



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

VIA E-MAIL

October 24, 2011

Mr. John Matessino
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Dear John and Paul:

On behalf of Secretary Greenstein, thank you for your letter of October 18th in which you provided, on behalf of your member hospitals, additional questions regarding Louisiana's plan to improve health outcomes and better invest taxpayer dollars through the Medicaid program. We appreciate your continuing support and the ongoing dialogue to resolved outstanding issues as implementation rapidly approaches.

Programmatic/Budget Issues/Rating

- a. How long are the PMPMs that DHH pays CCNs locked-in? Beyond the risk adjustment that will eventually occur, can the PMPMs change at any time or only on an annual basis? If annually, when?

The Contract between DHH and Health Plans does not include a rate "lock-in period." The capitation rates to Health Plans are subject to change if services are added, or DHH changes provider rates. Rate changes require an amendment to the Contracts with Health Plans and mutual agreement by both parties. DHH intends to limit any changes in the capitation rate (other than Risk Adjustment) to no more than twice yearly. We have initiated discussions with our actuary as to the earliest possible for the effective month of capitation rate changes pursuant to any legislative action during the annual Session which concludes in June.

- b. From a service district hospital perspective, how will the CCN program affect CPEs?

Implementation of CCNs will not impact public hospitals' ability to certify uncompensated care costs as public expenditures eligible for DSH payment under our current state plan. The Medicaid cost shortfall (or longfall) on Prepaid Health Plan, Shared Savings Health Plan and fee for service claims are all components of the hospital specific uncompensated care cost limits.

- c. We have reviewed the latest hospital per diem spreadsheet with the GME breakout posted on the DHH website. Has DHH operationalized the distribution of GME funding, and if so, what is DHH's plan and timeline?

No. A rule will be promulgated and state plan amendment will be submitted with effective date of February 1, 2012 to cover GME payments that were removed from rates for Prepaid Health Plan claims. DHH is considering a quarterly distribution using the GME component removed from the capitation rate and Prepaid Health Plan's paid days for services that had been reimbursed for GME.

- d. It is our understanding that a 'rate sheet' specifying, by hospital, the various components of reimbursement (IP, OP, special services etc.) and how they are reimbursed under Medicaid Fee-for-Service has been in development by the Department. Is that available? If not, when does DHH anticipate it being so?

You may be referring to the Excel spreadsheet titled "DHH Hospital Reimbursement Request 10.21.11." The document –which is a snapshot in time—is being forwarded to you and will be posted on the Making Medicaid Better website.

- e. When will the specific operational guidelines from Cypress regarding how CCN-P days and services should be reported be available?

A letter with detailed instructions has been added to the Making Medicaid Better website under "For Providers" and is also being mailed to each hospital this week.

- f. If a provider negotiates prospective payment greater than or equal to current Medicaid cost reimbursement, would the provider be required to complete and submit the alternative payment request?

Unless the negotiation also involves an alternate methodology in addition to the higher rate, e.g. the higher prospective payment rate is intended to negate cost settlements, submission of a "Provider Initiated Request for Alternative Payment Arrangement" form to DHH for approval is not required.

Operational Issues

- a. On which eligibility database should providers ultimately rely—CCN or Medicaid?

The Medicaid eligibility verification process available through Molina

- b. If a patient presents to the ER either in-network or out-of-network, for an issue that does not meet the prudent layperson standard, is the provider allowed to charge the patient?

If a Prepaid Health Plan member presents to the ER for a condition that is subsequently (and appropriately) determined by the Health Plan to have not been an emergency medical condition under the prudent layperson standard at 42 CFR 438.114, federal Medicaid regulations do not explicitly prohibit the hospital from charging the patient for a non-covered Medicaid service. However, it is important that the denials be determined on a case-by-case basis, not on a global code basis, consistent with the prudent layperson standard. With respect to in-network providers, Health Plans may decide to address payments for such situations in their provider contracts (such as payment of a triage fee consistent with the hospital's EMTALA obligation) in which case the provider would have to consider payment from the Health Plan as payment in full and not bill the Medicaid/LaCHIP member. With respect to out-of-network providers in an emergency setting, the Health Plan may attempt to negotiate a payment amount with the hospital and, again, as long as the hospital is also enrolled in Louisiana Medicaid, the hospital must accept that payment as payment in full and not bill the Medicaid/LaCHIP member. If the hospital is the cause of the denial (*i.e.*, medical coding issues), then the member cannot be billed.

If the member is informed prior to treatment that any additional care is not a covered service or out-of-network and that they will be billed, the hospital is allowed to bill the member for that non-emergent care.

DHH will be tracking any denials of payment based on non-emergent use of ERs. If members are presenting to ERs for non-emergent conditions that result in a Health Plan denial of payment, this may be an indication, of the need for additional member education, increased primary care or specialist capacity, or a change in hospital behavior. If a hospital, whether in-network or out-of-network, has concerns about a Health Plan's determination that the prudent layperson standard has been met, this should be addressed to the Health Plan and not as a service billed to the member. DHH will be available to discuss any issues that cannot be resolved between the Health Plan and hospital.

- c. As a follow-up to our question on the provision prohibiting subcontractors from encouraging or suggesting that members be placed in state custody in order to receive medical or specialized behavioral health services covered by DHH, is this provision denying the facility the ability to transfer a patient under a PEC, CEC, or other physician committal to a state-operated hospital for behavioral health services, including inpatient care?

No

Further who is the responsible payer for a CCN-enrolled patient who has received services in an emergency room for behavioral health conditions such as a PEC situation?

All behavioral health involuntary commitments are the responsibility of the Louisiana Behavioral Health Partnership (LABHP) Statewide Management Organization (SMO) and not the Health Plans.

- d. Is DHH aware of any areas within the GSAs that CCNs have indicated they are not intending to build networks?

No –Relevant contract language includes § 2.1.1.9 which requires that the Health Plan “be willing and able to provide core benefits and services to all [emphasis ours] assigned members, whether chosen or auto-assigned, on the day the Medicaid CCN Program is implemented in the GSA” and § 7.3.2 which addresses travel time and distance requirements.

- e. If a CCN is just dropping off a contract to different people at hospitals and not returning the hospital’s call or emails to open contract discussions it is our opinion that does not qualify as a documented attempt per the definition in the RFP. What is DHH’s guidance for handling and reporting these instances?

You are correct that the exact action you are describing does not meet the contractual definition of a good faith or *bona fide* offer to contract.

If the Health Plan states in the contract packet it is willing to negotiate and the hospital has tried to contact the specified contact person either via correct phone number or email address as specified in the contract packet by the specified deadline date, the Health Plan shall be responsible to return with the hospital's call and/or email. If the Health Plan does not respond, this shall not constitute an attempt. However if the Health Plan can demonstrate it has responded, it shall constitute an attempt.

If a representative of the Health Plan drops off a contract to a potential provider, this can be considered as a good faith effort, if said contract includes a cover letter stating that the Health Plan is offering to contract at the Medicaid rate in effect on date of service and includes the deadline (10th day) for response. If this is the case, it is the hospital's decision as to whether they will or will not accept the terms being proposed and respond accordingly to the Health Plan.

It is important that Health Plan and the hospital keep documentation of any communication relative to contracting.

Should the Health Plan notify the provider that they have make the requisite three documented attempts to contract and the provider disputes, the provider should contact the Medicaid Managed Care Program, which will be responsible for ongoing

monitoring of Health Plans. DHH will make available on the Making Medicaid Better website the procedure for submitting a complaint on this issue.

- e. For specialty care physicians, is emergency or consultative specialty care availability on a 24/7 basis a program requirement?

Health Plans must (1) meet and require providers to meet DHH's standards for timely access to care and services, taking into account the urgency of the need for services and (2) make services included in the Contract, including specialty care physicians, available 24/7 when medically necessary (see 42 CFR 438.206(c)(1)(i) & (iii) regarding timely access to services). This would include emergency or consultative specialty care physician services when medically necessary.

- f. Our interpretation of the subcontractor requirements put forth by DHH is that they are baseline requirements and that there is no prohibition regarding negotiation of alternative terms, as long as those terms at least meet DHH's guidelines. For example, the claims payment timelines of 90% within 15 business days and 99% within 30 calendar days are a minimum. The parties are free to negotiate terms of fewer days if they so desire as long as the baseline standard is met. Can DHH confirm our interpretation?

Your interpretation is correct. The reference in Section 42 of the Code of Federal Regulations (CFR) that addresses this is §447.46. It states (2) *Exception*. The MCO and its providers may, by mutual agreement, establish an alternative payment schedule. (3) *Alternative schedule*. Any alternative schedule must be stipulated in the contract. [the contract between Health Plan and provider]

Making Medicaid Better Website

We would also like to ask DHH to consider a "recently added" section for its Making Medicaid Better website. While the website is a useful resource, it is difficult to determine what has been added recently, particularly with the amount of information presently posted.

Thank you for this suggestion. We will be making changes to the website to focus attention on newly added content.

We appreciate the opportunity to answer these additional questions. If there is anything unclear in our response, please contact us immediately for additional clarity. I am happy to make myself or our team available to meet with you or offer additional written response.

Sincerely,

/s/ J. Ruth Kennedy