  8. **Providers are responsible for checking eligibility as well as Plan enrollment prior to rendering a service.**

Will Louisiana Medicaid's electronic eligibility verification system be updated with the correct information by the go-live dates? **Yes. As stated above the file of all eligibles and the Health Plan to which they are assigned for the month of February will be created the night of January 27<sup>th</sup>. The eligibility verification**

**systems maintained by Molina (MEVS, REVS, Web) will include the name of the recipient's Health Plan and begin date.**

**When does DHH anticipate identification cards being mailed to enrollees? Each Health Plan is responsible for mailing identification cards to their members. DHH anticipates cards will be mailed starting in early January 2012 and daily throughout the month as new members are assigned to Health Plans via the daily eligibility file they will receive.**

**Who is responsible for reimbursing providers if there are eligibility errors or unavailability during the implementation? We do not anticipate eligibility errors in the verification systems maintained by Molina. Category of assistance can be determined retroactively, impacting Plan's capitation payment but eligibility is not affected. The eligibility response from Molina will include the name of the Health Plan to which the recipient is linked. Providers are—as always—responsible for verifying eligibility, including Plan enrollment prior to rendering any service.**

**Based on our discussions, it is our understanding that DHH will be collecting all the encounter data from CCN-P plans. Will DHH or its FI be producing annual payment summaries similar to Medicaid's MRO-14 report? DHH intends to produce the necessary reports from encounter data to calculate cost settlements and uncompensated care costs for DSH.**

#### *Network Issues*

**There are instances in which rural hospitals own rural health clinics beyond 30 miles of the hospital. Would a CCN be able to require the physicians at those clinics to admit patients to another hospital within 30 miles of the clinic? If there is an in-network hospital that meets the time and distance requirements, which is less than 30 miles from the member's residence (not the location of the Rural Health Clinic) and an in-network hospital that is greater than 30 miles from the member's residence, the Health Plan is required to provide the services to the member at an in-network facility that meets the time and distance requirement, unless the recipient requests to be admitted to a hospital outside these requirements.**

As always, if additional clarification of our responses is needed, please do not hesitate to contact us.

Sincerely,

/s/ J. Ruth Kennedy