



State of Louisiana
Department of Health and Hospitals
BAYOU HEALTH

February 23, 2012

VIA ELECTRONIC MAIL

John Mattesino, President & CEO
Louisiana Hospital Association
9521 Brookline Avenue
Baton Rouge, LA 70809-1431

Dear Mr. Mattesino:

I am responding on behalf of Secretary Bruce D. Greenstein to your letter dated February 14 in which you provided us with a list of 16 issues related to BAYOU HEALTH implementation. The Department of Health and Hospitals (DHH) is committed to rapidly responding to and resolving issues as they are reported and as a result many questions and problems have already been brought to a successful resolution.

As always, I would encourage you and your member hospitals to share any concerns or issues with us in real-time to ensure minimal interruption in your daily operations. DHH continues to host daily calls for providers each Monday through Friday from 12:00 Noon to 1:00 PM. Pre-registration is not necessary and the toll-free number is 1-888-278-0296. In addition, issues submitted for resolution via e-mail to ruth.kennedy@la.gov are typically resolved in 24 hours or less.

Several of the issues in your letter are addressed in numbered Informational Bulletins that are posted on our website www.MakingMedicaidBetter.com, including bulletins addressing Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Screening (which was previously called "KidMed" in Louisiana); newborns; referrals prior to go-live date; and policies and procedures during the 30 day transition period. The website contains additional information for providers such as answers to "Frequently Asked Questions".

Your letter also requested the formation of a workgroup consisting of DHH representatives, hospital representatives, and Health Plan representatives to address BAYOU HEALTH issues. DHH will be establishing our BAYOU HEALTH Administrative Simplification Workgroup in the very near future, which will consist of representatives from each Health Plan, providers, and DHH. In the meantime, Secretary Greenstein has expressed his agreement with your request for a meeting between representatives of the Health Plans, hospitals and DHH, and I understand that his assistant will be reaching out to your team this week to schedule the first meeting. While we believe the Administrative Simplification Workgroup as well as the ad hoc meeting you have

requested will be important tools to develop solutions and further open channels of communication between the three parties, we should not wait for the meetings to solve problems. I would strongly encourage your members to immediately contact DHH with implementation issues that cannot be resolved through contact with the Health Plan.

Attached to this letter you will find point by point responses to the issues raised in your letter. Understandably, your letter lacked specificity so as to ensure broad applicability to your membership. Likewise, these responses are general in nature. For most of the questions, we solicited responses from the Health Plans as well, and their answers are incorporated. We can also discuss these issues and more in further detail at the meeting we will be scheduling.

Thank you again for your continued engagement in this critical transformation. Only by working together as provider, plan and payer will we begin to lift Louisiana out of 49th place for health outcomes.

Sincerely,

/s/ J. Ruth Kennedy
Medicaid Deputy Director

DCG: JRK

Attachment

c: Bruce Greenstein
Senator David Heitmeier
Jerry Phillips
Representative Scott Simon

1. LaCare is not providing Out-of-Network benefits for services scheduled prior to implementation to its members resulting in canceled procedures.

This issue is addressed and each plans' protocols can be found in Informational Bulletins 12-1 and 12-2 which are posted at www.MakingMedicaidBetter.com .

LaCare responded that they are indeed honoring referrals that were previously received by hospitals from CommunityCARE PCPs for the first 30 days. Hospitals can fax a copy of the referral to 866-397-4522, to the attention of Jonice Stewart. Hospitals can also call the Utilization Management line at 888-913-0350 and ask for Brandi Bishop, the LaCare RN responsible for processing these authorizations.

Newly enrolled members in LaCare who were receiving medically necessary covered services the day before becoming a LaCare Member, can continue to receive such medically necessary services for the first thirty (30) calendar days of enrollment, **without prior authorization and without regard to whether such services are being provided by a participating or non-participating LaCare Practitioner/Provider**. After thirty (30) calendar days, prior authorization requirements apply for those services identified as requiring prior authorization. LaCare will continue to provide coverage for services determined to be medically necessary for an additional sixty (60) calendar days or until the Member may be reasonably transferred without disruption, whichever is less. LaCare will not deny authorization solely on the basis that the Practitioner/Provider is not a participating LaCare Practitioner/Provider.

2. Community Health Solution (CHS) is conference calling PCP offices with member on the phone to schedule appointments when the PCP has already been over assigned members due to incorrect system load.

There is no contract violation if a Primary Care Provider (PCP) assists a patient in calling a Plan's Member Services to request assignment of the patient or changing the patient's PCP to themselves. This is something that we anticipate will happen frequently. The only issue would be if the PCP has already exceeded their capacity.

We contacted **CHS** for a response and they stated as part of Care Coordination and Member Services, they assist members to schedule appointments with their PC P or select a PCP. While the Care Management and Member Services staff do not monitor capacity prior to providing coordination services, Provider Relations staff monitors provider member assignment against capacity levels and will be working with providers to maintain compliance within DHH's maximum capacity standards.

CHS's internal policies and procedures require that each Provider Relations Representative monitor the maximum capacity and alert a provider when he or she is within one hundred members of the number allotted by the provider to CHS members. At that point the provider can allot additional slots to CHS if he or she has them available or CHS closes enrollment for the identified provider.

3. UnitedHealthcare (UHC) is requesting completion of form for all OP Rehab patients and asking if “par” or “non-par”.

We requested that UHC respond and they advised us that they are in the process of updating their outpatient rehabilitation forms to remove the "par/non-par" language, and will only be asking if the provider is enrolled in Louisiana Medicaid. They wish to extend their apologies for any confusion the "par/non-par" language may have caused.

4. Bayou Health members are calling and showing up at walk-in clinics and informing clinic staff that their Bayou Health plan told them that if a provider isn't contracted with their plan to use their regular Medicaid card since they are already Medicaid providers.

As this had not been previously reported to DHH, we asked for a response from each of the five Health Plans relative to this concern.

Amerigroup stated that during the 30-day transition period, new Amerigroup members who are receiving medically necessary covered services that were authorized prior to the go-live date can continue to receive such medically necessary services from their provider, regardless of the provider's status with Amerigroup.

When Maximus corrected the auto-enrollment process and reran the auto-enrollment assignment the week of 1/30, there was a period of time that members may have needed to see providers and had not yet received their correct Health Plan card. Amerigroup communicated to members calling their National Customer Care unit and providers that the provider could check the DHH eligibility verification site (e-MEVS) and using the member's Medicaid ID card, obtain an up-to-date status of the member's Health Plan assignment for the month of February.

CHS stated that they have not intentionally directed their members to go to walk-in clinics. They noted that BAYOU HEALTH represents major cultural change for Louisiana Medicaid recipients as well as providers and that member education needs relative to the appropriate use of health care are tremendous and will take time to achieve. CHS indicated their intent to continually refer CHS Members to their Member Handbook and offer support through their Member Services Call Center while all get accustomed to the program changes. Once Members are established with each Plan, receive their Plan issued membership cards and each of the providers is more familiar with Plan requirements, CHS believe that if this is currently occurring, it will greatly diminish.

LaCare noted that their new members who have contacted them requesting to use a non-participating provider that they haven't previously seen are encouraged to search for a participating provider with LaCare. The member services representatives are assisting members with that search. During the 30-day transition period, new members who are receiving medically necessary covered services the day before becoming a LaCare member can continue to receive such medically necessary services without prior authorization and without regard to whether such services are being provided by a participating or non-

participating LaCare Practitioner/Provider. However, LaCare states that they have not advised any members to present to a provider with their Medicaid ID card.

LHC indicated that their call center staff has been trained to instruct members to use their Louisiana Healthcare Connections card, not the state issued Medicaid ID card. They take every opportunity to reinforce training and provide additional information to their call center staff. Every evening they review with their staff all results they find through quality monitoring, frequently ask questions, and new information they receive from DHH. In all of their written material, including the Member Handbook, members are reminded to take their LHC ID cards with them. If a member presents for service and does not have their ID card, the provider can easily verify eligibility by using LHC's secure provider web site (available to participating and non-participating providers) or they can call 866-595-8133 where information can be validated through Interactive Voice Response (IVR) or speaking with an agent. LHC's call center staff takes encourages members to select a medical home (Primary Care Provider) who will coordinate their care utilizing primarily contracted providers and non-contracted providers when appropriate.

While LHC requires Prior Authorization for some services, the use of non-contracted providers always requires a Prior Authorization except in the case of an emergency. This is communicated through all of LHC's provider correspondence and is clearly posted on their public web site.

United has communicated to their call centers and member interfacing staff to ensure that they will not give members this type of directive.

5. In-patient Bayou Health members – Are they to remain as regular Medicaid until discharge and then access Bayou Health coverage? Different plans are handling this differently.

This is a question that has been discussed at length on the noon provider calls. The three pre-paid Health Plans are well aware of the policy that if a member is hospitalized prior to 12:01 AM on the "go live" date, DHH will be responsible for all inpatient and out-patient charges through the date of discharge or date of transfer to another facility. Further, if a member is transferring from one Health Plan to another and is hospitalized on the effective date, the relinquishing Plan remains responsible for inpatient and outpatient charges through the date of discharge or transfer to another facility. In our discussion of this policy with the Plans, Amerigroup noted that if a patient has been identified as an Amerigroup member they will begin following these patient for coordination purposes prior to discharge.

6. Bayou Health plans have over assigned membership to PCPs beyond contractual limit – actively working to correct but patients angry with clinic staff.

This is another issue that had not previously been called to DHH's attention. None of the Health Plans have finalized their PCP assignments in GSA A as they must provide at least ten days for the approximately 180,000 members who were auto-assigned to choose a PCP. While we will need more information to properly investigate this issue, the Plans offered

their perspective on PCPs being over assigned membership beyond their contractual limits. We look forward to addressing this issue further during our workgroup, or before.

Amerigroup sets PCP panel limits based on information received from the provider during the contracting process. If no panel limit was set by the provider, the default is 1,500. Amerigroup is correcting any panel issues that the providers have notified them about.

CHC indicated they have not knowingly over assigned members to any provider. During the first month of implementation, this was not an issue they were expecting to encounter. **LaCare** also sets PCP panel limits based on information received from the provider upon contracting. If no panel limit is set by the provider, their default limit is set to 1,000. In response to LHA raising the question they conducted a review and determined that they have not over-assigned membership to any PCP's in their network.

LHC was unsure how this was possible. As all plans used the same claims data to assign members to PCPs, no PCP should have received more than the 2,500 maximum unless that provider had been working with more than 2,500 prior to the implementation of Bayou Health or that plan covered a very large number of members who did not have a relationship with a given PCP.

UHC stated than to their knowledge, they have not had any issues with PCP assignments above the contractual limits. If any of their network providers are experiencing an issue, they requested that the provider please provide a description of the issue to them and they will investigate immediately.

7. Non-contracted Bayou Health (LHC) plan assigned members to non-contracted providers– How is this even possible when there is no contract?

LHC said that they do not understand how this could have happened as within their systems a provider must both be participating and have an open panel. They advises that they can certainly continue to research, however they will need some specific examples of which non-participating providers have been assigned membership inappropriately.

LHC members are assigned to network PCPs. Out-of-network services have been authorized for the month of February as part of the 30 day transition period for members and providers. Other than for emergency services, there will also be special circumstances in the future where a member needs services from a provider outside the LHC network. These situations will be handled on a case- by- case basis to provide the best services to meet the needs of the member.

8. Pediatric patients are being linked to regular PCP when they should be linked to a pediatrician in order for EPSDT criteria to be obtained & reported.

Please note that there is no prohibition of linking members under age 18 to non-pediatricians. DHH routinely did so in CommunityCARE. It is not necessary for the PCP to be a pediatrician in order for members to receive EPSDT screening services.

9. AMG & CHS plans do not have a pre-authorization form for inpatient care, nor did they have a concurrent form to report daily clinical information for their inpatients.

Amerigroup does not require a provider to use a particular pre-authorization form or a concurrent information form. There is a pre-certification form on their web site in case the provider would like one, and the concurrent review nurse sends the authorization approval information to the provider.

CHS has offered a simple form for pre-authorization requests; this form is located on their website. This same form can also be used for concurrent reviews. CHS did not create separate forms for different requests as they thought this would reduce administrative burden. They will also accept and act upon a request based upon submission of clinical documentation.

10. Plans are not familiar with KidMed process.

KIDMED is the name that DHH used during the 1990s for the Medicaid EPSDT Screening Program in Louisiana. With the implementation of BAYOU HEALTH, DHH will no longer administer EPSDT screening as responsibility is assumed by the Health Plans. DHH has enrolled KIDMED providers, made annual inspection visits to each KIDMED provider site and had special claim form attachments that were submitted to Molina.

We are quite confident that all five of our BAYOU HEALTH Plans are very familiar with the EPSDT Screening Program requirements and DHH's expectation that EPSDT screening rates improve.

Amerigroup stated that with the phase-out of the KIDMED program, they have focused their orientation and materials on their EPSDT services. If the provider is in their network, they will continue to reimburse the provider for EPSDT screening services in accordance with the terms of their contract with DHH. If the provider is out-of-network or non-participating, they will pay according to the out-of-network requirements, assuming that the provider has obtained an authorization from Amerigroup for EPSDT services. For lab work, any CLIA-certified provider can perform the lab work or utilize their lab vendors Quest and LabCorp. More information is contained in their provider handbook at www.amerigroup.com/providers.

CHS has made every effort to become familiar the rules that were specific to Louisiana's KIDMED Program (which is ending). EPSDT screening protocols are federal mandates and

they are aware of those rules. The changes resulting from DHH no longer enrolling KIDMED Clinics staffed by RNs (Provider Type 66) does create a unique set of rules that are being adjusted, but they indicated that it is not something that cannot be overcome. As part of the contract for a PCP with CHS, there are requirements specific to compliance with EPSDT screenings. Additionally, CHS, as required by their contract with DHH, has dedicated staff to assist their providers in understanding the requirements for EPSDT screening as they transition to a role previously managed through the KIDMED program. CHS is committed to minimizing the administrative burden for providers in complying with all state and federal reporting requirements for EPSDT screenings.

LaCare stated that they are familiar with the EPSDT screening program and requirements (formerly called KIDMED). This program is addressed in detail in LaCare's Provider Manual, beginning on page 73. Providers can access the Manual at the following site: <http://www.lacarelouisiana.com/pdf/provider/resources/manual/provider-manual.pdf>.

LHC indicated that they feel they are very comfortable in their understanding of KidMED. They have answered multiple questions related to KidMED in the Q&A section of our website (<http://www.louisianahealthconnect.com/for-providers/provider-resources/frequently-asked-questions/>), and have addressed multiple EPSDT screening questions on their twice weekly open provider calls (Tuesday and Thursday from 1:00 PM to 2:00 PM) and it is discussed in detail on page 37/38 of their Provider Manual which is posted on their web site.

UHC follows the same EPSDT screening process as required by the state by ensuring that providers perform these checkups which include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. As claims are submitted with EPSDT codes, the code data is tracked to ensure compliance with federal and state EPSDT requirements. As United's EPSDT screening providers must be enrolled in Louisiana Medicaid, provider would still need to meet the state's criteria for provider enrollment. Providers no longer need to complete and submit the claim attachment known as the KM3. They only need to submit EPSDT codes on their claim form (codes are contained in the State's EPSDT Manual) and United will extract the EPSDT code data from claims. The provider should document in the medical record what services were provided for auditing purposes and must maintain the medical records for three years. Providers may use any laboratories that are part of the Louisiana Medicaid network. UnitedHealthcare is not contracting with or limiting access to ancillary providers. If the ancillary provider is a Louisiana Medicaid provider, they are considered "in-network" for UnitedHealthcare.

11. Plans are having difficulty with electronic eligibility verification, and some information being provided by plans is incorrect.

Amerigroup stated that providers can verify eligibility by calling their 24-hour IVR system at 1-800-600-4441 or logging into the secure provider web site. They noted that they have received no reports of difficulty or inaccuracy in eligibility.

CHC indicated that they have been able to verify enrollment with CHS; however, as noted previously, have not had adequate time for each member to be linked to a CHS PCP. They are confident that PCP verification will be accurate when PCP assignment is completed. They are in the process of outreach to new Members to ensure that they get established with their PCP. CHS intends to auto-assign members who have not made a PCP choice so that they will be linked to a PCP and receive their Plan ID card with the name of the PCP and other member materials prior to March 1st.

LaCare said that their member eligibility information has been provided since February 1st through Navinet and IV). Navinet and IVR information is accessed in real time and was tested in preparation for LaCare's go-live. They report having had no complaints regarding accuracy of information. Facilities must be credentialed in order to access Navinet which can be initiated by calling Navinet at 1-888-482-8057 to sign up for the system. Requests are being processed within 48 hours, and there is no back log for provider access.

LHC states they know of no significant challenges related to electronic eligibility verification and its accuracy.

UHC's provider web portal is up and functional. They are not aware of issues with providers checking member eligibility. They continue to monitor their portal to ensure it is functioning properly. When there is a question of eligibility, the DHH eligibility site (e-MEVs) is being used as the final confirmation. If providers are experiencing an issue with them they are requesting that they provide a description of the issue so that they can investigate immediately.

12. 10 to 40 minute wait times when calling health plans in some instances.

Amerigroup has confirmed with their National Customer Care team that calls have been answered in less than 30 seconds on average.

CHC indicated that they have had periodic long hold times; however, overall, they have not been unable to meet Member or Provider needs. The Average hold time is 15-17 Seconds for Member and Provider Services.

LaCare average speed of answer (ASA) has been 5 seconds or less since 2/1. The ASA is the average amount of time it takes for a caller to reach a customer service representative.

LHC said that Member and Provider services are of the utmost importance during any implementation and they strive to exceed the standards in their contract with DHH. To that end they are confident in reporting that the expended hold times being reported are being experienced by callers to 866-595-8133. Call Center statistics for dates February 1st through February 11th show an average time to answer of one second for members and providers. One of LHC's specialty companies did have a minor technical issue during the first week of operations causing the lower than expected service level. That issue has been fixed and LHC expects to see the service level above 95% going forward. If necessary, LCH can provide hour by hour detail from each day of operation.

UHC reports that they have not experienced hold time issues. Their call centers, from 2/1 through 2/10, have averaged contact with a live person within 30 seconds 82% of the time in their member call center and 90% of the time in their provider call center.

13. Identification cards issued by plans are incorrect, and plan information has changed for member. One plan has not even issued ID cards yet. (LaCare)

The initial auto-assignment was flawed by a data error and was immediately rerun upon discovery of the problem. Some member ID cards had already been mailed and members were subsequently assigned to a different Health Plan. On February 6th, DHH requested that further mailings of materials to members be halted until an issue with the accuracy of Heads of Household could be resolved. Mailings have now resumed.

DHH is advising that providers always check e-MEVS, MEVS, or REVS (the Medicaid eligibility verification systems maintained by Molina), as it is the ultimate source for a recipient's enrollment in BAYOU HEALTH and if enrolled, the name of the Health Plan. Enrollment in a BAYOU HEALTH Plan will always be for the entire calendar month; it will not change mid-month. Any changes are effective the 1st day of the month.

LaCare did in fact mail member ID cards prior to DHH's February 6th direction to suspend mailings until further notice. They anticipate that all of the members assigned to them for February will receive a member ID card before the end of the month.

14. Health plans have not provided edit information and only one plan (Louisiana Healthcare Connections) has tested with providers.

Amerigroup's Provider Contract templates and Provider Handbook mention the right to utilize claims editing software as follows: "AMERIGROUP reserves the right to use a code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure." They will be happy to share edit information with providers upon request.

CHC is a FFS program and, as such, mirrors the legacy Medicaid Program's billing policies and fee schedules. During provider training they have stressed that billing policies and requirements remain as they have been and that providers should follow the existing Medicaid billing policies.

LaCare is unsure what “edit information” specifically refers to. With more detail they can provide an accurate response. Their systems were fully tested internally and are the same systems being used by other lines of business nationally.

As **UHC** only pre-processes claims, they do not have edits in their systems that require testing. Claims for UHC members should be submitted as they were prior to the implementation of BAYOU HEALTH but sent to UHC instead of Molina.

15. Infant linking with mother’s plan is creating notification issues in NICU setting in instances where infant may have been transferred to another facility after birth.

DHH provided the following response to a hospital that indicated they felt this could become an issue: *“The sending hospital should have the birth mother's name, DOB, and Medicaid # readily available. It should not delay the transport of the newborn to collect the information about the birth mother that the sending facility collects when registering/admitting the birth mother. A copy of the mother's face sheet would provide the necessary information and could be requested by fax prior to the transfer or obtained when the team picks up the infant.”*

16. Assignment of infants not happening timely, and issues with infant being officially recognized by Plan.

There should be no question relative to the Health Plan the newborn is enrolled in for the month of birth as it will always be the Health Plan in which the mother is enrolled on the date of birth. If the mother is enrolled in the legacy Medicaid Program, the newborn will be enrolled for the month of birth in legacy Medicaid as well.

Hospitals will continue to request assignment of Medicaid ID # for newborns through the web-based system that has been utilized for this purpose since 2002. Within three working days of receipt, a 13 digit Medicaid ID# is assigned and the newborn is added to the Medicaid eligibility file. That night, the new member is transmitted to the Enrollment Center who will include the newborn on the next daily Enrollment File (X12 834) to the mother’s Health Plan. The Health Plan adds the newborn to their Member Files and if a PCP has not already been selected, provides the mother 14 days to select a PCP for the newborn before auto-assigning one. **For the first thirty days following birth, any network provider can be reimbursed for services provided to the newborn.**

Amerigroup indicated that the State’s established process is for the hospital to report the birth via the Request for Newborn ID System (152-N) in order for the baby to receive a Medicaid ID number and be listed on the mother’s plan. Once the baby appears on the file, Amerigroup will then follow up.

LaCare indicated that if a newborn claim or inquiry is received by them prior to their receipt of the newborn’s information on the 834 file, LaCare’s procedure is to match the child to the

mother through their member records. The newborn is enrolled in their plan upon receipt of his/her information in the 834 file and the enrollment is retroactive to the date of birth. Their process is to hold all infant claims for a full five business days if they are unable to immediately process the claim.

LHC said that they do not require any additional information about the newborn other than the notification of the birth that includes the basic descriptive data about the newborn. They have an internal process set up to officially recognize the baby as a plan member for the first month after birth using the notification of birth information.

UHC assumes that if the mother is a member of their Plan that the newborn is too. They create a temporary ID for the infant and link through a family link to the mother. UHC's concurrent, discharge planning and case management staff will follow the newborn's case and assist with any care coordination needs. Once the newborn is added to the 834 file from DHH and Medicaid assigns the newborn to United, the newborn's record is merged from the temporary ID to the permanent ID.

UHC is not aware of any issues with newborns not being assigned timely or with difficulty recognizing them in their system. They are requesting that any provider who has experienced an issue provide a description and they promise to investigate immediately.