Louisiana Department of Health and Hospitals
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7.22.2010	AUTOMATIC ASSIGNMENT	Will the department contract with one or more third parties to conduct choice counseling and enrollment? ▪ Based on what criteria will auto-assignment be made? ▪ Please describe the auto-assignment process as specifically as possible. ▪ Will distinction be made between prepaid plans and fee-for-service plans in the assignment? ▪ Will distinction be made between plans contracted to provide services only for a parish as opposed to those contracted to provide services in broad regions?	Assisting Medicaid/LaCHIP enrollees with selecting the CCN that best meets their needs will be within the scope of DHH's Enrollment Broker contract with Automated Health Systems (AHS) Auto assignments are being made to CCNs who will in turn be responsible for auto-assignment members to a PCP if necessary. At the CCN level, the auto-assignment algorithm will consider previous linkage with a CommunityCARE PCP (during the implementation of the CCN program) and subsequent to implementation, any previous relationship with a CCN; and then round robin with equal consideration given to both CCN-S and CCN-P models. Specifics are still being finalized. To incentivize coverage of an entire region, the auto-assignment algorithm will give preference to CCNs that include all parishes within the region.

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			Distinction will **not** be made between CCN-P and CCN-S in the automatic assignment process. When quality performance measure outcomes become available, they will be factored into the auto-assignment algorithm.
7.22.2010	AUTOMATIC ASSIGNMENT	If an enrollee is linked to a provider and that provider is enrolled in a single CCN will the enrollee be automatically assigned to that network in the auto-assignment process?	No. All existing CommunityCARE enrollees and new enrollees will be given the opportunity to select the CCN of their choice. For those individuals who do not affirmatively select a CCN, the algorithm for auto assignment during the phase-in implementation of the CCN program, will consider the enrollee's current CommunityCARE PCP. If the PCP is in more than one CCN, assignments will be distributed equally among the CCNs.

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7.22.2010	AUTOMATIC ASSIGNMENT	What is time period for enrollees to change CCNs once auto-assigned?	CCN enrollees have ninety days to change their Network without cause, as required in federal Medicaid regulations (in the absence of a waiver).
7.22.2010	AUTOMATIC ASSIGNMENT	How would multiple contracts with one plan affect auto-assignment?	In the event that an entity is enrolled as both a CCN-S and CCN-P in the same service area, that entity will be treated as one CCN for auto-assignment purposes, with members evenly distributed between the two models.
7.22.2010	AUTOMATIC ASSIGNMENT	Does DHH expect to apply any differing policies to CCN-S versus CCN-P entities (e.g., member assignment or transfer to another CCN)	No.
7.22.2010	AUTOMATIC ASSIGNMENT	Will the state (or its designee) attempt to determine whether an enrollee has a prior or ongoing relationship with a provider in one of the CCNs? Will the enrollee be assigned to that provider and CCN whenever it is feasible?	The automatic assignment algorithm will consider previous linkage with a CommunityCARE PCP (during the implementation of the CCN program) and subsequent to implementation, any previous relationship with a CCN.
7.22.2010	BENEFIT PACKAGE	Will outpatient rehab continue as fee-for-service or will it be managed through	With the exception of Early Steps, therapy and

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		a CCN?	rehabilitation are not carved out services for the CCN-P model. Under the CCN-S model, outpatient rehab will continue to be reimbursed FFS. However the CCN would be responsible for service authorization. Under the CCN-P model, the CCN will be responsible for both the payment to the provider and service authorization. Certain eligibility categories will be excluded from CCN enrollment, while enrollment for others will be voluntary and can "opt out" of CCNs. Both will continue to be FFS. *Chisholm* class members fall into the category of **excluded** enrollees, as well as, children with other health insurance and children enrolled in a Home & Community Based Services Waiver. Voluntary children include those under age 18 who are receiving Supplemental Security Income (SSI) because of

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			their disability, foster children and children in out of home placement, and children receiving services through OPH Children's Special Health Services Clinics.
7.22.2010	BENEFIT PACKAGE	Health plans agree that the program should "strongly support the integration of both physical and behavioral health services." However, the limited involvement of CCNs described in Section 4.11 does not seem to be the best way to achieve such integration. Also, since the references Policy and Procedures Guide has not been published, the division of responsibility between CCNs and DHH is not clear. ▪ Will DHH consider full integration of behavioral health in the services expected of a CCN? ▪ If full integration is not to be included, is DHH open to recommendation on how to make specific the responsibility of a CCN?	The decision to initially carve out specialized behavioral health services was made because a significant portion of behavioral health services are currently being provided and reimbursed outside the Medicaid system. DHH is in the process—through the Systems of Care project—of making changes to bring these services into Medicaid in 2011. At that time Medicaid can begin collecting the necessary data to add specialized behavioral health to the benefit package within the next three (3) years. DHH is open to comments on CCN responsibility for coordination of specialized behavioral health services included in the ***Policy & Procedures Guide***.
7.22.2010	BENEFIT PACKAGE	Specialty mental health services, home and community based care, prescription drugs, nursing homes, nursing homes, hospice and adult dental will continue to be offered under the fee-for-service system, and patients will	The initial decision to carve out pharmacy benefits was made because of the very high percentage of the drug rebates received by Louisiana Medicaid (37%), which

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		get them through that system. The plan is to move mental health care into the managed care system by 2013. We are concerned that these carve-outs for drugs and mental health in particular will disrupt the continuity of care and make effective care coordination more difficult to achieve. We recommend the department study how to integrate these carved out services into the CCN system prior to the phase II implementation of CCN.	exceed the savings CCNs could realistically be expected to achieve in pharmacy in the absence of rebates. The Affordable Care Act (ACA) includes a provision that permits Medicaid drug rebates to be received through Medicaid pharmacy services provided through pre-paid risk bearing entities. DHH is continuing to analyze and is waiting for guidance to be issued and pharmacy and other carve outs could be added to the benefit package in the future.
7.22.2010	CARE COORDINATION	In Section 4.9, it says that we are not responsible to coordinate but shall provide any required referrals for a list of services that include adult day care, hospice, EPSDT, transportation, school district services, nursing home, etc. Please clarify expectations around "referrals." For example, do we need to provide names, addresses, phone numbers, etc.?	The Model Provider Agreement is being amended to include coordination, as it was inadvertently omitted from the draft. The CCN shall coordinate all referrals for all services, including in- and out-of-network services and carved-out services. The expectation is for the CCN to assist members with scheduling referred services and exchange appropriate information with those providers to ensure coordination and continuity of care.
7.22.2010	CONVERSION	After implementation, when may an entity convert from one model to the other?	An entity may submit an application packet to convert at any time, however, the earliest effective date for

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		▪ From fee-for-service to prepaid? ▪ From prepaid to fee-for-service?	conversion of the CCN to a different model will begin subsequent to a full year of operations within the service area(s) for which conversion is being requested. If an entity converts to a different CCN model, members will be enrolled by default in the new model and will be sent notice allowing them 90 days to affirmatively choose a different CCN.
7.22.2010	DATA EXCHANGE	Will DHH accept encounter data electronically, in paper form or both?	Electronic only.
7.22.2010	DATA EXCHANGE REPORTS	Please confirm that this certification from a CEO, CFO or other delegated individual applies solely to data and reports submitted and not to every individual "document" that the CCN may submitted to DHH.	That is correct.
	DATA EXCHANGE	Will DHH and their agents (e.g., Enrollment Broker) transact the x12 standard transactions (834, 837, 820, etc.) at the onset of the CCN program with the	Yes, the Enrollment Broker (AHS) will use the 834 and the Fiscal Intermediary (Molina) will use the 837, 820, and

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		CCNs? If they are not currently transacting, will DHH consider working with their MMIS vendor and the CCNs to initiate for program inception?	835.
7.22.2010 **Updated 8.12.2010**	DATA EXCHANGE	Will there be an exchange of paid claim data from the FFS MMIS to the CCNs to support care management, HEDIS, monitoring, PIPs, etc.? If so, in what format will the data be?	Initially, CCNs will be provided 2 years of paid claims data (including pharmacy) on a DVD for their linked members. Subsequently, incremental claims data will be refreshed on a weekly basis and retrievable from the Molina website. **Updated 8.12.2010:** A sample format for providing CCNs with historical claims data has been posted online here. Please submit any comments or suggestions for revisions/improvements to DHH at coordinatedcarenetworks@la.gov.
7.22.2010	DATE EXCHANGE	Will the CCN also need to be able to facilitate data exchange with the Enrollment Broker?	Yes. CCNs will be required to have systems in place and have successfully exchange test files with the Enrollment Broker before the CCN Enrollment Process can be completed.
7.22.2010	ENROLLEE CHOICE	Whenever Possible, we recommend that consumers have a choice of at least	At this point, DHH cannot determine which types of

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		two CCN plans of each type – prepaid and shared savings – in each region. In rural areas where such choices are not feasible, DHH should adopt measures to ensure that consumers have choice of physicians and the ability to receive services from out-of-network providers in appropriate circumstances.	entities will apply and where they will choose to operate The CCN model type—whether shared savings or prepaid—is expected to be seamless to Medicaid and LaCHIP enrollees. In urban parishes, enrollees will have the choice of at least two CCNs or may choose between the one CCN and Medicaid fee-for-service. Within the CCN, enrollees may choose their PCP. As provided for in federal law, members will be allowed to receive services from out-of-network providers in certain circumstances.
7.22.2010	ENROLLEE CHOICE	Patients are allotted 15 days after receiving information from an enrollment broker for them to make their plan selection. This 15-day window for plan selection is not an ideal timeframe for the targeted population because it does not provide enough time to make an informed selection. Instead, we suggest that current program enrollees be given no less than 30 days and new program enrollees be given no less than 45 days to make a plan selection.	Enrollees in CommunityCARE will have 30 days in which to make a selection with follow up by the Enrollment Broker if a selection has not been affirmatively made by the 15th day. New enrollees will be given 15 days and advised that they can request an additional 15 day extension if requested by the 15th day.
7.22.2010	ENROLLEE CHOICE	Consumers should have the right to designate and change the designation of	The Provider Agreement includes this right.

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		their primary care provider within a CCN	
7.22.2010	ENROLLEE CHOICE	We recommend that consumers who are automatically enrolled in a CCN plan have the opportunity to change plans within 90 days of receiving notification of such automatic enrollment.	Medicaid/LaCHIP enrollees who do not affirmatively select a CCN will be auto-assigned. The notice will include language advising of the 90 day window in which enrollees can request enrollment in a different CCN for any reason.
7.22.2010	ENROLLEE CHOICE	If an urban area has only one CCN, will enrollees be mandated into that one or will they still have a choice?	For mandatory eligibility groups in **urban** areas the choice will be between the one CCN and the existing CommunityCARE. If non-mandatory CommunityCARE or voluntary eligibility group, the choice will be between the CCN and fee-for-service.
7.22.2010	ENROLLEE CHOICE	How are choice periods defined for members who change CCNs? If members change from one CCN to another during the choice period, does the 90 day choice period start again? If members change from one CCN to another and back to the original CCN during the choice period, after they return to the	Members may choose and change their CCN choice an unlimited number of times within the 90 day choice period. The choice period is not refreshed after each choice. The enrollees choice prior to the end of the 90-

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		original CCN must they stay with the original CCN?	period will be considered the enrollees choice.
7.22.2010	ENROLLEE CHOICE	When does open enrollment occur?	The open enrollment period begins on the third to last working day in October and runs through the third to last working day in December.
7.22.2010	ENROLLEE EDUCATION & OUTREACH	How will Medicaid patients be held accountable for their care? Currently we have difficulty getting patients to keep their appointments or be compliant. How do you change these behaviors? Is this addressed in the plan?	Compliance is not an eligibility factor and therefore benefits cannot be terminated for failure to comply. DHH strongly encourages the CCNs to address some of the reasons for non-compliance through patient outreach and education, care coordination, and the option for case management.
7.22.2010	ENROLLEE EDUCATION & OUTREACH	Are CCNs able to perform retention services/reminders with their members - specifically, the Enrollment Broker including the member's program expiration date in the enrollment data to the CCN and then the CCN assisting by providing reenrollment reminders (written and verbal) to their member.	The degree of churning will be minimal. In Louisiana, the number of Medicaid and CHIP enrollees who lose coverage at annual renewal for a paperwork or procedural reason is less than 1% of enrollees due for renewal. The renewal process in Louisiana is paperless and a signed form is not a condition of continued eligibility. Eligibility

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			caseworkers are pro-active and aggressive in locating families and getting needed verifications.
7.22.2010	ENROLLEE EDUCATION & OUTREACH	Please confirm that materials that fall into a reading grade levels between 4.0 and 4.9 will be acceptable.	Requirements are being revised to state that materials must be written in a style and reading level that will accommodate the reading skills of most Medicaid and CHIP enrollees. In general, the writing should be at no higher than a sixth-grade level (6.9), taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. DHH reserves the right to require evidence that materials have been tested against the sixth-grade reading-level standard.
7.22.2010	ENROLLEE OUTREACH & AWARENESS	When/ how are we going to start patient education campaign on CCNs?	Approximately three (3) months prior to implementation within the region. Outreach and education efforts are being planned—PSAs, mail, integration into Medicaid/LaCHIP outreach, small contracts with community organizations.

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7.22.2010	ENROLLEE OUTREACH & AWARENESS	Will that campaign be shared with providers prior to launch?	Yes, it will be shared. In the meantime, we welcome input and suggestions.
7.22.2010	ENROLLEE OUTREACH & AWARENESS	Will Spanish language campaign be available?	Yes, all materials will be available in Spanish and Vietnamese.
7.22.2010	ENROLLEE OUTREACH & EDUCATION	What percent of members have good contact information at the State after six months?	We have not calculated an actual percentage. As is the case in all states, the Medicaid and CHIP population is highly mobile. For purposes of renewing eligibility, Medicaid eligibility caseworkers have a good rate of success in finding current contact information when correspondence is returned by the Post Office as undeliverable.
7.22.2010	GENERAL	As a recipient of Medicaid enrolled in a CCN-P, will I receive an allotment, like a prepaid phone card, that can be used for doctor's service fees during that month? How will the card work? Who will cover expenses outside of the co-pay that my CCN-P and my card covers?	Under the CCN-Prepaid model, the monthly payment will be made to the CCN who will be responsible for providing your medically necessary care for those services included in the benefits. The process for getting certain services including --but not limited to --pharmacy, dental,

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			specialized behavioral health, and hospice) is not changing. The CCN or their providers cannot bill you for any balance. Co-pays cannot be more than in the fee-for-service Medicaid program, which is a co-pay ranging from .50 to $3 for pharmacy only.
7.22.2010	GENERAL	May one plan submit multiple proposals using the two models? ▪ For the same geographic area? ▪ For different geographic areas?	Yes, an entity may enroll as a Coordinated Care Network-Prepaid (CCN-P) provider and/or Coordinated Care Network-Shared Savings (CCN-S) provider in either the same or different service areas.
7.22.2010	GENERAL	Is Molina Healthcare permitted to participate in the prepaid model? It operates a Unisys subsidiary that handles claims administration for Louisiana Medicaid.	No.
7.22.2010	GENERAL	How many of the 1.15 million Medicaid beneficiaries are mandatory vs. voluntary vs. excluded?	Based on enrollment in Louisiana Medicaid as of 7/1/10 is it anticipated there will be:

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			Mandatory: 800,000 Voluntary: 44,000
7.22.2010	GENERAL	If an enrollee needs to be referred outside of network for a test, who pays?	For the CCN-P model, the CCN is responsible for payment. In the CCN-S model, all providers are reimbursed by DHH.
7.22.2010	GENERAL	Is there a target or projection for how many members will enroll in prepaid plans versus the shared savings model?	We will not know this until we begin receiving applications for enrollment.
7.22.2010	GENERAL	What does DHH plan to do to manage the number of contracted plans? ▪ Will a minimum enrollment be required? ▪ What will happen if a plan does not enroll what it considers a sufficient number and decides not to continue its participation? ▪ What will happen if the department receives no proposal for a geographic area? ▪ Will the department offer some type of incentive to include rural areas in a proposal?	The number of CCNs is not limited. Any willing CCN who meets the requirements may enroll. Actuarially, the **minimum** number of members enrolled in a CCN is recommended at 15,000 for CCN-S and 25,000 for a CCN-P and that capacity must be demonstrated prior to final enrollment approval as a CCN provider. Once the agreement is final, a CCN is required to provide DHH notice via the required *120 Day Notice of Termination* prior to withdrawal from the program. If no CCN is enrolled within a service area, the existing

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			PCCM program, CommunityCARE, will continue. An incentive for including rural areas in the service area is that the auto assignment algorithm will distinguish between those CCNs whose service area is region-wide vs. less than region-wide.
7.22.2010	GENERAL	Is the enrollee assigned to the provider or the CCN?	The Enrollment Broker transmits enrollee's CCN choice and PCP preference (if available) to the CCN. However, the CCN may or may not be able to link the enrollee to their preferred PCP as the PCP's panel may be full or the PCP may have restrictions (for example, age) that would not allow for the request.
7.22.2010	GENERAL	Who will be the enrollment broker?	Automated Health Systems (AHS).
7.22.2010	GENERAL	Is DHH open to holding a second CCN-S/P rate reimbursement meeting just for the technical discussion of rates – a week or so following the release of the data book and rates?	Yes, such a meeting is being scheduled.
7.22.2010	GENERAL	6.6.12 Is the referenced "maximum enrollment by designated service area"	PCP capacity; the ratio is 1:2000 inclusive of ALL CCN

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		[which CCNs will report to CCNs monthly] based on PCP capacity solely or are there other factors in the calculation of the CCNs capacity?	enrollees if the PCP is participating in multiple CCNs.
7.22.2010	GENERAL	12.11 Emergency Services states that DHH is financially responsible. Should this really state the CCN?	In the CCN-S model, all services are reimbursed fee-for-service. Therefore DHH is financially responsible for all emergency services for CCN-S members.
7.22.2010		How long will DHH accept and consider comments and questions regarding the Coordinated Care Networks and the Provider Agreements?	DHH will consider all comments received as of July 27th (and July 31st for the Medical Care Advisory Committee members) in the development of the CCN Provider Agreements. We will continue to review comments and answer questions after that date. We will make every effort, to the extent possible, to incorporate those comments into the final Provider Agreements (currently scheduled for release on Monday, August 16, 2010).
7.22.2010	IMPLEMENTATION TIMELINE	What is the schedule for the preparation and mailing of choice materials/choice notices?	Choice materials must be ready to go out to CCN enrollees 60 days prior to the "go live" date. For Phase 1, that date is currently scheduled for Feb. 1, 2011. To be included in first market entry, the Readiness Review and must have

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			been successfully completed 90 days prior to the "go live" date so that Choice Materials can be printed.
7.22.2010	IMPLEMENTATION TIMELINE	Given the state's plans to phase in CCNs, if a potential CCN wishes to be statewide and submits their statewide application will the state review their application for readiness for all regions? And, if the potential CCN meets readiness criteria in those parishes/regions not yet phased in, will eligibles be allowed to enroll prior to the state's roll-in date for auto-assignment (can CCNs go live without auto assignment and marketing efforts in any region where they meet the state's readiness criteria)?	The state recognizes that first-market entry is an advantage. Therefore, in the interest of fairness, we do not intend to allow implementation of CCNs in the subsequent two phases prior to the scheduled roll out date (even though readiness and network sufficiency may have been successfully established). For additional information regarding implementation, as well as a timeline for implementation, please visit www.MakingMedicaidBetter.com
7.22.2010	IMPLEMENTATION TIMELINE	I do not see a launch timeline. Is one available yet?	April 1, 2011 with statewide implementation scheduled for completed on April 1, 2012.
7.22.2010	IMPLEMENTATION TIMELINE	When will a CCN be notified that its application/readiness review has been successful? How much time prior to the "go live" date can a CCN expect to receive notice of a successful application?	Successfully enrolled CCNs will be announced at the point that all requirements are met, including demonstration of network sufficiency. Timing of notification to each CCN will depend on the dates that: 1) all required submissions are determined to be satisfactory, 2) the readiness review is successfully completed and 3) the CCN demonstrates

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			network adequacy. For first market entry, CCNs will have a minimum of three months notice prior to the "go live" date.
7.22.2010	IMPLEMENTATION TIMELINE	Will applications for CCNs be accepted on ongoing basis or is there a final deadline?	Ongoing basis. There will however be final deadlines for receipt of complete application packets and satisfactory submissions for first market entry in each region. All required paperwork and submissions must have been received and passed the desk review, so that the onsite portion of the readiness review can be scheduled, four months prior to the "go live" date for the region. The on-site review, network adequacy and the successful data exchange with the fiscal intermediary and enrollment broker must be successfully completed three months prior to the "go live" date for the region.
7.22.2010	IMPLEMENTATION TIMELINE	When will DHH begin to accept applications for contracts?	DHH will accept application packets for CCN enrollment at any time after the official Model Provider Agreements are released (scheduled for August 16th). Once all of the required submissions are in order and the desk review has been completed, DHH will schedule an onsite review at

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			the CCN's Louisiana location.
7.22.2010	IMPLEMENTATION TIMELINE	What is the timeline of activity, as specific as possible, including but not limited to the following? ▪ Drafting and promulgation of rules and regulations ▪ Release of Policies and Procedures Guide ▪ Release of final proposed contract with prepaid rates ▪ Awarding of contracts	Rulemaking is scheduled to begin in early fall. The content of the Rule can be found in the Model Provider Agreement. The draft Policy and Procedures Guide for prepaid CCNs is being released by July 23rd. Updated versions will be released along with the Model Provider Agreements. The Policy & Procedures Guides are intended to be dynamic documents and will be continually updated. The final model Provider Agreements are scheduled for release on Monday, August 16, 2010. CCNs will be enrolled and announcements made at the point in time they meet all requirements and are officially enrolled as a Medicaid CCN provider but not sooner than October 1, 2010.
7.22.2010	IMPLEMENTATION TIMELINE	Will information on current Louisiana providers participating in Medicaid be included in the Guide or made available through another source?	That information is now available in the document library at www.MakingMedicaidBetter.com

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7.22.2010	LICENSING & ACCREDITATION	What kind of discussion has been conducted with Department of Insurance officials regarding readiness to process licensing applications for prepaid entities, in order to meet DHH's timeframe? ▪ What is DOI's expected turnaround time? ▪ Are they prepared to process multiple applications concurrently? ▪ Will DHH consider allowing a plan to proceed through the process provisionally, with proof of license required at the time of implementation?	The Department of Insurance has committed to a 60 to 90 day turnaround time—sooner if possible. DOI is aware that they will be receiving multiple applications for Medicaid Coordinated Care Networks Proof of any required license(s) will be required prior to actual enrollment of the entity as a Medicaid CCN provider but is **not** required to be submitted with the initial request and forms formally applying.
7.22.2010	LICENSING & ACCREDITATION	Section 1.8 of the draft provider agreement requires that a CCN hold NCQA accreditation or obtain NCQA accreditation within 18 months. In order for plans to have the required data and experience necessary to apply for and obtain NCQA accreditation, new plans will require at least 24 months from the start date of operations. We recommend that this language be revised to allow plans to obtain NCQA accreditation within 24 month from the implementation date of the final phase where the CCN is participating to roll-out.	The requirement is being changed to require evidence of application for NCQA or URAC Health Plan accreditation at the earliest possible date that the plan is eligible to apply (24 months following the start date of operations).
7.22.2010	LICENSING & ACCREDITATION	Will CCN-S model be required to post bond?	Several bonds are required: 1) Performance Bond of $1 million (or an irrevocable letter of credit in lieu of the

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			Performance Bond), 2) Surety bond for the "at risk" portion of the care management fee and 3) Fidelity bond
7.22.2010	LICENSING & ACCREDITATION	Does the CCN-P need to have a license from DOI at the point of submitting an application or at the readiness review stage?	The license does not have to be submitted to begin the application process. Before the onsite readiness review is scheduled, a copy of the CCN-P's license must be provided to DHH. The licensing process may take between 60 and 90 days.
7.22.2010	LICENSING & ACCREDITATION	Please comment on the stated accreditation requirements: ▪ Why are both URAC and NCQA accreditation required? ▪ Why is only 18 months allowed for achievement of NCQA accreditation when the accrediting body's advice to health plans is to allow two years? ▪ Is the department open to recommendations from the industry on how to specify accreditation requirements to ensure contractor quality while not acting as a barrier to qualified plans' participation?	This requirement is being changed as follows: URAC Utilization Management accreditation will not be required. The Prepaid CCN must apply for NCQA or URAC health plan accreditation at the earliest date possible (24 months after operations begin). We believe the change in requirements referenced above is responsive to the industry's recommendations; we continue to be open to recommendations that will help achieve our goal of balance between quality and

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			reasonable requirements of enrolled CCN providers.
7.22.2010	LICENSING & ACCREDITATION	Section 1.8 of the draft provider agreement identifies that a CCN must hold URAC Health Utilization Management certification. We recommend that DHH remove the requirement for a specific URAC accreditation. Currently, the URAC online directory only identifies 3 entities that have Louisiana site locations that are covered under this accreditation. This particular accreditation assures that a company has appropriate utilization review procedures in place for its members. If plans are required to be licensed HMOs, these assurance will already be in place through the LA DOI review of an applicant's utilization review programs. Additionally, DHH may consider requiring applicants to hold a Medical Necessity Review Organization certificate or registration from the LA DOI, which will provide assurances that the company's programs are in compliance with LA specific statutes and regulations.	The URAC-UM certification requirement is being removed and DHH is adding the requirement that the CCN be licensed or authorized as a Medical Necessity Review Organization by the Louisiana Department of Insurance.
7.22.2010	LICENSING AND ACCREDITATION	Section 1.8 of the draft provider agreement identifies that CCNs must have a Third Party Administrator License from the Louisiana DOI and URAC Health Utilization Management certification.	This requirement is being changed to require than a CCN-S provider either be licensed as or have a contract with a Medical Necessity Review Organization (MNRO) licensed

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		Third Party Administrator licenses are typically required for entities responsible for claims payment or premium collection. Per LA RS 22:1641, TPAs are defined as "any individual, partnership, corporation, or other person... who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, or residents of another state from offices in this state, in connection with life or health insurance coverage or annuities..." As this contract does not require the CCN to collect premiums or perform claims payment functions, we recommend that DHH remove the requirement for CCNs to hold a TPA license. Requiring entities to hold a current URAC Health Utilization Management certification will limit the list of potential participants significantly. Currently, the URAC online directory contains only three companies that hold URAC Health Utilization Management for Louisiana based sites. Per the URAC description of this program, this particular certification "ensures that only appropriately trained, qualified clinical personnel conduct and oversee the utilization review process, that a reasonable and timely appeals process is in place, and that medical decisions are based on valid clinical criteria." We recommend that in lieu of requiring entities to hold this specific URAC accreditation that DHH require entities to demonstrate that they hold a valid Medical Necessity Review Organization certificate issued by the Louisiana Department of Insurance prior to DHH's on-site review during the application	**or** authorized by the Louisiana Department of Insurance. The CCN-S must conduct service authorization and pre-process all claims (with the exception of carved out services) and routinely exchange electronic data including HIPAA X-12 transactions with the Medicaid fiscal intermediary and enrollment broker.

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		process. During the licensure process for MNROs, LA DOI reviews the same types of policies and procedures to ensure that utilization review activities are being performed in accordance with Louisiana statutory and regulatory requirements related to patient protection and utilization review.	
7.22.2010	LICENSING & ACCREDITATION	It has been reported that the draft agreement for prepaid entities states a requirement of $150 per member per month in financial reserves. ▪ Is this provision included? ▪ If so, doesn't this provision conflict with the provisions of Act 1 and those of Section 2.10 of the Provider Agreement, requiring a prepaid entity to meet insurer solvency standards described in Title 22?	This requirement has been deleted.
7.22.2010	LICENSING & ACCREDITATION	Please confirm that any licenses and/or accreditations that are ultimately required for a CCN to participate in the program are not required to be in place until the time of the on-site review during the provider enrollment process.	Required licenses, except as otherwise specified, must be in place as a condition of scheduling the onsite readiness review.
7.22.2010	MEDICAL LOSS RATIO	The way that the various expense categories listed in Section 2.1.7 affect the	You are correct that this is language from ACA and the

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		Medical Loss Ratio is not clear. ▪ The document refers to MLR thresholds for "small group plans" and "large group plans." This language seems to have been lifted from the federal Patient Protection and affordable Care Act. Do we assume correctly that this does not apply to CCNs? What is the MLR level at which a DHH review would be required? ▪ Please specify how each of the "Direct Administrative Costs," "Other Direct Costs," "Indirect Costs," and "Other" would be used to calculate MLR. ▪ Since one of the primary objectives of the CCN program is to improve quality of care and health outcomes, do we understand correctly that the cost of activities included in the description of "Medical Management" are to be included as claims expense in the MLR calculation? ▪ Is the department open to recommendations from the industry regarding the elements of claims expense?	federal statute is not statutorily applicable to Medicaid and CCNs. DHH considers 85% to be the desired minimum MLR with the caveat that our intent is to incentivize initiatives to improve quality of care and health outcomes, and such costs will be considered as claims expense in the MLR calculation. DHH is open to comments regarding elements of claims expense to help us achieve our desired health outcome goals. We do not plan to include a requirement that money be refunded to DHH if the MLR is less than 85%.
7.22.2010	MEMBER SERVICES	8.2 Please clarify whether the call center must be located in Louisiana, allowed in other states or off-shored.	The member services call center must be physically located in the United States. The Nurse Advice Line is no longer a requirement, but a recommendation.

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7.22.2010	NETWORK ADEQUACY	We recommend that CCNs be required to have robust provider networks. We are concerned that the requirements of the draft agreement may not be strong enough to ensure patient access to care in a timely fashion. We recommend that the required ratio of primary care providers to patients be increased significantly. In addition, the standard in many medical home practices today is that patients with urgent, nonemergency needs be seen on the same day that they contact the office. We recommend adopting this standard.	The current ratio of 1:2000 is consistent with other state Medicaid requirements. In comparison, the ratio for CommunityCARE is 1:2500 The timeliness of care requirement for urgent care is within 24 hours.
7.22.2010	NETWORK ADEQUACY FINALIZATION	The Provider Enrollment Process for the CCN-Prepaid program identifies that an electronic listing of the network providers must be included with the Agreement. Plans will be unable to contract providers on approved model contracts without advance review by DHH. Will DHH accept model provider contracts for review and approval prior to submitting a Provider Agreement? If so, who is the appropriate contact to submit model contracts to so that plans may begin network development activities with approved models?	The Provider Agreement is being revised. Model contracts must be submitted with the initial enrollment forms; however demonstration of network adequacy is not expected until after the on-site readiness review and will be one of the last steps in the enrollment process.

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7.22.2010	NETWORK ADEQUACY FINALIZATION	Page 4 of the Provider Enrollment Process document identifies that the Network Adequacy Desk Review is submitted upon passing the Readiness review process, however pages 4-5 Required Submission section identifies that the network file should be submitted with the Provider Agreement Signature Pages and other required submissions. Please confirm that applicants are not required to submit a contracted network at the time the initial provider agreement is submitted, but rather the network must be submitted after readiness review approval. Requiring a contracted PCP network with DHH model contracts at the time the applications are first submitted in August or September does not allow interested parties sufficient time to build the required PCP network.	The Provider Agreement is being revised. Model contracts shall be submitted with the initial enrollment forms; however demonstration of network adequacy is not expected until after the on-site readiness review and will be one of the last steps in the enrollment process.
7.22.2010	NETWORK ADEQUACY FINALIZATION	Can you provide detail on the requirements and timelines for CCNs to have provider network agreements reviewed/approved by DHH? Will these agreements require approval from DHH? When will DHH begin accepting agreement submissions for review? What is the expected turnaround time for approval from DHH	Provider access requirements are outlined in the Policy and Procedure Guide. The final step in the CCN enrollment process is determination of network sufficiency. DHH will approve model contracts with network providers but not each individual contract. We will accept required submissions for CCN enrollment

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			effective the day after the official Model Provider Agreement and Policies & Procedures Guides are released. Desk reviews will begin upon receipt of submission or September 7th, whichever is later. Anticipated turnaround timelines are outlined in the Policy and Procedure Guide. However, these time lines are dependent on the timeliness and completeness of submissions, the need for follow up information during the desk review and on-site Readiness Review process, successful data exchange with the fiscal intermediary and enrollment broker, and demonstration of network adequacy,
7.22.2010	PROVIDER CONTRACTS	For CCN-S, there are no prompt pay requirements listed in the contract. What are they and where are they located; regulation, policy manual?	The CCN-S will not be responsible for claims payment; therefore, prompt pay is not applicable. DHH does expect the PCP care management fee to be paid to the PCP monthly.
7.22.2010	PROVIDER CONTRACTS	Section 5.1.42 states that contractors must submit all claims for payment no later than twelve (12) months from the date of service. Is the intent of this statement that we must allow no lesser than 12 months to submit or can we	The intent is to allow not less than 12 months to submit claims (same as Medicaid fee-for-service timely filing

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		use a shorter timeframe? If the intent is that we must allow, would DHH consider using a shorter timeframe or is this based on a state regulation that cannot be changed?	definitions) and will not be shortened.
7.22.2010	PROVIDER ISSUES	Are Coordinated Care Networks mandated to take all current Medicaid providers?	No, however the Department is asking that CCNs give consideration to every current Medicaid provider who requests to be in their provider network.
7.22.2010	PROVIDER ISSUES	Will CCNs have timely payment criteria for clean claims? If so, what is time?	Yes, this is required in both federal Medicaid regulations and state law and is the same as Louisiana Medicaid FFS. The CCN shall pay 90% of all clean claims within thirty (30) days of the date of receipt. The CCN shall pay 99% of all clean claims within ninety (90) days of the date of receipt. The date of receipt is the date the CCN receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. The CCN and its providers may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the

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			contract. "Clean claim" is defined in the ***Policy & Procedures Guide***
7.22.2010	PROVIDER ISSUES	We understand a CCN will be required to contract with Federally Qualified Health Centers. Certainly plans want to include FQHCs in their networks. ▪ Conversely, will FQHCs be required to contract if Medicaid-level reimbursement is offered? ▪ Is this the only other "any willing provider" provision?	The CCN shall make a good faith effort to execute a contract with Federally Qualified Health Centers (FQHC), and, where applicable, Rural Health Clinics (RHC). In the event an agreement cannot be reached and an entity does not participate in the CCN, the CCN shall maintain documentation detailing efforts which were made. If an agreement cannot be reached with a FQHC/RHC, the CCN is not required to reimburse the FQHC/RHC except in the following cases: • Unless the medically necessary services are required to treat an emergency medical condition; • If there are no CCNs in a service area that provide in-network access to FQHCs, then all CCNs within

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			the service area would be required to reimburse the PPS rate for medically necessary out-of-network services specified in the Provider Agreement; or • DHH has chosen to recognize FQHCs that are certified Office of Public Health school-based health clinics; therefore whether the FQHC/SBHC is within their network or not, the CCN shall reimburse the FQHC/SBHC the PPS rate, for all services provided in the "school setting". However, if the child had a separate visit to the FQHC/SBHC outside the "school setting", the CCN could deny payment as out-of-network.
7.22.2010	PROVIDER ISSUES	Can you confirm that the required reimbursement rate by a CCN to a non-participating provider will be the Medicaid rate?	The CCN-P shall reimburse the non-participating provider the current Medicaid fee-for-service rate.
7.22.2010	PROVIDER ISSUES	Is it mandatory that providers join a Coordinated Care Network?	Medicaid providers will not be mandated to become part of any particular Coordinated Care Network. However, we

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			would note at least 70 percent of Medicaid enrollees will be enrolled in a CCN (some mandatory, some voluntary).
7.22.2010	PROVIDER ISSUES	What does a current Medicaid provider need to do to prepare for Coordinated Care Implementation? Is there paper work or an application that can be completed?	Providers can begin discussions with prospective Coordinated Care Networks. Providers will enter into contracts (approved by DHH) with the CCNs and each will have their own application process. Providers may contract with multiple CCNs, just as they contract with multiple private insurance companies.
7.22.2010	PROVIDERS	What do I need to do to enroll my physician?	The names of Coordinated Care Networks who have submitted applications to DHH will be posted on the www.Making MedicaidBetter.com website as well as contact information for prospective providers.
7.22.2010	QUALITY	To ensure that all consumers are receiving high quality care, we recommend that the Department implement a comprehensive and transparent quality improvement process. Public reporting of plan performance, external reviews of plan performance, and consumer feedback should be the central features of this process. Under no circumstances should providers be given incentives to reduce or limit medically necessary care.	The Department intends to implement a comprehensive and transparent quality improvement process with public reporting of quality measures including consumer feedback on the CAHPS Survey. We will soon be issuing a Request for Proposals (RFP) to obtain the services of an External Quality Review Organization.

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			Provider Agreements prohibit CCN contracts with providers that include incentives for reducing or limiting medically necessary care.
7.22.2010	QUALITY	Will providers or networks be required to track the quality measures?	Yes. We feel compelled to improve the quality of the care we are paying for and tracking is important. "What gets measured gets done." The quality measures are primarily those that are determined from analysis of claims data but also CAHPS satisfaction surveys and chart reviews. We expect CCNs to share with providers their performance on quality measures. Distribution of shared savings is contingent on meeting the quality performance measure benchmarks.
7.22.2010	QUALITY	2.1 Would DHH please clarify the benchmarks and how they are established?	Initial quality performance measure baselines will be determined utilizing data from the most current measurement year for members specific to each network (based on their historic claims). The benchmarks will be determined by the Department and will be dependent on the baselines. We are looking for improvement and the percentage of improvement will depend on the baseline.

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7.22.2010	QUALITY	2.1.1.2 If any performance measure goals are associated with, or reliant upon, patient behaviors over which the PCP ultimately has no control, the PCP may not be able to meet those measures and thus be penalized despite his/her best efforts. Can DHH provide information on what those performance measures are?	Appropriate and timely patient outreach, education and follow-up are paramount to the improvement of quality outcomes. All clinical quality performance measures are dependent, in part, on patient behaviors. We recognize that improvement will be gradual and benchmarks will not be stated as absolutes. The benchmarks will be region specific. The proposed performance measures are available on the www.MakingMedicaidBetter.com website.
7.22.2010	REIMBURSEMENT	Prepaid Entity Reimbursement Rates: ▪ Will the complete data book used to determine prepaid rates be released along with the rates? ▪ For what period of time will this data be? ▪ What kind of protection of prepaid entities will be built into three-year agreements regarding maintaining rates?	Yes, the complete data book used to determine prepaid rates will be released along with the rates. The period of time is State Fiscal Years 08 and 09. Any legislative Medicaid rate changes will be applicable to prepaid CCN rates, as well as, in the FFS program and adjustments will be made accordingly.

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7.22.2010	REIMBURSEMENT	To build the robust network the state requires, health plans will need to pay some providers more than 100% of Medicaid. How is Mercer building this into the rates?	In applying the managed care savings adjustment, Mercer has separated the adjustment into two components, utilization and unit cost. Where it is anticipated the CCN entities will have to contract at greater than 100% of Medicaid, an adjustment greater than 1.00 was applied to the unit cost component of managed care savings.
7.22.2010	REIMBURSEMENT	If the program is not about saving money but is instead about quality, why not set rates equal to FFS costs for the first two years to allow the health plans the opportunity to provide services early on to raise the quality?	Both the CCN-S and CCN-P programs are intended to improve quality and reduce cost to the state through a better and more efficient delivery system. The development of the actuarially sound rate range takes into consideration savings observed from implementing Medicaid managed care in other states and the current fee-for-service rates.
7.22.2010	REIMBURSEMENT	What is the rationale for offering rates by region, but letting plans choose a portion of the region? It seems that this would encourage cherry-picking of parishes (like in Florida).	CCNs which include all parishes in a region in their service area will be preferred in the auto assignment of members who do not affirmatively select a CCN. The goal is to get better coordination of care for as many Medicaid and CHIP enrollees as possible, as quickly as possible, with the recognition that for some extremely

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			rural parishes, this may be more difficult. The rationale for region as one of the factors in determining rates is the wide variation in health status and health costs within the geographic regions of Louisiana.
7.22.2010	REIMBURSEMENT	When will rates for the CCN-P entities be available?	The scheduled date is August 16, 2010.
7.22.2010	REIMBURSEMENT	Are the care management services described in this section in addition to the monthly ($3.00) pm/pm paid to the PCP?	The $3 case management fee is included in the enhanced primary care case management fee paid to the CCN. We expect CCNs to provide PCPs with a minimum of $3 PMPM for PCP care management services.
7.22.2010	REIMBURSEMENT	Are incentive payments to come from the monthly Enhanced Primary Care Case Management Fees paid to the CCN?	The CCN may utilize the enhanced primary care case management fee or savings for incentive payments.
		What is to stop the providers that operate the CCN-Ss and also contract with CCN-Ps from counseling their sicker members or members who do not work on their health quality to move to the CCN-P?	If sicker members are directed to the CCN-P program, we would expect the risk-scores to reflect the appropriate level of risk born by the plan so that the plan is appropriately compensated. This action is also strictly prohibited by federal law. This violation can trigger denial of payment pursuant to section 1903 (m) (5) of the Social

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			Security Act due to discrimination among Medicaid enrollees with respect to enrollment, re-enrollment, or disenrollment on the basis of the Medicaid enrollees' health status or requirements for health care services and will be subject to sanctions.
7.22.2010	REPORTING REQUIREMENTS	Will DHH consider lowering this liquidated damage amount? $10,000 per calendar day per deliverable seems excessively high for these deliverables. Many states have liquidated damages in amounts of $500 or $750 per day per deliverable that are more proportionate to the failure to provide the deliverable.	The language reads "up to" $10,000 per day. It is our intent that the amount of liquidated damages will be progressive. Our thinking is that if the maximum liquidated damages are a maximum of $500 or $750 per day, it could be more advantageous to pay the liquidated damages than provide the deliverable.
7.22.2010	REPORTING REQUIREMENTS	One of the material changes a CCN is required to report for approval thirty days in advance by DHH is the "composition of the provider network or contractor network." The nature of provider contracting and negotiation is such that advance notice is not always possible. The draft agreement also states that "DHH shall make the final determination as to whether a change is material." ▪ Is DHH open to recommendations regarding the definition of "material change" to a provider network" and a reasonable standard for	DHH is open to suggestions for recommendations for wording that will help to achieve the goal of having advance knowledge of changes that might reasonably expected to impact access to and timeliness of care. Material change is defined in the Appendix A.

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		reporting such changes?	
7.22.2010	RISK ADJUSTMENT	Please provide a thorough description of how the risk adjustment process will work.	Please reference the CCN Health-Based Risk Adjustment Fact Sheet dated July 21, 2010, for further details. This document can be found in the document library at www.MakingMedicaidBetter.com.
7.22.2010	SERVICE AREA	Can a CCN have a shared-savings contract and a prepaid contract in the same region?	While it is possible that an entity can have both a shared-savings CCN and a prepaid CCN within a service area they will be considered as one entity for auto-assignment purposes (with auto-assignments evenly divided between their two models).
7.22.2010	SERVICE AREA	Would DHH please confirm that CCNs must serve parishes in their entirety (e.g., a CCN may not have a designated service area that includes one entire parish and part of another parish)?	That is correct.
7.22.2010	SHARED SAVINGS	Please describe as specifically as possible the methodology for DHH's determination of achievement of benchmarks and the calculation of shared savings.	The benchmark PMPM will be developed by trending historical FFS data forward to the effective period to estimate the FFS equivalent PMPM. Adjustments for IBNR, fee schedule changes, prescription rebates, etc. will be considered in the development of the benchmark PMPM. The benchmark PMPM will be risk adjusted

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			according to the risk profile of the members enrolled in the plan. The risk-adjusted benchmark PMPM will be compared to the actual cost PMPM plus the enhanced management fee. If the actual cost PMPM plus the enhanced management fee is less than the benchmark PMPM, savings is achieved and will be shared 60/40 with 60% of the savings going to the CCN-S entity. If the actual cost PMPM plus the enhanced care management fee is greater than the benchmark PMPM, there are no savings and the plan will have to return a portion of the enhanced care management fee. Additional details regarding the development of the benchmark PMPM will be provided at the rate-setting meeting to be scheduled. Please reference the CCN-S Financial Risk Sharing Fact Sheet dated July 21, 2010 for additional information at the www.MakingMedicaidBetter.com website.