Office of State Procurement
Contract Certification of Approval

This certificate serves as a confirmation that the Office of State Procurement has reviewed and approved the contract referenced below.

Reference Number: 2000950646

Vendor: MAGELLAN COMPLETE CARE OF LA INC

Description: Magellan Complete Care of Louisiana, INC

Approved By: PAMELA RICE

Approval Date: 09/17/2025 11:20:26

The above referenced number has been assigned by this office and will be used as identification for the approved contract. Please use this number when referring to the contract in any future correspondence or amendment(s).

The Internal Revenue Service (IRS) may find that this contract creates an employment relationship between your agency and the contractor. You should be advised that your agency is responsible for all taxes and penalties if such a finding is forthcoming. It is incumbent upon your agency to determine if an employee/employer relationship exists. Your agency must make the appropriate withholdings in accordance with law and IRS regulations, if applicable.

CONTRACT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

LaGov # 2000950646

OBH

Office of Behavioral Health Agency # 330

State Office

AND

Magellan Complete Care of Louisiana, Inc.

FOR

Personal Service ☐ Professional Service ☐ Consulting Services ☐ Social Services ✓ Governmental (State/Agency) ☐ Governmental (Local) ☐

RFP NUMBER (if applicable)

Emergency ✓ Sole Source ☐

1) **Contractor (Registered Legal Name)** Magellan Complete Care of Louisiana, Inc.

5) **Vendor Supplier #** 310234128 5a) **State LDR Account #(if applicable)** 757742001

2) **Street Address** 8550 United Plaza Blvd. Suite 704

6) **Parish(es) Served** (List all that apply) All parishes in LA

City Baton Rouge **State** LA **Zip Code** 70810

7) **License or Certification #** N/A

3) **Telephone Number** 225-367-3000

8) **Contractor Status**

Subrecipient:	☐ Yes	✓ No
Corporation:	✓ Yes	☐ No
For Profit:	✓ Yes	☐ No
Publicly Traded:	☐ Yes	✓ No

4) **Mailing Address (if different)** Same as above

City N/A **State** N/A **Zip Code** N/A

8a) **CFDA#(Federal Grant#)** N/A

9) **Brief Description Of Services To Be Provided:**

The Contractor will operate as a Prepaid Inpatient Health Plan (PIHP) healthcare delivery system, as defined in 42 CFR 438.2. The Contractor will be responsible for the coordination and management of specialized Medicaid behavioral health benefits and services included in the Louisiana Medicaid State Plan and the Centers for Medicare and Medicaid Services (CMS) approved waivers to Medicaid child and youth who meet the Coordinated System of Care (CSoC) eligibility criteria. The Contractor will manage behavioral health services throughout the State of Louisiana to individuals enrolled with multiple state agencies including Medicaid, Louisiana Department of Health - Office of Behavioral Health, Department of Children and Family Services, Office of Juvenile Justice, and the Department of Education.

10) **Effective Date** 08/01/2025

11) **Termination Date** 06/30/2026

12) **Maximum Contract Amount** $ 75,423,084.00

13) **Estimated Amounts by Fiscal Year** FY26: $75,423,084.00

14) **Terms of Payment**

If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows:

The Contractor will be paid a retrospective Per Member Per Month (PMPM) fee of $2,364.36 per Medicaid recipient (no duplication) enrolled in the CSoC program during the service month. Daily CSoC enrollment may not exceed 2,900 recipients (no duplication). At least annually commencing January 1, 2026, the PMPM rate shall be evaluated by a third party contractor, in order to ensure that the rate is, and remains, actuarially sound. LDH will pay Contractor by the second Tuesday of each month the Per Member Per Month (PMPM) fee of $2,364.36 per Medicaid recipient (no duplication) enrolled in the CSoC program during the previous service month. LDH will make final payment to the Contractor by the second Tuesday following sixty (60) days after termination of contract, and no invoice(s) shall be required of the Contractor.

Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

14a) **PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:**

First Name Robyn **Last Name** McDermott

Title Deputy Assistant Secretary, OBH **Phone Number** 225-342-1945

15) **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**

List all required Attachments

Attachment 1: Statement of Work
Attachment 2: Fee Schedule
Attachment 2a: CSoC Rate Certification
Attachment 3: Special Provisions
Attachment 4: Standard Provisions Attachment
5: Addendum to CF-1

List all required Exhibits

Exhibit A: Board Resolution
Exhibit B: Job Descriptions
Exhibit C: Licenses
Exhibit D: Disclosure of Ownership

Types of Attachments and Exhibits

ATTACHMENTS

- Statement of work
- Fee Schedule/Budget
- Special Provisions
- Standard Provisions
- Diversity and Inclusion Statement

EXHIBITS

- Board Resolution/Signature Authority
- Resume
- License

During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. **Discrimination Clause:** Contractor hereby agrees to abide by the requirements of the following, as applicable: Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. §18116); Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d, et seq.); Title VII of the Civil Rights Act of 1964 (42 U.S.C. §2000e, et seq.); Title IX of the Education Amendments of 1972 (20 U.S.C. §1681, et seq.); the Age Discrimination Act of 1975 (42 U.S.C. §6101, et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. §794d); the Americans with Disabilities Act of 1990 (42 U.S.C. §12101, et seq.); the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. §4212); the Fair Housing Act of 1968 (42 U.S.C. §3601, et seq.); and Federal Executive Order 11246; and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services.

   Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, sexual orientation, age, national origin, disability, political affiliation, veteran status, or any other non-merit factor. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable, shall be grounds for termination of this Contract.

2. **Confidentiality:** Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and patient/client confidentiality. Information obtained under this Contract shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. **Right to Audit:** The Louisiana Legislative Auditor, Office of the Governor, Division of Administration, and Department auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this Contract during the Contract and for a period of five (5) years following final payment. Contractor grants to the State of Louisiana, through the Office of the Louisiana Legislative Auditor, Louisiana Department of Health, and State Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or Department policy requiring an audit of Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the term of this contract, for any period, four (4) copies of the audit report shall be sent to the Louisiana Department of Health, Attention: Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797 and one (1) copy of the audit shall be sent to the originating office within the Department.

4. **Record Retention:** Contractor agrees to retain all books, records, and other documents relevant to the Contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 75.361, whichever is longer.

   Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit, or copy records at Contractor's site, without expense to the Department.

5. **Record Ownership:** All records, reports, documents, and other material delivered or transmitted to Contractor by the Department shall remain the property of the Department, and shall be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract. All records, reports, documents, or other material related to this Contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of the Department, and shall, upon request, be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract.

6. **Nonassignability:** Contractor shall not assign any interest in this Contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this Contract may be assigned to a bank, trust company, or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of State Procurement.

7. **Taxes:** Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this Contract shall be Contractor's. Contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.

8. **Insurance:** Contractor shall obtain and maintain during the term of this Contract all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect Contractor, the Louisiana Department of Health, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the Contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

9. **Travel:** In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The Contract contains a maximum compensation that shall be inclusive of all charges including fees and travel expenses.

10. **Political Activities:** No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the Legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

11. **State Employment:** Should Contractor become an employee of the classified or unclassified service of the State of Louisiana during the term of the contract, Contractor must notify his/her appointing authority of any existing Contract with the State of Louisiana and notify the contracting office with the Department of any additional State employment. This is applicable only to contracts with individuals.

12. **Ownership of Proprietary Data:** All non-third party software and source code, records, reports, documents, and other material delivered or transmitted to Contractor by the State shall remain the property of the State, and shall be returned by Contractor to the State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this Contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of the State, and shall be returned by Contractor to the State, at Contractor's expense, at termination or expiration of this contract.

13. **Subcontracting:** Contractor shall not enter into any subcontract for work or services contemplated under this Contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by Contractor of items and services that are incidental but necessary for the performance of the work required under this contract.

    No subcontract shall relieve Contractor of the responsibility for the performance of contractual obligations described herein.

14. **Conflict of Interest:** Contractor acknowledges that the Code of Governmental Ethics, La. R.S. 42:1101, et seq., applies to Contractor in the performance of services under this contract. Contractor warrants that no person and no entity providing services pursuant to this Contract on behalf of Contractor or any subcontractor is prohibited from providing such services by the provisions of La. R.S. 42:1113. Contractor agrees to immediately notify the Department if potential violations of the Code of Governmental Ethics arise at any time during the term of the contract.

15. **Unauthorized Services:** No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs that have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to offset and withhold said amounts from any amount due to Contractor under this Contract for costs that are allowable.

16. **Fiscal Funding:** This Contract is subject to and conditioned upon the availability and appropriation of federal and/or state funds; and no liability or obligation for payment will develop between the parties until the Contract has been approved by required authorities of the Department; and, if Contract exceeds $2,000, the Division of Administration, Office of State Procurement.

    The continuation of this Contract is contingent upon the appropriation of funds from the Legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

17. **State and Federal Funding Requirements:** Contractor shall comply with all applicable requirements of state or federal laws or regulations relating to Contractor's receipt of state or federal funds under this contract.

    If Contractor is a “subrecipient” of federal funds under this contract, as defined in 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), Contractor shall comply with all applicable requirements of 2 CFR Part 200, including but not limited to the following:

    - Contractor must disclose any potential conflict of interest to the Department and the federal awarding agency as required by 2 CFR §200.112.
    - Contractor must disclose to the Department and the federal awarding agency, timely and in writing, all violations of federal criminal laws that may affect the federal award, as required by 2 CFR §200.113.
    - Contractor must safeguard protected personally identifiable information and other sensitive information, as required by 2 CFR §200.303.
    - Contractor must have and follow written procurement standards and procedures in compliance with federally approved methods of procurement, as required by 2 CFR §§200.317 - 200.326.
    - Contractor must comply with the audit requirements set forth in 2 CFR §§200.501 - 200.521, as applicable, including but not limited to:
        - Electronic submission of data and reports to the Federal Audit Clearinghouse (FAC) (2 CFR §200.512(d)).
        - Ensuring that reports do not include protected personally identifiable information (2 CFR §200.512(a)(2)).

    Notwithstanding the provisions of paragraph 3 (Auditors) of these Terms and Conditions, copies of audit reports for audits conducted pursuant to 2 CFR Part 200 shall not be required to be sent to the Department.

18. **Amendments:** Any alteration, variation, modification, or waiver of provisions of this Contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if the Contract exceeds $5,000, by the Division of Administration, Office of State Procurement. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

19. **Non-Infringement:** Contractor will warrant all materials, products, and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against the Department, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in the Department's name, but at Contractor's expense and shall indemnify and hold the Department harmless against any loss, expense, or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists, or other allied health providers solely for medical services.

20. **Purchased Equipment:** Any equipment purchased under this Contract remains the property of Contractor for the period this Contract and future continuing contracts for the provision of the same services. Contractor must submit a vendor invoice with the reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of one thousand dollars ($1,000.00) or more. Contractor has the responsibility to submit to the Contract Monitor an inventory list of equipment items when acquired under the Contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of the contracted services, the equipment purchased under this Contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within thirty (30) days of termination of services.

21. **Indemnity:** Contractor agrees to protect, indemnify, and hold harmless the State of Louisiana and the Department from all claims for damages, costs, expenses, and attorney fees arising in Contract or tort from this Contract or from any acts or omissions of Contractor's agents, subcontractors, employees, officers, or clients, including, but not limited to, premises liability and any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which La. R.S. 40:1237.1, *et seq*. provides malpractice coverage to Contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (La. R.S. 13:5108.1(E)). Further, it does not apply to premises liability when the services are being performed on premises owned and operated by the Department.

22. **Severability**: Any provision of this Contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in state or federal law, or applicable state or federal regulations.

23. **Entire Agreement**: Contractor agrees that the current Contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of this contract.

24. **E-Verify**: Contractor acknowledges and agrees to comply with the provision of La. R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under this contract.

25. **Remedies for Default**: Any claim or controversy arising out of this Contract shall be resolved by the provisions of La. R.S. 39:1672.2-1672.4.
    Other Remedies: If the Contractor fails to perform in accordance with the terms and conditions of this Contract, or if any lien or claim for damages, penalties, cost and the like is asserted by or against the State, then, upon notice to the Contractor, the State may pursue all remedies available to it at law or equity, including retaining monies from amounts due the Contractor and proceeding against any surety of the Contractor.

26. **Governing Law**: This Contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana, including but not limited to La. R.S. 39:1551-1736; rules and regulations; executive orders; standard terms and conditions, and specifications listed in the Request for Proposals (RFP), if applicable; and this contract.

27. **Contractor's Cooperation**: Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the State, when requested. This applies even if this Contract is terminated and/or a lawsuit is filed. Specifically, Contractor shall not limit or impede the State's right to audit or shall not withhold State-owned documents.

28. **Continuing Obligation**: Contractor has a continuing obligation to disclose to the Department any suspension or debarment by any government entity, including, but not limited to, the General Services Administration (GSA). Failure to disclose may constitute grounds for suspension and/or termination of the Contract and debarment from future contracts.

29. **Eligibility Status**: Contractor and each tier of subcontractors, shall certify that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving Federal funds or grants from the Federal Government. Contractor and each tier of subcontractors shall certify that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with Executive Orders 12549 and 12689, and "NonProcurement Debarment and Suspension" set forth at 2 CFR Part 376.

30. **Act 211 Taxes Clause**: In accordance with La. R.S. 39:1624(A)(10), the Louisiana Department of Revenue must determine that Contractor is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the Louisiana Department of Revenue prior to the approval of this Contract by the Office of State Procurement. Contractor hereby attests to its current and/or prospective compliance, and agrees to provide its seven-digit LDR Account Number to the Department so that Contractor's tax payment compliance status may be verified. Contractor further acknowledges understanding that issuance of a tax clearance certificate by the Louisiana Department of Revenue is a necessary precondition to the approval and effectiveness of this Contract by the Office of State Procurement. The Department reserves the right to withdraw its consent to this Contract without penalty and proceed with alternate arrangements should Contractor fail to resolve any identified apparent outstanding tax compliance discrepancies with the Louisiana Department of Revenue within seven (7) business days of such notification.

31. **Termination for Cause:** The Department may terminate this Contract for cause based upon the failure of Contractor to comply with the terms and/or conditions of the contract; provided that the Department shall give Contractor written notice specifying Contractor's failure. If within thirty (30) days after receipt of such notice, Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the Department may, at its option, place Contractor in default and the Contract shall terminate on the date specified in such notice. Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the Department to comply with the terms and conditions of this contract; provided that Contractor shall give the Department written notice specifying the Department's failure and a reasonable opportunity for the State to cure the defect.

32. **Termination for Convenience**: The Department may terminate this Contract at any time by giving thirty (30) days written notice to Contractor. Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

33. **Confidentiality:** Contractor shall protect from unauthorized use and disclosure all information relating to the State's operations and data (e.g. financial, statistical, personal, technical, etc.) that becomes available to the Contractor in carrying out this Contract. Contractor shall use protecting measures that are the same or more effective than those used by the State. Contractor is not required to protect information or data that is publicly available outside the scope of this Contract; already rightfully in the Contractor's possession; independently developed by the Contractor outside the scope of this Contract; or rightfully obtained from third parties. Under no circumstance shall the Contractor discuss and/or release information to the media concerning this project without prior express written approval of the State.

34. **Prohibition of Discriminatory Boycotts of Israel:** In accordance with La. R.S. 39:1602.1, any Contract for $100,000 or more and for any contractor with five (5) or more employees, Contractor, and any subcontractor, shall certify it is not engaging in a boycott of Israel, and shall, for the duration of this Contract, refrain from a boycott of Israel. The State reserves the right to terminate this Contract if Contractor, or any subcontractor, engages in a boycott of Israel during the term of the contract.

35. **Cybersecurity Training:** In accordance with La. R.S. 42: 1267 (B)(3) and the State of Louisiana's Information Security Policy, if the Contractor, any of its employees, agents, or subcontractors will have access to State government information technology assets, the Contractor's employees, agents, or subcontractors with such access must complete cybersecurity training annually, and the Contractor must present evidence of such compliance annually and upon request. The Contractor may use the cybersecurity training course offered by the Louisiana Department of State Civil Service without additional cost.

    For purposes of this Section, "access to State government information technology assets" means the possession of credentials, equipment, or authorization to access the internal workings of State information technology systems or networks. Examples would include but not be limited to State-issued laptops, VPN credentials to credentials to access the State network, badging to access the State's telecommunications closets or systems, or permissions to maintain or modify IT systems used by the State. Final determination of scope inclusions or exclusions relative to access to State government information technology assets will be made by the Office of Technology Services.

36. **Code of Ethics:** The Contractor acknowledges that Chapter 15 of Title 42 of the Louisiana Revised Statutes (R.S. 42:1101 et. seq., Code of Governmental Ethics) applies to the Contracting Party in the performance of services called for in this Contract. The Contractor agrees to immediately notify the state if potential violations of the Code of Governmental Ethics arise at any time during the term of this Contract.

37. **Countersignature**: This Contract may be executed in two or more counterparts, each of which shall be deemed an original, but all of which, taken together, shall constitute one and the same instrument.

38. **No Employment Relationship**: Nothing in this Contract shall be construed to create an employment or agency relationship, partnership, or joint venture between the employees, agents, or subcontractors of Contractor and the State of Louisiana.

39. **Venue**: Venue for any action brought with regard to this Contract shall be in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana.

40. **Commissioner's Statements**: Statements, acts, and omissions made by or on behalf of the Commissioner of Administration regarding the RFP or RFP process, this contract, Contractor, and/or any subcontractor of Contractor shall not be deemed a conflict of interest when the Commissioner is discharging his duties and responsibilities under law, including, but not limited, to the Commissioner of Administration's authority in procurement matters.

41. **Order of Precedence Clause**: In the event of any inconsistent or incompatible provisions in a Contract which resulted from an RFP, this signed Contract (excluding the RFP and Contractor's proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of Contractor's proposal. *This Order of Precedence Clause applies only to contracts that resulted from an RFP.*

42. **Contractor must comply with the Office of Technology Services (OTS) Information Security Policy,** https://www.doa.la.gov/Pages/ots/InformationSecurity.aspx.

    a. Contractor must report to the State any known breach of security no later than forty-eight (48) hours after confirmation of the event. Notify the Information Security Team (“IST”) by calling the Information Security Hotline at 1-844-692-8019 and emailing the security team at infosecteam@la.gov.

    b. Contractor must follow OTS Information Security Policy for Data Sanitization requirements for any equipment replaced during the Contract and at the end of the contract, for all equipment which house confidential/restricted data provided by the State.

    c. Contractor must ensure appropriate protections of data is in accordance with HIPAA Rules and HITECH Acts.

    d. If Contractor will have access to data originating from the Centers for Medicare and Medicaid Services (CMS), then Contractor must ensure their computer system is in compliance with CMS latest version of the Minimum Acceptable Risk Standards for Exchanges (MARS-E) Document Suite, currently MARS-E 2.0. The CMS MARS-E 2.0 requirements include but are not limited to the below listed requirements:

        - Multi-factor authentication is a CMS requirement for all remote users, privileged accounts and non-privileged accounts. In this context, a “remote user” is referencing staff accessing the network from offsite, normally with a client virtual private network with the ability to access CMS data.

        - Perform criminal history check for all staff prior to granting access to CMS data. All employees and contractors requiring access to Patient Protection and Affordable Care Act (PL 111-148) sensitive information must meet personnel suitability standards. These suitability standards are based on a valid need-to-know, which cannot be assumed from position or title, and favorable results from a background check. The background checks for prospective and existing employees (if not previously completed) should include, at a minimum, contacting references provided by the employee as well as the local law enforcement agency or agencies.

43. **HIPAA Business Associate Provisions**

    If Contractor is a Business Associate of the Department, as that term is defined herein, because Contractor either: (a) creates, receives, maintains, or transmits protected health information (PHI) for or on behalf of the Department; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for the Department involving the disclosure of PHI, the following provisions will apply:

    a. Definitions: As used in these provisions -

        i. The term “HIPAA Rules” refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 CFR Parts 160 and 164, which were originally promulgated by the U. S. Department of Health and Human Services (DHHS) pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”) of 1996 and were subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health (“HITECH”) Act of the American Recovery and Reinvestment Act of 2009.

        ii. The terms “Business Associate”, “Covered Entity”, “disclosure”, “electronic protected health information” (“electronic PHI”), “health care provider”, “health information”, “health plan”, “protected health information” (“PHI”), “subcontractor”, and “use” have the same meaning as set forth in 45 CFR §160.103.

        iii. The term “security incident” has the same meaning as set forth in 45 CFR §164.304.

        iv. The terms “breach” and “unsecured protected health information” (“unsecured PHI”) have the same meaning as set forth in 45 CFR §164.402.

    b. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this Contract as required by the HIPAA Rules and by this Contract.

    c. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule, regulation (including the HIPAA Rules), or as otherwise required or permitted by this Contract.

    d. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this Contract, including administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Department.

    e. In accordance with 45 CFR §164.502(e)(1)(ii) and (if applicable) §164.308(b)(2), Contractor shall ensure that any agents, employees, subcontractors, or others that create, receive, maintain, or transmit PHI on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information, and it shall

ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees', or subcontractors' actions or omissions do not cause Contractor to violate this Contract.

f. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this Contract, report such disclosure in writing to the person(s) named in Terms of Payment on page 1 of this document. Disclosures which must be reported by Contractor include, but are not limited to, any security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La. R.S. 51:3071 *et seq*. At the option of the Department, any harm or damage resulting from any use or disclosure which violates this Contract shall be mitigated, to the extent practicable, either: (a) by Contractor at its own expense; or (b) by the Department, in which case Contractor shall reimburse the Department for all expenses that the Department is required to incur in undertaking such mitigation activities.

g. To the extent that Contractor is to carry out one or more of the Department's obligations under 45 CFR Part 164, Subpart E, Contractor shall comply with the requirements of Subpart E that apply to the Department in the performance of such obligation(s).

h. Contractor shall make available such information in its possession which is required for the Department to provide an accounting of disclosures in accordance with 45 CFR §164.528. In the event that a request for accounting is made directly to Contractor, Contractor shall forward such request to the Department within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR §164.528 for at least six (6) years after the date of the last such disclosure.

i. Contractor shall make PHI available to the Department upon request in accordance with 45 CFR §164.524.

j. Contractor shall make PHI available to the Department upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR §164.526.

k. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by Contractor on behalf of the Department available to the Secretary of the DHHS for purposes of determining the Department's compliance with the HIPAA Rules.

l. Contractor shall indemnify and hold the Department harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this provision by Contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.

m. The parties agree that the legal relationship between the Department and Contractor is strictly an independent contractor relationship. Nothing in this Contract shall be deemed to create a joint venture, agency, partnership, or employer- employee relationship between the Department and Contractor.

n. Notwithstanding any other provision of the contract, the Department shall have the right to terminate the Contract immediately if the Department determines that Contractor has violated any provision of the HIPAA Rules or any material term of this contract.

o. At the termination of the contract, or upon request of the Department, whichever occurs first, Contractor shall return or destroy (at the option of the Department) all PHI received or created by Contractor that Contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, Contractor shall extend the confidentiality protections of the Contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.

SIGNATURES TO FOLLOW ON THE NEXT PAGE

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

CONTRACTOR	STATE OF LOUISIANA, LOUISIANA DEPARTMENT OF HEALTH
Signed by: Derrick Duke 0C5C9BCD93C0442...	Signed by: Bruce D. Greenstein 3BC9323F50424C5...
SIGNATURE	SIGNATURE
7/31/2025	8/1/2025
DATE	DATE
Derrick Duke	Bruce Greenstein
NAME	NAME
President	Secretary, Louisiana Department of Health or Designee
TITLE	TITLE
Office of Behavioral Health	Office of Behavioral Health
DocuSigned by: Robyn McDermott D027A9C8D900473...	Signed by: Karen Stubbs Church, J.D. 1D1D910B7F444B8...
SIGNATURE	SIGNATURE
7/25/2025	7/31/2025
DATE	DATE
Robyn McDermott	Karen Stubbs Church, J.D.
NAME	NAME
Deputy Assistant Secretary	OBH Assistant Secretary
TITLE	TITLE

Statement of Work

I. OVERVIEW

A. The Contractor will operate as a Prepaid Inpatient Health Plan (PIHP) healthcare delivery system responsible for coordination and management of specialized Medicaid behavioral health benefits and services included in the Louisiana Medicaid State Plan and the Centers for Medicare and Medicaid Services (CMS) approved waivers to Medicaid children and youth who meet the Coordinated System of Care (CSoC) eligibility criteria.

B. The Contractor shall operate as a PIHP, as defined in 42 CFR §438.2, to provide management of the following criteria and functions, including but not limited to:

1. Twenty-four (24) hour, seven (7) days a week toll-free telephone access line for providers and members;
2. Member services;
3. Care management (CM);
4. Utilization management (UM);
5. Quality management (QM);
6. Grievances and appeals;
7. Provider network management, including provider training;
8. Member protections, rights and responsibilities;
9. Reporting and monitoring;
10. Implementation planning;
11. Administrative organization;
12. Primary care coordination;
13. Transition planning;
14. Fraud and abuse monitoring and compliance; and
15. Technical requirements.

C. The Contractor is responsible for coordination and cooperation with LDH in the implementation of any court-mandated initiatives related to the CSoC population.

II. GOALS AND OBJECTIVES

A. The Office of Behavioral Health desires to obtain a contractor for the administration and management of specialized behavioral health for children and youth, currently ages five (5) through twenty (20), referred to or enrolled in the CSoC Program and achieve the following objectives:

1. Maintain the CSoC for children/youth and their families/caregivers, utilizing a family and youth-driven practice model, providing wraparound facilitation by child and family teams that also utilize family and youth supports, and overall management of these services by the Contractor.
2. Continue to advance system of care values and principles.
3. Reduce the rate of avoidable hospital stays and readmissions.
4. Improve access, quality, and efficiency of specialized behavioral health services for children and youth through management of these services.
5. Coordinate specialized behavioral health services, which the Contractor is responsible for with the Integrated Medicaid Managed Care Program Contractor responsible for the member's health care services not covered by the Contractor.
6. Implement best, evidence-based and informed practices that are effective and efficient as supported by the data from measuring outcomes, quality, and accountability.
7. Increase patient quality of care: outcomes, access, and member experience of care.
8. Increase member and family personal responsibility and self-management.
9. Decrease fraud, abuse, and wasteful spending.

III. BACKGROUND

Louisiana's Coordinated System of Care or CSoC is the state's effort to bring the System of Care philosophy and approach to Louisiana. CSoC is guided by an overarching System of Care (SOC) philosophy and values which include: family driven, youth guided, home and community based, strengths based, individualized, culturally and linguistically

competent, integration across systems, connection to natural supports, data driven and outcomes oriented and unconditional care.

IV. DELIVERABLES

A. Reporting

1. General Requirements

a. The Contractor shall comply with all the reporting requirements established by the contract and in accordance with any LDH issued companion and reporting guide(s). As per 42 CFR §438.242(a)(b)(1)-(3), the Contractor shall maintain a management information system (MIS) that collects, analyzes, integrates and reports data that complies with LDH and Federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The Contractor shall collect data on member and provider characteristics and on services furnished to members.

b. The Contractor shall create deliverables which may include documents, manuals, files, plans, and reports using the electronic formats, instructions, and timeframes as specified by LDH and at no cost to LDH. Any changes to the formats must be approved by LDH prior to implementation.

c. In the event that there are no instances or data to report, the Contractor shall submit a report in the required template so stating.

d. Data submitted by the Contractor including, but not limited to, all documents specified by LDH, reports, encounter and claims data and other information required as a deliverable in the contract, shall be certified.

e. As required by 42 CFR §438.604(a) and (b), and 42 CFR §438.606, the Contractor shall certify all submitted data, documents and reports. All data reported must be certified to include, but not limited to, financial reports, encounter data, and other information as specified within the contract. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The Contractor must submit the certification concurrently with the certified data and documents. LDH may identify data that does not require certification.

f. The data shall be certified by one of the following:

a. The Contractor's Chief Executive Officer (CEO);

b. The Contractor's Chief Financial Officer (CFO); or behavioral health for children and youth

c. An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

g. The Contractor shall provide the necessary data extracts to LDH or its designee as required by this contract or specified in *the PIHP CSoC Systems Companion Guide.*

h. All contract required implementation deliverable deadlines associated with contract go-live are subject to change as reasonably agreed upon between LDH and Contractor subsequent to contract approval.

i. Failure to submit deliverables (including ad hoc reports) on or before the due date and in the correct format may result in remediation as per the *Remediation* section of this contract. If a due date falls on a weekend or State-recognized holiday, deliverables will be due the next business day.

j. The Contractor shall submit deliverables as specified in this

contract. LDH shall have the right to approve, disapprove or require modification of these documents.

k. LDH reserves the right to request follow-up to any deliverable. Follow-up may include, but not be limited to, providing additional information, on-site monitoring by LDH or its designated entity, tracking of issues identified in the deliverable, request for corrective action plan (CAP) and LDH monitoring of CAP, or requiring changes to the deliverable.

l. LDH reserves the right, at its discretion, to discontinue any report or deliverable outlined in this contract.

m. LDH requirements regarding reports, report content, and frequency of submission of reports are subject to change at any time during the term of the contract. The Contractor shall comply with all changes specific by LDH.

n. The Contractor may be responsible for continued reporting beyond the term of the contract.

o. Software Reporting Requirements:

a. All reports submitted to LDH by the Contractor must be in a format accessible and modifiable by the standard Microsoft Office Suite of products, Version 2007 or later, or in a format accepted and approved by LDH; and

b. The system shall make reports available in Microsoft Excel 2007 or later as requested by LDH when appropriate to report in Excel format.

2. Ownership Disclosure

a. Federal laws require full disclosure of ownership, management, and control of Medicaid managed care entities (42 CFR §§455.100-455.106.) The Medicaid Ownership and Disclosure Form is to be submitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the Contractor's management, ownership or control occurs.

3. Other Reporting Requirements in this Contract

a. Reporting requirements are outlined throughout this contract including but not limited to staff reporting, network reporting, financial reporting and Program Integrity reporting.

4. Transparency Report

a. The Contractor shall designate a single staff member to serve as the single point of contact for all Transparency Report requests.

b. The Contractor shall comply with all timelines, data requests and independent surveys from LDH or its designee.

c. For purposes of Contractor reporting on payment to providers, an adjustment to a paid claim shall not be counted as a claim and electronic claims shall be treated as identical to paper based claims.

5. Encounter Data

a. The Contractor shall comply with the required format provided by LDH. Encounter data includes claims paid or denied by the Contractor or the Contractor's subcontractors for services delivered to enrollees through the Contractor during a specified reporting period. LDH collects and uses this data for many reasons such as: Federal reporting, rate setting, service verification, managed care quality improvement program, utilization patterns and access to care, LDH hospital rate setting and research studies.

b. LDH may change the Encounter Data Transaction requirements included in the *PIHP CSoC Systems Companion Guide*, with ninety

(90) calendar days' written notice to the Contractor. The Contractor shall, upon notice from LDH, provide notice of changes to subcontractors.

6. Financial Reporting

a. The Contractor shall develop and submit to LDH for approval within thirty (30) days of DOA/OSP approval of the signed contract a procedure relative to recovery of overpayments to providers upon reaching a certain threshold. The procedure shall require that the Contractor immediately report to LDH on all overpayments upon reaching the approved threshold and provisions for notifying the affected provider(s). The Contractor shall track all provider notifications resulting from overpayment, amounts of overpayment, and any other related data.

b. The Contractor shall implement processes for verifying the accuracy and timeliness of reported data, screen the data for completeness, logic, and consistency, and collect service information in standardized industry formats. The Contractor shall submit timely, accurate, and complete data or shall be subject to remediation as reflected in the *Remediation* section.

c. The Contractor shall develop an accounting and financial reporting system sufficient to support state and Federal reporting requirements, including but not limited to reporting requirements for 1915(b) and 1915(c) waivers.

d. The Contractor shall not make subsequent payment adjustments within its data warehouse on previously reported dates of payment.

e. The Contractor shall report the managed care days and payments to hospitals in order to comply with Section 1932(g) of the Social Security Act, "Identification of Patients for Purposes of Making DSH Payments", and 42 CFR §445.299 reporting requirements. The Contractor shall ensure this reporting meets the needs of the State (all inpatient and outpatient encounters must include ancillary charges and the appropriate revenue codes).

f. The Contractor shall submit to LDH unaudited quarterly program financial statements, an annual audit following the requirements of 2 CFR Part 200, The Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements, Subpart F Audit Requirements, applied to Louisiana funding and 42 CFR §438.3(m), and annual program financial statements, using the required format provided by LDH via the Financial Reporting Template. The financial statements shall be specific to the operations of the Contractor rather than to a parent or umbrella organization. Audited annual statements of a parent organization, if publicly available, shall also be submitted.

g. The quarterly unaudited financial statements must be submitted no later than sixty (60) days after the end of each calendar quarter, and shall include, but not be limited to, the following:

a. Balance Sheet;

b. Income Statement;

c. Statement of retained earnings; and

d. Annual Disclosure.

e. Additional financial and utilization data in a format prescribed and provided by LDH sixty (60) days prior to contract go-live. This data shall include, but not be limited to, detailed administrative and service costs broken out by eligibility group, profitability reporting, incurred but not reported (IBNR) reporting, lag schedules, utilization reporting inclusive of average lengths of stay and costs per person to be utilized to evaluate and monitor the

performance and operations of the Contractor.

h. The Audit Report and annual program financial statement shall be submitted within thirty (30) days after the completion of the audit, but no later than six (6) months after the close of the Contractor's fiscal year. One (1) copy of the audit shall be sent to the Louisiana Department of Health, Attention: Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030, and one (1) copy of the audit shall be sent to the LDH Contract Monitor.

i. All financial reporting shall be based on Generally Accepted Accounting Principles (GAAP) and auditing standards.

j. The Contractor shall calculate and report a MLR in accordance with 42 CFR §438.8.

7. Report Errors

a. The Contractor agrees to prepare complete and accurate reports for submission to LDH. If after preparation and submission, a Contractor error is discovered either by the Contractor or LDH, the Contractor shall correct the error(s) and resubmit accurate reports for encounters and all other reports (including ad hoc) within seven (7) calendar days from the date of discovery by the Contractor or date of written notification of the error by LDH (whichever is earlier).

8. Submission Timeframes

a. The Contractor shall ensure that all required deliverables, including documents, manuals, files, plans, and reports, as stated in this contract, are submitted to LDH for review and approval in accordance with the time frames required by this contract or by the associated Federal authorities, unless changed by mutual agreement of the parties. The Contractor's failure to submit the deliverables as specified may result in the assessment of penalties as stated in this contract.

b. Appropriate reporting timeframes for quarterly and annual reports will be established by LDH or in accordance with the Federal authorities associated with the contract.

c. LDH may, at its discretion, require the Contractor to submit additional deliverables, both ad hoc and recurring, beyond the deliverables outlined in this contract. If LDH requests any revisions to the deliverables already submitted, the Contractor shall make the changes and re-submit the deliverables, according to the time period and format required by LDH.

d. Extension deadline requests for deliverables may be honored on a rare, non- routine basis only with advance notice. No request will be approved after the due date, absent extenuating circumstances. The required advance notice period is a minimum of three (3) business days; however, situational circumstance extension deadline requests will be considered until noon on the due date. All such deadline extension requests must be submitted in writing via electronic mail and include the reason for the request, the anticipated delivery date, and be submitted to LDH before noon on the due date.

e. In the event that a deliverable is not included in the contract but required by the Federal authorities associated with the contract, the Contractor is not exempt from the deliverable requirement.

9. Ad Hoc Reports

a. The Contractor shall prepare and submit any other reports as required and requested by LDH, any of LDH's designees, the Legislature, or CMS, that are related to the Contractor's duties and obligations under the contract. Information considered to be of a proprietary nature shall be clearly identified as such by the Contractor at the time of submission.

b. Ad Hoc reports shall be submitted within five (5) business days from the date of request, unless otherwise approved by LDH.

10. Court-Ordered Reporting

a. The Contractor shall comply with all court-ordered reporting requirements as they exist now and in the future including but not limited to the Wells v. Gee and Chisholm v. Gee cases in the manner specified by LDH. Wells v. Gee information is available at https://ldh.la.gov/page/legal-compliance-monitoring.

V. DETAILED REQUIREMENTS

A. Technical Requirements

1. General Requirements

a. The Contractor shall maintain an automated Management Information System (MIS) which shall support 1) the functions of all programs and services provided through the CSoC and 2) LDH as the managing agency of the contract. The MIS support function shall include, but not be limited to, management of care for CSoC members, data exchange with the WAAs, the ability to store and analyze claims, encounter, and eligibility information, requirements stated in 42 CFR §438.242 and the ability to meet the reporting requirements of the contract.

b. In addition, the Contractor's systems shall support the following:

a. Member services for CSoC members (including, but not limited to using Medicaid ID for data associated with CSoC eligibility, Level of Care changes, presumptive eligibility, members aging out of Medicaid, Medicaid Expansion coverage, .217 eligibility, incarceration or detention, and per member per month reconciliation);

b. WAA data collection;

c. Care management for CSoC members;

d. Grievances and appeals;

e. Provider network management;

f. Financial reporting claims payment for capitated services; g. Encounter tracking and submissions for capitated services; h. Business continuity, disaster recovery and emergency preparedness;

i. Performance measurement and accountability; and

j. A secure online web-based portal that allows providers to submit and receive responses to PA for services.

c. The MIS shall accept and process provider claims, verify eligibility, collect and report encounter data and validate prior authorization and pre-certification in compliance with LDH and applicable Federal reporting requirements. The Contractor shall ensure that its system meets the requirements of the Contract, all applicable state-issued guides including, but not limited to, the *PIHP CSoC Systems Companion Guide*, and all applicable state and Federal laws, rules and regulations, including all applicable confidentiality and privacy laws.

d. The Contractor's system shall have, and maintain, capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the contract requirements.

e. The Contractor's application systems foundation shall employ a

relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. The Contractor's application system shall support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) or Object Linking and Embedding (OLE), are desirable.

f. The Contractor shall comply with the CMS Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issues of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers (referred to as the "CMS Interoperability and Patient Access final rule") in accordance with timelines established by CMS and as directed by LDH or OBH through the MCE Interoperability Compliance Plan.

g. All the Contractor's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with LDH's systems and shall conform to applicable standards and specifications set by LDH.

h. The Contractor shall minimize any necessary modifications to LDH's current computer system(s) in order to establish and process the interface(s). All interfaces must be fully tested by the Contractor.

i. The Contractor interface connections with the State must be established, monitored, and maintained in compliance with the State's Information Security Policy located at: http://www.doa.la.gov/pages/ots/informationsecurity.aspx.

j. The Contractor shall adhere to state and Federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of the contract.

k. The Contractor shall clearly identify toLDH, prior to implementation and use of systems, any systems or portions of systems outlined in the proposal which are considered to be proprietary in nature.

l. Any confidential information must be encrypted to the Federal Information Processing Standard (FIPS) 140-2 when at rest or in transit.

m. The Contractor's systems shall utilize mailing address standards in accordance with the United States Postal Service.

n. All information, whether data or documentation and reports that contain or references to that information involving or arising out of the contract is owned by LDH. The Contractor is expressly prohibited from sharing or publishing LDH's information and reports without the prior written consent of LDH. In the event of a dispute regarding the sharing or publishing of information and reports, LDH's decision on this matter shall be final.

o. Contractor systems shall conform and adhere to the data and document management standards of LDH and the Medicaid FI, inclusive of standard transaction code sets.

p. Contractor owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA part 164).

q. Any Contractor use of flash drives or external hard drives for storage of LDH data must first receive written approval from the Department and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

r. All Contractor-utilized computers and devices must:

a. Be protected by industry standard virus protection software which is automatically updated on a regular schedule;

b. Have installed all security patches which are relevant to the applicable operating system and any other system software;

c. Have encryption protection enabled at the Operating System level; and

d. Failure to keep systems accurate and up-to-date shall make the Contractor subject to remediation, as specified in the *Remediation* section of this contract.

s. The Contractor shall be responsible for maintaining standardized data collection processes and procedures, and provide training and support to all provider staff and state staff.

t. The Contractor shall perform data quality and utilization management, in order to demonstrate that the data are accurate, appropriate, complete and timely reported.

2. Data Exchange with WAAs

a. The Contractor will work in conjunction with LDH to form a stakeholder committee which includes the Contractor, LDH and WAAs, to determine the needs and a mutually agreeable strategy for requirements, architecture and implementation for the WAAs to electronically collect required child-specific information and manage the care of the CSoC population.

b. The systems shall (at a minimum):

a. Collect client demographics;

b. Provide an electronic plan of care (POC) and the ability to update the POC electronically;

c. Collect wraparound process measures;

d. Collect assessment, referral, enrollment, inpatient, incarceration/detention, and discharge data and dates;

e. Collect continuity of care information;

f. Document collection for each member (including, but not limited to, all iterations of the Freedom of Choice (FOC), the brief and comprehensive Child and Adolescent Needs and Strengths Assessment Tool (CANS), and the Independent Behavioral Health Assessment (IBHA);

g. Collect utilization data (for example, of supports and services); and

h. Collect quality indicators and provide reporting capabilities to the Wraparound Agency (WAAs).

3. HIPAA Standards and Code Sets

a. The Contractor's system shall be able to transmit, receive and process data in current HIPAA-compliant and LDH-specific formats or methods, including, but not limited to, Secure File Transfer Protocol (SFTP) over a secure connection such as a Virtual Private Network (VPN). Data elements and file format requirements may be found in the *PIHP CSoC Systems Companion Guide*.

b. All HIPAA-conforming exchanges of data between LDH and the Contractor shall be subjected to the highest level of compliance as measured using an industry- standard HIPAA compliance checker approved by LDH.

c. The system shall conform to the following HIPAA-compliant 5010 standards for information exchange. Batch transaction types

include, but are not limited to, the following:

a. ASC X12N 835 Claims Payment Remittance Advice Transaction;

b. ASC X12N 837I Institutional Claim/Encounter Transaction;

c. ASC X12N 837P Professional Claim/Encounter Transaction;

d. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

e. ASC X12N 276 Claims Status Inquiry;

f. ASC X12N 277 Claims Status Response;

g. ASC X12N 278 Utilization Review Inquiry/Response; and

h. ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

d. The Contractor shall not revise or modify the standardized forms or formats.

e. Transaction types are subject to change and the Contractor shall comply with applicable Federal and HIPAA standards and regulations as they occur.

f. The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are approved by LDH. These shall include, but not be limited to, HIPAA based standards, Federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual located at: CMS State Medicaid Manual.

g. The Contractor shall require that its providers comply at all times with standardized billing paper forms and electronic formats, and all future updates for Professional and Institutional claims. All data shall be submitted to LDH or its designee in the standard 5010 HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-provider Coordination of Benefits (COB transaction formats (P - Professional, and I - Institutional).

4. Connectivity

a. The Contractor's systems shall interface with LDH, the Medicaid Fiscal Intermediary (FI), and other potential LDH contractors. Contractor systems shall conform and adhere to the data and document management standards of LDH and the Medicaid FI, inclusive of standard transaction code sets.

b. The MIS shall support electronic and manual claims processing and administration, membership management, provider network management, including provider profiling, outcomes and quality of care information, care management, UM, grievances and appeals, and member services. The Contractor shall utilize current state and Federal standards and procedures for this system and will maintain a uniform service and provider (credentials) taxonomy for billing and information management purposes. Some examples these Federal standards and procedures that can be used are HL7, HIPAA, CMS, CPT, ICD-10, and DSM-5. The Contractor shall provide technical assistance and consultation to providers regarding supporting use of Contractor applications.

c. The Contractor shall provide an electronic method for the collection of data from the WAA (i.e., demographics, referral dates, Freedom of Choice signature date, initial planning, discharge, authorizations, iterations of the FOC, the electronic Plan of Care, the brief and comprehensive CANS assessment, and the IBHA);

d. LDH shall require the Contractor to comply with transitional requirements as necessary should LDH contract with a new

Medicaid FI during the contract at no cost to LDH or its FI.

e. The Contractor shall be responsible for all initial and recurring costs required for access to LDH-approved system(s), as well as LDH access to the Contractor's system(s). These costs include, but are not limited to, hardware, software, licensing, and authority/permission to utilize any patents, annual maintenance, support, and connectivity with LDH.

f. LDH may require the Contractor to complete an Information Systems Capabilities Assessment (ISCA), which will be provided by LDH. If required, the ISCA shall be completed and returned to LDH no later than thirty (30) days from the date requested.

5. Information Systems Documentation Requirements

a. The Contractor shall comply with State of Louisiana Information Technology standards that can be located at website http://www.doa.la.gov/Pages/ots/standards.aspx and policies located at: http://www.doa.la.gov/Pages/ots/Policies.aspx. This includes, but is not limited to, call center operations, claims EDI operations, authorized services operations, and member services operations.

b. The Contractor shall ensure that written systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems. The Contractor shall develop, print, maintain, and distribute to LDH distinct systems design and management manuals, user manuals and quick reference Guides, and any updates. These manuals shall be available online and in printed form if requested.

c. The Contractor shall ensure the systems user manuals contain information about, and instruction for, using applicable systems functions and accessing applicable system data.

d. The Contractor shall provide to LDH a Systems Quality Assurance Plan prior to contract go-live, which shall include, but not be limited to:

a. Written system procedure and process plans;

b. Systems helpdesk process and workflows;

c. Systems access request forms;

d. Procedures and measures for safeguarding against unauthorized modification to the Contractor's systems;

e. An outline of how systems within the Contractor's span of control will be systematically assessed to determine the need to modify, upgrade or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, or

f. Systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors; and

g. Data back-up policies and procedures.

e. Resource Availability

a. The Contractor shall provide Systems Help Desk services to state staff or providers that have direct access to the Contractor's systems. The System Help Desk shall:

i. Be available via local and toll-free telephone service, and via e-mail at least Monday through Friday, 7 a.m. to 5 p.m. Central Time. After hours, the systems

help desk shall provide a means for users to leave voice messages or emails in which the Contractor's stall shall respond to by noon (Central Time) the next business day.

ii. Answer questions regarding the Contractor's system functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate LDH staff;

iii. Ensure, in the event that the system helpdesk is down during required business hours, individuals who place calls have the option to leave a message. The Contractor's staff shall respond to messages by noon the next business day; and

iv. Ensure recurring problems not specific to systems unavailability identified by the Systems Help Desk shall be documented and reported to Contractor management within one (1) business day of recognition so that deficiencies are promptly corrected.

6. Systems Changes

a. The Contractor's systems shall conform to future Federal or LDH specific standards for complete and accurate encounter data prior to the standard's effective date or earlier, unless otherwise directed by LDH.

b. If a system update or change is necessary, the Contractor shall draft appropriate revisions for the documentation or manuals, and present to LDH thirty (30) days prior to implementation of system change, for LDH review and approval. Documentation revisions shall be accomplished electronically and shall be made available for Department review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of implementation of system change.

c. The Contractor shall notify LDH staff of the following changes to its system within its span of control at least ninety (90) calendar days prior to the projected date of the change, unless otherwise directed by LDH:

a. Major changes, upgrades, modification or updates to application or operating software associated with the following core production system:

i. Claims processing;

ii. Eligibility and enrollment processing;

iii. Service authorization management;

iv. Provider enrollment and data management;

v. Conversions of core transaction management systems; and

vi. Any system to which LDH has access.

d. The Contractor shall respond to LDH notification of system problems not resulting in system unavailability according to the following timeframes:

a. Within five (5) calendar days of receiving notification from

LDH, the Contractor shall respond in writing to notices of system problems.

b. Within fifteen (15) calendar days after the Contractor's response to notification, the correction shall be made or a requirements analysis and specifications document will be due.

c. The Contractor shall correct the deficiency by an effective date to be determined by LDH.

e. The Contractor's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

f. The Contractor shall put in place procedures and measures for safeguarding against unauthorized modification to the Contractor's Systems.

g. Unless otherwise agreed to in advance by LDH, the Contractor shall not schedule systems unavailability to perform system maintenance, repair or upgrade activities to take place during hours that can compromise or prevent critical business operations. The Contractor shall provide at least five (5) days' notice to LDH of any system upgrades, repairs or maintenance.

h. The Contractor shall work with LDH pertaining to any testing initiative as required by LDH and shall provide sufficient system access to allow testing by LDH or its Medicaid FI of the Contractor's system.

i. The Contractor shall have or obtain access to additional resources, including additional corporate/national support, in the event systems modifications are beyond the resources and manpower available to the Contractor. LDH reserves the right to request the Contractor utilize additional resources.

7. Electronic Messaging

a. The Contractor shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with LDH. This e- mail system shall be capable of attaching and sending documents created using software compatible with LDH's installed version of Microsoft Office and any subsequent upgrades as adopted.

b. As needed, the Contractor shall be able to communicate with LDH over a secure Virtual Private Network (VPN).

c. The Contractor shall comply with national standards for submitting protected health information (PHI) electronically and shall set up a secure emailing system with that is password protected for both sending and receiving any protected health information.

8. Eligibility and Enrollment Data Exchange

a. The Contractor shall:

a. Receive, process, and update enrollment files. Receive historic claims files for Medicaid beneficiaries within the eligible age range for CSOC. Receive provider files;

b. Transmit to LDH or the LDH FI, in the format and method specified by LDH, members who have been clinically determined eligible for CSOC or changes in clinical eligibility determinations;

c. Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;

d. Transmit to LDH, in the formats and methods specified by LDH, member address changes and telephone number changes;

e. Be capable of uniquely identifying (i.e., via Master Patient Index) a distinct Medicaid member across multiple populations and systems within its span of control; and

f. Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by LDH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

b. The Contractor shall also reconfirm eligibility on each member upon claims submission and processing.

9. Information Systems Availability

a. The Contractor shall:

a. Allow LDH staff, Louisiana Legislative Auditor staff, agents of the Louisiana Attorney General's Office or individuals authorized by LDH or the Louisiana Attorney General's Office and upon request by CMS, direct, real-time access to its data related to the contract for the purpose of data mining and review;

b. Ensure that member and provider internet/intranet or telephone- based Interactive Voice Response (IVR) functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled system unavailability agreed upon by LDH and the Contractor. Unavailability caused by events outside of the Contractor's span of control is outside of the scope of this requirement;

c. Ensure that at a minimum all other system functions and information are available to the applicable system users between the hours of 7 a.m. and 7 p.m., Central Time, Monday through Friday;

d. Ensure that the systems and processes within its span of control associated with its data exchanges with LDH's FI and its Contractors are available and operational twenty- four (24) hours per day, seven (7) days per week;

e. Ensure that in the event of a declared major failure or disaster, the Contractor's core eligibility/enrollment and claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;

f. Notify designated LDH staff via phone and electronic mail within one (1) hour of discovery of declared major failure or disaster to provide LDH with details of the impact to critical path processes such as enrollment management and detailed and accurate encounter submission processes:

i. Upon discovery of a problem within or outside the Contractor's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this section, including any problems impacting scheduled exchanges of data between the Contractor and LDH or its Medicaid FI; and

ii. Upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on system unavailability protocol.

g. Provide information on unscheduled system unavailability events, as well as status updates on problem resolution, to appropriate LDH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone or electronic mail; and

h. Provide a range of system restoration options and timelines for implementation within one (1) hour of official declaration of unscheduled system unavailability of critical functions caused by the failure of system and telecommunications technologies within the Contractor's span of control for LDH approval:

i. Ensure cumulative systems unavailability caused by systems or IS infrastructure technologies within the Contractor's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period;

ii. Ensure unscheduled system unavailability to all other system functions caused by system and telecommunications technologies within the Contractor's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of system unavailability; and

iii. Within five (5) business days of the occurrence of a problem with system availability, the Contractor shall provide LDH with full written documentation that includes a CAP describing how the Contractor will prevent the problem from reoccurring.

10. Contingency Plan

a. The Contractor, regardless of the architecture of its systems, shall develop and be continually ready to invoke, a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.

b. Contingency plans shall include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc. in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee notification processes, alternate sites, and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.

c. The Contractor shall have a Contingency Plan that must be submitted to LDH for approval no later than thirty (30) days from the date the signed contract is approved by DOA/OSP.

d. At a minimum, the Contingency Plan shall address the following scenarios:

a. Alternate site options for continuous operations;

b. The central computer installation and resident software are destroyed or damaged;

c. The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that are active in a live system at the time of the outage;

d. System interruption or failure resulting from network,

operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system; and

e. System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the system, such as it causes unscheduled system unavailability.

e. The Plan shall specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

f. The Contractor shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to LDH that it can restore systems functions. LDH shall be notified of this testing period at least one week in advance, and testing shall be conducted in such a way that normal business operations are not disturbed.

g. In the event the Contractor fails to demonstrate through these tests that it can restore systems functions, the Contractor shall be required to submit a CAP to LDH within ten (10) business days describing how the failure shall be resolved. After LDH has approved the CAP, the Contractor must re-test the system contingency plan within thirty (30) days.

11. Off Site Storage, Remote Back-up, and Retrieval

a. The Contractor shall provide for off-site storage and remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

b. The Contractor shall maintain data back-up policy and procedures which shall include, but not be limited to, the following:

a. Descriptions of the controls for back-up processing, including how frequently back-ups occur;

b. Documented back-up procedures;

c. The location of data that has been backed up (off-site and on-site, as applicable);

d. Identification and description of what is being backed up as part of the back-up plan;

e. Any change in back-up procedures in relation to the Contractor's technology changes;

f. A list of all back-up files to be stored at remote locations and the frequency with which these files are updated; and

g. Data back-up policies and procedures shall be made available to LDH upon request.

12. Records Retention

a. The Contractor shall have online retrieval and access to documents and files for six (6) years in live systems for audit and reporting purposes and ten (10) years in archival systems. Online access to claims processing data shall be by the Contractor-assigned unique member identifier, provider ID or ICN (internal control number) to include pertinent claims data and claims status. The Contractor shall provide forty-eight (48) hour turnaround or less on requests for access to information that is six (6) years old, and seventy-two (72) hour turnaround or less on requests for access to information in machine readable form, that is between six (6) to ten (10) years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or

criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

b. The historical encounter data submission shall be retained for a period of not less than ten (10) years, following generally accepted retention guidelines.

c. Audit Trails shall be maintained online and additional history shall be retained for no less than ten (10) years and shall be provide seventy-two (72) hour turnaround or less on request for access to information in machine readable form, that is between six (6) and ten (10) years old.

d. The Contractor shall retain as per 42 CFR §438.3(u), and require subcontractors to retain, as applicable, enrollee grievance and appeal records as per 42 CFR §438.416, base data as per 42 CFR §438.5(c), MLR reports in 42 CFR §438.8(k), and data, documentation and information specified in 42 CFR §§438.604, 438.606, 438.608 and 438.610 for a period of no less than 10 (ten) years.

13. Information Security and Access Management

a. The Contractor's system shall:

a. Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

i. Establish unique access identification per Contractor employee;

ii. Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only, will not be permitted to modify information;

iii. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by LDH and the Contractor;

iv. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences and require users to have identification confirmed and password reset;

v. Make system information available to duly authorized representatives of LDH and other state and Federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed; and

vi. Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed by the Contractor and approved by LDH.

vii. Ensure that audit trails be incorporated into all systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

1. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete

action and, if applicable, the ID of the system job that effected the action;

2. Have the date and identification “stamp” displayed on any on-line inquiry;

3. Have the ability to trace data from the final place of recording back to its source data file or document;

4. Be supported by listings, transaction reports, update reports, transaction logs, or error logs;

5. Facilitate auditing of individual records as well as batch audits; and

6. Have inherent functionality that prevents the alteration of finalized records.

viii. Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide LDH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the contract;

ix. Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;

x. Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as Contractor key and electrical alarms, monitored by security personnel;

xi. Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of the Contractor’s span of control. This includes, but is not limited to any provider or member service applications that are directly accessible over the Internet which shall be appropriately isolated to ensure appropriate access;

xii. Ensure that remote access users of its systems can only access said via methods such as VPN, which must be prior approved by LDH no later than thirty (30) calendar days after the date the signed contract is approved by DOA/OSP; and

xiii. Comply with recognized industry standards governing security of state and Federal automated data processing systems and information processing. The Contractor shall attest to this compliance through the provision of an information security plan within the Systems Quality Assurance information management policies.

B. <u>Project Requirements</u>

1. General Contractor Requirements

a. For the term of the Contract, the Contractor must:

a. Meet solvency standards as specified in Federal regulations including 42 CFR §438.116 and Title 22 of the Louisiana Revised Statutes. The Contractor shall, at all times, maintain capitalization and surplus requirements set forth in La. R.S. 22:254. In addition, the Contractor's financial solvency shall be evaluated by the Louisiana Department of Insurance. LDH will review the Contractor's solvency and financial condition quarterly (upon submission of quarterly financial reports), annually (upon submission of annual audited financial statements), and upon any suspicion or findings of possible financial inadequacy for performance of the Contract;

b. Meet National Committee for Quality Assurance (NCQA) Managed Behavioral Healthcare Organization Accreditation or agree to submit an application for accreditation at the earliest possible date allowed by NCQA and once achieved, maintain accreditation through the life of the Contract. Accreditation status shall appear on the Contractor's website. Contractor shall inform LDH of any additional accreditation by other independent accrediting entities;

c. Comply with External Quality Review (EQR) activities and subsequent findings;

d. Have a sufficient provider network to meet member needs (see the *Provider Network Requirements* section of this Contract for access requirements);

e. Not have an actual or perceived conflict of interest that would interfere or give the appearance of possibly interfering with its duties and obligations under the Contract or any other Contract with LDH; and

f. Demonstrate ability to provide benefits and services to all assigned Members.

b. The Contractor shall be responsible for the administration and management of the CSoC Program in accordance with waiver authorities, CSoC Standard Operating Procedure, CSoC Payment Guidance, the requirements and responsibilities under the Contract and any and all LDH issued policy manuals and guides. This is also applicable to all Subcontractors, providers, employees, agents and anyone acting for or on behalf of the Contractor. In addition, the Contractor shall work with LDH to update a CSoC Standard Operating Procedure Manual (CSoC SOP) available at https://ldh.la.gov/assets/csoc/Documents/SOPManual/CSoC_SOP_3-2020.pdf.

c. The Contractor shall maintain appropriate personnel as specified in the *Personnel Qualifications* section of this Contract.

d. The Contractor shall comply with all current state and Federal statutes, regulations, and administrative procedures that are or become effective during the term of the Contract, including the Code of Federal Regulations as applicable to managed care entities. LDH is not precluded from implementing changes to the CSoC Program and services as mandated by amendments to state or Federal statutes, rules or administrative procedures that become effective during the term of the Contract.

e. The Contractor must continue to maintain policies and procedures concerning advance directives with respect to all adult individuals receiving services by or through the Contractor in accordance with 42 CFR Part 489 and 42 CFR §438.3(j). The written information provided by the Contractor must reflect any changes in Louisiana law as soon as possible, but no later than ninety (90) days after the effective date of the change.

f. The Centers for Medicare and Medicaid Services (CMS) Regional

Office must approve the Contract. If CMS does not approve the Contract entered into under the Terms and Conditions described herein, the Contract will be considered null and void.

g. The Contractor shall protect confidential information and documents in accordance with 42 USC §671(a)(8), 42 USC §5106a, 42 USC §290dd-2, 45 CFR §1355.21, 45 CFR §205.50, 45 CFR §1355.30, 42 CFR Part 2, La. R.S. 46:56, and 45 CFR Parts 160 and 164, as applicable.

2. CMS Waiver Authorities

a. The currently approved CMS authorities for CSoC include:

a. 1915(b) waiver PIHP with mandatory enrollment and selective services contracting,

b. 1915(c) children's CSoC Severely Emotionally Disturbed (SED) Home and Community-Based Waiver, and

c. CMS approved LDH amendments for various Medicaid State Plan service categories.

d. These concurrent authorities are administered through the 1915(b) waiver authority.

b. The Contractor must comply with any changes/amendments to current SPAs or waivers and shall conform to any new services adopted by an approved SPA or waiver. The Contractor may reassess costs associated with waiver and SPA changes to determine whether there is a PMPM impact. Contractor is encouraged to share this information with LDH.

3. Management of Services for CSoC Members

a. The Contractor will manage Medicaid specialized behavioral health services to children who meet the CSoC Level of Care for the purpose of promoting the best, evidence-based informed practices that improve access and delivery of efficient and high quality services.

b. The Contractor shall be responsible for contracting with providers for the provision of specialized behavioral health services for the CSoC Population.

c. The Contractor shall continue efforts to develop crisis intervention and stabilization provider networks to better manage behavioral health issues in the community. The Contractor shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to, and assistance with, placement in behavioral health services required by the individual in need. Local crisis community collaborations consist of an array of public and private partners such as law enforcement, emergency department directors, psychiatric acute unit directors, coroners, behavioral health advocates, and peer supports. The Contractor shall familiarize itself with the local crisis collaboration and work to facilitate crisis resolution for members. The Contractor will actively work to remove barriers to development of crisis intervention and stabilization. The Contractor will collaborate with the IMMCP contractors to continue to develop services for CSoC children.

d. The Contractor shall continue to maintain and further develop an effective service array for children/youth in the community and avoid out-of-home placement whenever possible. Children/youth with specialized behavioral health needs must be able to access effective and coordinated services.

e. The Contractor shall manage the Medicaid State Plan specialized behavioral health services for CSoC children/youth including, but not limited to, Functional Family Therapy (FFT), and other critical

evidence-based and informed services available for children and their families as provided in the Medicaid Behavioral Health Services Provider Manual available at https://www.lamedicaid.com/provweb1/providermanuals/BHS_main.htm.

f. The Contractor shall manage outpatient treatment for substance use disorders for CSoC members. Substance use services include the American Society of Addiction Medicine (ASAM) levels of care.

g. The Contractor shall screen members to determine level of care (LOC) for the purpose of service authorization based on medical necessity. Based on this medical necessity determination, the Contractor shall authorize the Medicaid State Plan and waiver services as appropriate.

h. The Contractor shall finalize a sustainable plan of care that is consistent with the needs of the child/youth and medical necessity guidelines.

i. The Contractor shall ensure, through the WAA, collaboration with state agencies, including LDOE, OJJ and DCFS regarding members enrolled in CSoC.

j. The Contractor shall track and monitor individual members, including, but not limited to the services provided, outcomes, and costs of services.

k. The Contractor shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability. The Contractor shall continue to offer contracting to providers when gaps in services are identified.

4. Subcontracting Information

a. The Contractor shall notify LDH prior to entering into a subcontracting relationship. While Contractor may enter into subcontractor arrangements, total responsibility for the entire Contract lies with the Contractor. Network provider agreements shall be governed by the network requirements of this Contract.

b. The Contractor shall be the single point of contact for all subcontract work.

c. The Contractor will provide letters of agreement, contracts or other forms of commitment which demonstrate that all requirements pertaining to the Contractor will be satisfied by all Subcontractors through the following:

a. The Subcontractor(s) will provide a written commitment to accept all Contract provisions and to comply with 42 CFR §438.3(k) and §438.230.

d. The Subcontractor(s) will provide a written commitment to adhere to an established system of accounting and financial controls adequate to permit the effective administration of the Contract.

5. Compliance with Court Ordered Settlements

a. The Contractor shall comply with all requirements of court judgments or settlements as directed by LDH. LDH reserves the right to amend the Contract in accordance with future court orders or settlements.

b. The Contractor's policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210 and state laws and regulations and the court-ordered requirements of Chisholm v. Gee and Wells v. Gee for initial and continuing authorization of services that include, but are not limited to, the following:

a. Written policies and procedures for processing requests for

initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;

b. Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;

c. Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease;

d. Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;

e. The Contractor's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and

f. The Contractor's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the Contractor regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

6. Resources Available to Contractor

a. The Office of Behavioral Health will have an assigned staff member who will be responsible for primary oversight of the Contract. This individual will schedule meetings to discuss progress of activities and problems identified.

7. Term of Contract

a. The term of this Contract shall be for eleven (11) months and shall begin on August 1, 2025 and end on June 30, 2026. With all proper approvals and concurrence and approval with Contractor, the parties may agree to extend the Contract term for up to twenty-four (24) additional months at such rates, terms and conditions as the parties may mutually agree. Prior to the extension of the Contract beyond the initial eleven (11) month term, approval by the Joint Legislative Committee on the Budget (JLCB) (or other approval authorized by law) shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the Contract amendment implementing the extension, to the Division of Administration, Office of State Procurement (DOA/OSP).

i. No Contract/amendment shall be valid, nor shall the State be bound by the Contract/amendment, until it has first been executed by the head of the using agency, or his designee, the Contractor and has been approved in writing by the director of DOA/OSP. Total Contract term, with extensions, shall not exceed five (5) years. The continuation of the Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

8. Contract Reimbursement

a. *Payment Terms*

a. Services provided by a Subcontractor shall be billed to the

Contractor. Through a provider network agreement, the Contractor will make payment to network providers for the provision of services as stipulated in the *Provider Payments* section of this Contract.

b. The Contractor shall not assign its right to receive payment to any other entity.

c. The Contractor is not responsible for reimbursement of disproportionate share hospital (DSH) payments.

d. Payment for items or services provided under the Contract will not be made to any entity located outside of the United States. The term “United States” means the 50 states, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

e. The Contractor shall agree to accept payments as specified in this section and have written policies and procedures for receiving and processing payments and adjustments. The Contractor shall provide these to LDH within thirty (30) days of DOA/OSP approval of signed Contract and thirty (30) days prior to any changes or implementation of any new policy. Any charges or expenses imposed by financial institutions for transfers or related actions shall be borne by the Contractor.

f. The Contractor shall ensure that a claim is denied reimbursement until the Contractor coordinates all available benefits the member may have through other insurance.

g. The Contractor shall ensure that payment is not made for excluded populations. The Contractor may be subject to remediation for payment made for excluded populations.

h. The Contractor shall submit weekly encounter data on all services provided to covered populations. Submissions must meet client level detail sufficient for required financial reporting via the Financial Reporting Template for which instructions will be prescribed by LDH upon execution of the contract. Encounter data should not include payments, services, or populations that are not covered under the Contract.

i. In the event that Contractor does not provide the services listed under the Contract, or only provides a portion of the services, LDH reserves the right to withhold payments until such time as Contractor demonstrates that the services have been provided.

j. Changes to covered services mandated by Federal or State law subsequent to the signing of the Contract will not affect the contracted services for the term of the Contract, unless (a) agreed to by mutual consent, or (b) the change is necessary to continue to receive Federal funds or is necessary due to action of a court of law, or any other change in the applicable Federal authorities detailed in this Contract. The Contractor shall receive thirty (30) calendar days’ notice prior to such changes and the rates shall be provided accordingly. The method of retrospective reconciliation will not be altered by any changes in the payments.

k. Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn Federal authority, or which is the subject of a legislative repeal), The Contractor must do no work on that part after the effective date of the loss of

program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no- longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

l. The Contractor shall report overpayments made by LDH to the Contractor within sixty (60) calendar days after its receipt of the overpayment.

b. *Contractor Payment Schedule*

a. Capitated payments shall be made in accordance with the payment schedule established by LDH and published on the Fiscal Intermediary website at https://www.lamedicaid.com/Provweb1/billing_information/GeneralCheckWriteExLTC.htm*,* as of the date of execution of this Agreement.

b. The monthly capitation payment for a service month is made retrospectively in the subsequent month based on the previous month's member enrollment as determined by the total number of unduplicated Medicaid eligible assigned to the Contractor throughout the month, and submitted to, and accepted by, Medicaid's Fiscal Intermediary by the last business day of the service month.

c. Determination of Contractor Rates

a. Pending any required CMS approval, LDH shall develop and establish cost- effective and actuarially sound Per Member per Month (PMPM) rates in accordance with all applicable CMS rules and regulations. LDH will not use a competitive bidding process to develop the Contractor capitation, but will develop monthly capitation rates that will be offered to the Contractor on a "take it or leave it" basis and will not be subject to negotiation or dispute resolution. The rates are intended to cover all benefits and management services outlined in this Contract.

b. The Contractor shall be paid a monthly capitated rate developed based on a summary of historical CSoC expenditures as reflected in the Data Book Coordinated System of Care Services.

c. The rates will be reviewed and may be periodically adjusted. Any adjusted rates shall be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c).

d. LDH reserves the right to adjust the rate for instances including, but not limited to:

i. Changes to core benefits and services included in the monthly capitation rates;

ii. Changes to Medicaid population groups eligible to enroll in the PIHP;

iii. Legislative appropriations and budgetary constraints;

iv. Changes in the Federal authorities outlined in this Contract; or

v. Changes in Federal requirements.

d. *Annual Actuarial Study*

a. LDH will retain a qualified actuary to conduct an annual actuarial study of the Contractor program and rates. The Contractor shall provide in writing any information requested by LDH to assist the actuary in completion of the annual actuarial study. LDH will give the Contractor reasonable time to respond to the request and full cooperation by the Contractor is required. LDH will make the final determination as to what is considered reasonable.

b. The capitation rate may be adjusted based on applicable program changes, trend or other actuarial factors that impact rates as deemed appropriate by the State. Nothing in this Contract shall be construed to mean that the capitation rate will be increased, only that it will be evaluated by an outside actuarial consulting firm.

c. "Actuarially sound" is a Federal term defined at 42 CFR §438.6(c). The State shall provide the actuarial certification of the capitation rates and payments under the Contract. All payments under risk contracts and all risk-sharing mechanisms in contracts shall be actuarially sound.

d. Actuarially sound capitation rates are capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; that are appropriate for the populations to be covered and the services to be furnished under the Contract; and that have been certified as meeting the requirements of the regulation at 42 CFR §438.6(c) by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board.

e. Actuarially sound capitation rate ranges for the Medicaid members shall be set by LDH actuary, using the methodology described in the Mercer Capitation Rate Development Assumptions. The historical data used to set rates can be found in Data Book Coordinated System of Care Services (Attachment 5) for the capitated CSoC behavioral health program.

f. The Contractor shall agree to accept, as payment in full, the actuarially sound rate established by LDH pursuant to the Contract, and shall not seek additional payment from a member, or LDH, for any unpaid cost.

g. LDH shall be notified of any cost sharing requirements placed on members.

h. LDH reserves the right to defer remittance of the Per Member Per Month (PMPM) capitated payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.

e. Payment for Medicaid Eligible Children enrolled in CSoC

a. In full consideration of the contracted services rendered by the Contractor, LDH agrees to pay the Contractor monthly payments based on the number of Members.

b. Payment to the Contractor shall be based on Medicaid enrollment data each month during the term of the Contract. Payment for Members assigned by a month-end will be made according to a pre-determined schedule established by LDH and published on the Fiscal Intermediary website.

c. Individuals who lose eligibility for Medicaid due to failure to provide eligibility reports on a timely basis, but whose eligibility is consequently re-established prior to the end of the month, will receive a full month of eligibility, and will be reported on the daily eligibility files sent to the Contractor. Payment for these members will be made with the capitation payments for the next benefit month. The Contractor will be given notice if this payment schedule changes.

f. Payment Adjustments

a. In the event that an erroneous payment is made to the Contractor, LDH shall reconcile the error by adjusting the appropriate Contractor payment.

b. The Contractor is liable for unjustified or unauthorized or incorrectly authorized payments. The Contractor may be held financially liable for any error or omission on its part which results in the delivery and reimbursement of unjustified or unauthorized services as determined by LDH. The Contractor may also be held financially liable for incorrectly authorizing payment or services as determined by LDH.

c. Retrospective adjustments to prior payments may occur when it is determined that a member's type case was changed. Payment adjustments may only be made when identified within twelve (12) months from the date of the member's type case change for all services delivered within the twelve (12) month time period. If the member switched from a CSoC-eligible type case to an excluded type case, previous payments may be recouped from the Contractor.

d. LDH reserves the right to recover inappropriate payments, including PMPM payments when the Contractor actually authorized a service, if the member is subsequently determined to be ineligible for the month in question.

e. The Contractor shall not offset recoupment imposed on it by LDH to the provider when LDH has verified that the Contractor was at fault for the cause of the recoupment. For this purpose, fault shall be defined as responsibility for the mistake, failure, defect or act of wrongdoing which results in incomplete, incorrect, or inappropriate payment.

f. The State reserves the right to alter benefits or services under the Contract through an amendment and thirty (30) calendar days' written notice to the Contractor. Capitation rates will be adjusted accordingly and in conformity with actuarially sound rate ranges.

g. The Contractor shall have the right to not continue the Contract if the new or confirmed rates established by the actuary after each rate assessment are deemed to be insufficient, notwithstanding any other provision of the Contract. The Contractor shall notify LDH regarding its desire to continue the Contract within fifteen (15) calendar days of receipt of the new rates.

h. If, as a result of an audit or review of payments made to the Contractor, LDH and its designees discover a payment error or overcharge, LDH and its designees shall notify the Contractor of such error or overcharge. LDH and its designees shall be entitled to recover such funds as an

offset to future payments to the Contractor, or to collect such funds directly from the Contractor. The Contractor shall return funds owed to LDH within thirty (30) days after receiving notice of the error or overcharge, or interest may accrue on the amount due beginning on the 31st day after notice. LDH and its designees shall calculate interest at the Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which liability is assessed. In the event that an audit reveals that errors in reporting by the Contractor have resulted in errors in payments to the Contractor, the Contractor shall indemnify LDH for any losses resulting from such errors, including the cost of audit.

g. *Risk Sharing*

a. The Contractor shall assume one hundred percent (100%) liability for any expenditure above the monthly capitation rate.

h. *Medical Loss Ratio*

a. In accordance with the Financial Reporting Template provided by LDH the Contractor shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year.

b. An MLR shall be reported in the aggregate, including all medical services covered under the Contract.

c. If the aggregate MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the Contractor shall refund LDH the difference.

d. Managed care entities may be eligible for a credibility adjustment as described in

e. 42 CFR 438.8(h). The credibility adjustment is used to account for random variations in the MLR that have a disproportionate effect on plans with fewer member months. 42 CFR 438.8(b) divides plans into three (3) categories: Fully- credible (They will not receive any credibility adjustment), Partially-credible (They will be receive a partial credibility adjustment), and Non-credible (They will automatically meet the target MLR Standard).

f. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher.

i. *Return of Funds*

a. All amounts owed by the Contractor to LDH, as identified through routine or investigative reviews of records or audits conducted by LDH or other state or Federal agencies, are due no later than thirty (30) calendar days following notification to the Contractor by LDH unless otherwise authorized in writing by LDH. LDH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to LDH to future payments. LDH reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR §30.18. This rate may be revised quarterly by the Secretary of the Treasury and is published by the United States Department of Health and Human Services (HHS) in the Federal Register.

b. The Contractor shall reimburse all payments as a result of any Federal disallowances, penalties, or sanctions imposed on LDH as a result of the Contractor's failure to abide by the terms of the Contract. The Contractor shall be subject to any additional conditions or restrictions placed on LDH by HHS as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.

j. *Third Party Liability (TPL)*

a. General TPL Information

i. TPL refers to the legal obligation of third parties (i.e., certain individuals, entities, or programs) to pay all or part of the expenditures for medical assistance furnished under a state plan. TPL allows for the ability to transfer information and to bill other payers such as Medicare, commercial claims and private pay. TPL is required as per 42 CFR §433.135 et seq. and the Contractor shall ensure compliance with all Federal regulations.

ii. Pursuant to Federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available TPL resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. Exclusions to Medicaid being payor of last resort are identified in 42 CFR §433.139(b)(3)(i) and (ii) which include services for prenatal care for pregnant women, preventive pediatric services, or covered services furnished in cases where the third party resource is derived from the absent parent whose obligation to pay third party medical support is enforced by the State Title IV-D agency.

iii. The Contractor shall coordinate benefits in accordance with 42 CFR §433.135 et seq. and La. R.S. 46:460.71 so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post- payment recovery. The Contractor shall use these methods as described in Federal and state law.

iv. Establishing TPL takes place when data matches are conducted with insurance carriers that confirm insurance coverage exists for the recipient outside of Medicaid.

v. If the probable existence of TPL cannot be established, the Contractor must adjudicate the claim. The Contractor must then utilize post- payment recovery, which is described in further detail below.

vi. The term "state" shall be interpreted to mean "Contractor" for purposes of complying with the Federal regulations 42 CFR §433.135 and 42 CFR §433.139(b)(3)(i) and (ii). The Contractor may require Subcontractors to be responsible for coordination of benefits for services provided pursuant to the Contract.

b. Cost Avoidance

i. The Contractor shall cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed.

ii. Except in certain cases, the Contractor shall attempt to avoid payment in all cases where there is other insurance (Medicaid is payer of last resort).

c. Post-payment Recoveries

i. Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of TPL at the time services were rendered or paid for, and was unable to cost avoid. The following sets forth requirements for Contractor recovery:

1. The Contractor must seek recovery of reimbursement from the third party to the limit of legal liability within sixty (60) days after the end of the month it learns of the existence of the liable third party or benefits become available per 42 CFR §433.139(d)(2).

2. The Contractor must have established procedures for recouping post-payments for LDH's review. The Contractor must submit adjusted encounter totals for the claims when a recoupment is made, even if the payment was recouped in full.

3. The Contractor will take responsibility for identifying and pursuing third party liability for Medicaid enrollees that are enrolled in its network with casualty insurance, tort claims and settlements or personal injury. The Contractor shall be required to seek amounts greater than five hundred dollars ($500) as required by Medicaid State Plan and Federal Medicaid guidelines (available at http://dhh.louisiana.gov/index.cfm/page/1718) and La R.S. 46:446 available at http://legis.la.gov/Legis/Law.aspx?p=y&d=100886). The amount of subrogation recoveries collected by the Contractor shall be reported through adjusted encounter data.

4. The amount of any recoveries collected by the Contractor outside of the claims processing system shall be treated by the Contractor as offsets to behavioral healthcare expenses for the purposes of reporting.

5. Prior to accepting a TPL settlement on claims equal to or greater than twenty-five thousand dollars ($25,000), the Contractor shall obtain approval from LDH. Additional information may be available through Health Plan Advisories that can be made available at http://ldh.louisiana.gov/index.cfm/page/37 .

d. Distribution of TPL Recoveries

i. The Contractor may retain up to one hundred percent (100%) of its TPL collections if all of the following conditions exist:

1. Total collections received do not exceed the total amount of the Contractor financial liability for the member;

2. There are no payments made by LDH related to fee-for- service, reinsurance or administrative costs (i.e., lien filing, etc.);

3. Such recovery is not prohibited by state or Federal law; and

4. Data will be used in calculating future capitation rates.

e. TPL Reporting Requirements

i. The Contractor shall provide LDH TPL information in a format and medium described by LDH and shall cooperate in any manner necessary, as requested by LDH, with LDH or a cost recovery vendor of LDH.

ii. The Contractor shall track its TPL recovery for members and report this recovery amount to LDH according to the format and schedule specified by LDH. Data transfer of TPL information on any member shall occur according to the format and schedule specified by LDH.

iii. The Contractor shall transfer to LDH or its designee any new TPL information on any member that comes to its attention. LDH or its designee shall also transfer to the Contractor any new TPL information for any member daily through the established SFTP site.

iv. The Contractor shall be required to include the collections and claims information in the encounter data submitted to LDH, including any retrospective findings via encounter adjustments.

v. Upon the request of LDH, the Contractor must provide information not included in encounter data submissions that may be necessary for the administration of TPL activity. The information must be provided within thirty (30) calendar days of LDH's request. Such information may include, but is not limited to, individual treatment records for the express purpose of a TPL resource to determine liability for the services rendered.

vi. Upon the request of LDH, the Contractor shall demonstrate that reasonable effort has been made to seek, collect or report TPL and recoveries. LDH shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination will take into account reasonable industry standards and practices.

vii. The Contractor is required to submit a TPL Collections Report monthly, quarterly, and annually and upon request of LDH with all health insurance collections for its members plus copies of any Form 1099's received from insurance companies for that period of time. The report shall indicate open receivables, closed receivables, amounts collected, amounts written off, and amounts avoided.

viii. In accordance with 42 CFR §433.138(e), the Contractor shall be responsible for identifying any accident or injury utilizing diagnosis and trauma related codes.

ix. The Contractor shall maintain other coverage

information for each member. The Contractor shall verify the other coverage information provided by LDH and develop a process to include additional other coverage information when it becomes available.

f. LDH Right to Conduct Identification and Pursuit of TPL

i. When the Contractor fails to collect payment from the TPL within three hundred and sixty-five (365) days from date of service, LDH may invoke its right to pursue recovery.

ii. If LDH determines that the Contractor is not actively engaged in cost avoidance activities the Contractor shall be subject to remediation.

iii. LDH will retain responsibility for collecting medical subrogation. LDH will coordinate these activities with the Contractor. The Contractor is required to comply with any information requests regarding medical subrogation.

k. *Responsibility for Payment for Specialized Behavioral Health Services Provided to Coordinated System of Care (CSoC) Recipients*

a. The Contractor shall be responsible for payment to network providers for the provision of specialized behavioral health services, with the exception of Psychiatric Residential Treatment Facility, Therapeutic Group Home, and SUD Residential treatment services, for each month during which the recipient has a 1915(c)/1915(b)(3) segment on the eligibility file with a begin date on or earlier than the first day of that month, or in the event that a recipient transfers between waivers during the month, but the previous segment began on or earlier than the first day of that month.

b. The Contractor shall be responsible for payment to network providers for the provision of specialized behavioral health services through the last day of the month which includes the end date of the 1915(c) / 1915(b)(3) segment on the eligibility file.

c. The IMMCP shall be responsible for payment to network providers for the provision of specialized behavioral health services for any month during which the recipient has a 1915(c) / 1915(b)(3) segment on the eligibility file with a begin date later than the first day of that month.

d. The IMMCP shall be responsible for payment of all authorized PRTF, TGH, and SUD Residential treatment services for CSoC enrolled youth.

e. If a CSoC enrolled youth no longer meets medical necessity criteria for a higher level service (e.g. inpatient hospital) that was authorized by the Contractor, and the IMMCP has authorized PRTF, TGH, or SUD Residential treatment services, but is unable to secure placement, the CSoC Contractor will not be responsible for assuming the continued authorization of, and payment for, the higher level service until placement is made.

l. *Health Insurance Provider Fee (HIPF) Reimbursement*

If the Contractor is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee (“Annual Fee”) whose final calculation includes an applicable portion of the Contractor’s net premiums written from LDH’s Medicaid/CHIP lines of business, LDH shall, upon Contractor satisfying completion of the requirements below, make an annual payment to the Contractor in

each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by LDH (and its contracted actuary) as an adjustment to the Contractor's capitation rate, in accordance with the Financial Reporting Guide, for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the Contractor for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.

a. The Contractor shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:

   i. Provide LDH with a copy of the final Form 8963 submitted to the IRS by the deadline to be identified by LDH each year. The Contractor shall provide LDH with any adjusted Form 8963 filings to the IRS within 5 business days of any amended filing.

   ii. Provide LDH Louisiana-specific Medicaid and CHIP-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by the deadline to be identified by LDH each year (for the initial Form 8963 filing) of the Fee Year and within 5 business days of any amended filing.

   iii. If the Contractor's Louisiana-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, provide with its Form 8963 a supplemental delineation of Louisiana-specific Medicaid/CHIP premium revenue that was listed on the Contractor's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the Contractor pursuant to this Contract) was determined.

   iv. Contractor shall also submit a certification regarding the supplemental delineation consistent with 42 CFR 438.604 and 42 CFR 438.606.

   v. Provide LDH with the preliminary calculation of the Annual Fee as determined by the IRS by the deadline to be identified by LDH each year.

   vi. Provide LDH with the final calculation of the Annual Fee as determined by the IRS by the deadline to be identified by LDH each year.

   vii. Provide LDH with the corporate income tax rates – Federal and state (if applicable) -- by the deadlines to be identified by LDH each year and include a certification regarding the corporate income tax rates consistent with 42 CFR 438.604 and 42 CFR 438.606

b. For covered entities subject to the HIPF, LDH will calculate the HIPF percentage in accordance with the steps outlined in the Financial Reporting Guide and based on the Contractor's notification of final fee calculation (i.e., HIPF liability) and all premiums for the Contractor subject to Section 9010, as reported on the Contractor's Form 8963, and agreed reasonable by LDH.

c. LDH (and its contracted actuary) will compute the change in capitation revenue that is due to the higher capitation rates by multiplying the adjusted capitation rates by the known member months to determine the total supplemental HIPF payment amount for the Contractor.

d. In accordance with the schedule provided in the Financial

Reporting Guide, LDH will make a payment to the Contractor that is based on the final Annual Fee amount provided by the IRS and calculated by LDH (and its contracted actuary) as an adjustment to the capitation rates in effect during the Data Year. This payment will only be made to the Contractor if LDH determines that the reporting requirements under this section have been satisfied.

e. Contractor shall advise LDH if payment of the final fee payment is less than the amount invoiced by the IRS.

f. Contractor shall reimburse LDH for any amount applicable to Louisiana Medicaid/CHIP premiums that are not paid towards the fee or are reimbursed back to the Contractor, at any time and for any reason, by the IRS.

g. LDH reserves the right to update the calculation and method of payment for the Annual Fee based upon any new or revised requirements established by CMS in regards to this fee. In the event the calculation methodology or method or timing of payment for the Annual Fee as set forth in Financial Reporting Guide requires modification, LDH will obtain the Contractor's input regarding the required modification(s) prior to implementation of the modification.

a. Payment by LDH is intended to put Contractor in the same position as the Contractor would have been in had Contractor's health insurance providers fee tax rate (the final Annual Fee as a portion of the covered entity's premiums filed on Form 8963) and corporate tax rates been known in advance and used in the determination of the Data Year capitation rates

9. Covered Benefits and Services

a. *General Provisions*

a. The Contractor shall have available for members, those core specialized behavioral health benefits and services specified in this Contract, Medicaid State Plan and its amendments, administrative rules, LDH policy and procedure manuals, and services specified in the 1915(c) and 1915(b) waivers. The Contractor shall possess the expertise and resources to ensure the delivery of quality behavioral healthcare services as specified in this Contract to members in accordance with Louisiana Medicaid program and prevailing industry standards.

b. The Contractor shall provide a mechanism to reduce inappropriate and duplicative use of behavioral healthcare services. Services shall be furnished in the amount, duration, and scope in the approved Medicaid State Plan as specified in 42 CFR §438.210. Upward variances of amount, duration and scope of these services are allowed.

c. The Contractor may exceed the service limits as specified in the Medicaid State Plan to the extent that those service limits can be exceeded with authorization. No service limitation can be more restrictive than those that currently exist under the approved Medicaid State Plan.

d. The Contractor shall provide the full range of required core benefits and services listed in this Contract in addition to the waiver services described below. Specialized Behavioral Health covered services are:

i. Psychiatric services

ii. Licensed Mental Health Professional (LMHP) services

iii. Mental Health Rehabilitation Services

1. Psychosocial Rehabilitation (PSR)

2. Crisis Intervention

3. Community Psychiatric Support and Treatment (CPST)

4. Evidence-Based Programs (EBPs) specialized for high-risk populations. This includes:

a. Functional Family Therapy (FFT)

b. Homebuilders

c. Assertive Community Treatment (limited to 18 years and older)

d. Multi-Systemic Therapy (MST)

e. Crisis Stabilization

iv. Inpatient Hospitalization for Behavioral Health Services

v. Outpatient Substance Use Disorder Services and Opioid Treatment Programs (OTPs) in accordance with the American Society of Addiction Medicine (ASAM) levels of care

vi. Crisis Response Services

1. Mobile Crisis Response (MCR)

2. Community Brief Crisis Support (CBCS)

e. The Contractor shall be responsible for the provision of specialized behavioral health services, with the exception of Psychiatric Residential Treatment Facility, Therapeutic Group Home, and SUD residential treatment services for CSoC enrolled youth.

f. The Contractor shall ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

g. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member.

h. Covered services shall be available statewide.

i. The Contractor shall limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Vol. 37, No. 1, p. 341) for medical necessity determinations. The Contractor shall make medical necessity determinations that are consistent with the State's definition. LDH shall make the final interpretation of any disputes about medical necessity and continuation of core benefits and services under the Contract.

j. The Contractor shall use the State Medicaid definition of "medically necessary services" in a manner that is no more

permissive or restrictive than the State Medicaid program. All services for which a member is eligible shall at a minimum cover:

i. The prevention, diagnosis, and treatment of behavioral health impairments.

ii. The ability to achieve age-appropriate growth and development.

iii. The ability to attain, maintain, or regain functional capacity.

k. Medicaid services shall be provided by Contractor's network providers that have been credentialed by the Contractor.

b. *1915(c) Children's CSoC Serious Emotional Disturbance (SED) Home and Community-Based Waiver*

a. The Contractor will be responsible for administration of the HCBS waiver in order to provide home and community-based waiver services to eligible enrollees who have a serious emotional disturbance and who, but for the provision of such services, would require the level(s) of care of a nursing home or hospital. Hospital levels of care include psychiatric care within a general hospital and inpatient psychiatric hospitals as defined in 42 CFR §440.160, as well as skilled nursing facilities.

b. The Contractor shall be responsible for ensuring wraparound facilitation is provided to all members of the 1915(c) waiver using high-fidelity wraparound practice consistent with the National Wraparound Initiative standards and principles. National Wraparound Initiative standards are available at https://nwi.pdx.edu/NWI-book/pgChapter2.php and principles at https://nwi.pdx.edu/pdf/Wraparound-implementation-and-practice-quality-standards.pdf.

c. In addition to the full array of Medicaid benefits, waiver services for the individuals that meet 1915(c) eligibility currently include Youth Support and Training (YST), Parent Support and Training (PST), Short-term Respite, and Independent Living/Skills Building (ILSB).

c. *1915(b)(3) Services for Children and Youth who are Functionally Eligible for CSoC*

a. The Contractor shall be responsible for administration of 1915(b)(3) services which will serve eligible individuals who meet the LOC of a PRTF or TGH, or who meet the LOC for 1915(c) but temporarily reside in an excluded HCBS setting.

b. Because these individuals meet CSoC functional eligibility, they receive Medicaid State Plan services and the same services as are in the 1915(c) waiver, which are YST, PST, Short-term Respite, and ILSB.

c. The Contractor shall be responsible for ensuring that wraparound facilitation is provided to all members of the 1915(b)(3) waiver, using high-fidelity wraparound practice consistent with the National Wraparound Initiative standards and principles.

d. Changes to Children/Youth Services Contingent on CMS Approval

a. LDH may submit to CMS additional SPAs or waiver amendments relative to specialized behavioral health services.

b. The delivery of Medicaid State Plan, 1915(c) and 1915(b) waiver services shall appear seamless to all members, but

retain separate fund accountability for audit and encounter data purposes. The Contractor may only use Medicaid funds to purchase Medicaid services for Medicaid enrollees.

c. LDH may expand, eliminate, or otherwise change core benefits and services as required by CMS. If changed, the Contract shall be amended and the Contractor given sixty (60) days advance notice, when possible. The Contractor shall adhere to all transition requirements provided by LDH upon implementation of such changes including, but not limited to, coordination of any data or records exchanges.

e. Coverage and Payment for Post-Stabilization Services

a. The Contractor shall reimburse providers for post-stabilization services in accordance with provisions set forth at 42 CFR §422.113(c).

f. Prior Authorization and Concurrent Utilization Review for Inpatient Psychiatric Hospitalization for Children/Youth

a. The Contractor will perform prior authorization (PA) and concurrent utilization review for admissions to inpatient general hospital distinct part psychiatric units, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental health hospitals. Medicaid will pay for only those inpatient concurrent utilization reviews that are covered by Medicaid.

b. The Contractor shall ensure that inpatient psychiatric hospital concurrent utilization reviews are completed by an LMHP for each member referred for psychiatric admissions to general hospitals. The criteria contain a two-fold definition: severity of need and intensity of service required, both of which shall be met.

c. LDH reserves the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.

d. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the Contractor shall notify the provider requesting the determination verbally within seventy-two (72) hours. If denied, the Contractor shall notify the individual requesting the determination within seventy-two (72) hours and provide written notification of the results to the provider and individual requesting the determination. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.

g. Procedure for Services Determined Medically Necessary Under EPSDT by a Child and Family Team but Not in Medicaid State Plan

a. For a service that is not covered in the Medicaid State Plan:

i. As much information regarding the recipient is gathered by the Contractor including, but not limited to age, diagnosis, condition, and treatment records relative to the service being requested.

ii. Information regarding the provider, enrollment status, and qualifications for rendering service as appropriate is gathered.

iii. Information regarding the requested service is gathered. This information includes but is not limited to, reasons/policy for non- coverage, alternative services, etc. All supporting information for coverage

and medical necessity in individual case is gathered.

iv. This information is presented by the Contractor to the Medicaid Director or his/her designee.

v. The designated clinician will review as much information on the recipient as possible, the prospective provider and the requested service to determine if the service being requested is medically necessary, if other possible treatment options exist or if there are rules, SPA or Federal regulations impacting coverage decision.

vi. A determination of availability of Federal financial participation (FFP) will be made by LDH. If FFP is not available, due to Federal regulations, then a recommendation for coverage and a request to pay out of all state funds is forwarded for approval to the Medicaid Director. If the service is determined medically necessary, but is investigational or experimental, then recommendation is sent to Medical Director for consideration of final approval and appropriate match rate.

vii. It is the Contractor's responsibility to ensure that the payment of authorized services that are normally not a Medicaid covered benefit are specially handled through the system, and to ensure that payment for the specified recipient occurs and no other non-intended recipients' services are paid.

h. Services for Co-occurring Behavioral Health and Developmental Disabilities

a. The Contractor shall create a framework for delivery of services, staff development, and policies and procedures for providing effective care for members with co- occurring behavioral health and developmental disabilities. This population should have the same reasonable access to behavioral health services as someone without a co-occurring behavioral health and developmental disability. If a member qualifies for services through OCDD, the Contractor shall coordinate with OCDD concerning the care of the member. A Statement of Approval for services from OCDD shall not preclude services from the Contractor.

10. Member Services

a. *General Requirements*

a. As outlined under the 1915(b) waiver, the State permits indirect marketing by the Contractor. Indirect marketing activities are marketing activities that exclude the use of targeting and segmentation practices. The Contractor is allowed to attend health fairs, sponsor community forums, radio spots, print media, etc. and provide general outreach, so long as the entity does not target its materials directly to Medicaid beneficiaries. The Contractor and Subcontractors shall be permitted to perform the following activities:

i. Distribute general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the internet, public transportation advertising, billboards and other media outlets) in keeping with prohibitions to placement as detailed in this Contract; and

ii. Attend or organize activities that benefit the entire community such as health fairs or other health education and promotion activities. Notification to

LDH-OBH must be made of the activity and details must be provided about the planned outreach activities at least ten (10) business days prior to any event.

b. Member education, which differs from marketing, is defined as communication with an enrolled member of the Contractor to retain the member and improve the health status of enrolled members. All member education materials and activities shall comply with the requirements of 42 CFR §438.10, §438.104, and the LDH requirements set forth in this Contract.

c. Marketing and member education include both verbal presentations and written materials.

d. Marketing materials generally include, but are not limited to, the concepts of advertising, public service announcements, printed publications, broadcasts and electronic messages designed to increase awareness and interest in the Contractor. This includes any information that references the Contractor, is intended for general distribution and is produced in a variety of print, broadcast or direct marketing mediums.

e. Member education materials generally include, but are not limited to, member handbooks, identification cards, provider directories, health education materials, form letters, mass mailings, e-mails and member letters and newsletters.

f. All marketing and member education guidelines are applicable to the Contractor, its agents, Subcontractors, volunteers, or providers.

g. The Contractor is responsible for creation, production and distribution of its own marketing and Member education materials to Members.

h. The Contractor shall comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Standards" and 42 CFR §440.262. Information may be found at the following url: https://thinkculturalhealth.hhs.gov/clas and participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members.

i. All postage for required written communication and notice to members shall be paid by the Contractor. No extra payment shall be made to the Contractor for postage.

j. The Contractor may be subject to remediation for marketing and member education violations as determined in the *Remediation* section of this Contract.

k. The Contractor shall include in all materials the following:

l. The date of issue;

m. The date of revision; or

n. If prior versions are obsolete.

o. The Contractor and all Subcontractors and providers are subject to the marketing and member education requirements set forth in this Contract.

p. The Contractor, Subcontractors, and network providers are not allowed to steer Members to providers or a specific Integrated Medicaid Managed Care Plan. LDH retains the

discretion to deny the use of marketing and member education material that it deems to promote undue Member steering.

VI. The Contractor shall adhere to the requirements specified in 42 CFR §438.10 and §438.104.

a. *Marketing and Educational Materials Approval Process*

a. The Contractor must obtain prior written approval from LDH for marketing, informational, and educational materials at least thirty (30) days prior to distribution unless previously approved by LDH. This includes, but is not limited to, print, television and radio advertisements; Member handbooks, identification cards and provider directories; Contractor website screen shots; promotional items; brochures; letters and mass mailings and e-mailings. Neither the Contractor nor Subcontractors may distribute any Contractor materials without LDH consent.

b. *Review Process for Materials*

a. LDH will review the submitted marketing and member education materials and either approve, deny or submit changes.

b. Prior to modifying any previously approved member material, the Contractor shall submit a detailed description of the proposed modification, how it differs from the original approved material, and accompanied by a draft of the proposed modification for LDH approval. Changes shall be made in tracked changes or with some other means to easily identify the changes made from a previous approved version.

c. LDH reserves the right to require the Contractor to discontinue or modify any marketing or education materials after approval.

d. The Contractor must review all marketing and member education materials on an annual basis and revise materials, if necessary, to reflect current practices. Any revisions must be approved by LDH prior to distribution.

c. *Review Process for Events and Activities*

a. LDH will review the submitted marketing and member education events and activities and either “approve, deny or submit changes” within fourteen (14) business days from the date of submission.

b. LDH reserves the right to require the Contractor to discontinue or modify any marketing or member education events after approval.

c. Any revisions to approved events and activities must be resubmitted for approval by LDH prior to the event or activity.

d. *Member Education Plan*

a. The Contractor shall develop and implement a plan detailing the member education activities it will undertake and materials it will create during the Contract term. The detailed plan must be submitted to LDH for review within thirty (30) calendar days from the date the Contract is approved by DOA/OSP.

b. A summary report of all member education efforts for the year must be submitted to LDH within thirty (30) days of the end of the calendar year.

c. The Contractor shall not begin member education activities prior to approval by LDH.

d. The Contractor shall take into consideration projected enrollment levels for equitable coverage of the state. Informational materials shall be distributed to its entire membership, unless otherwise approved by LDH. The plan shall include, but is not limited to:

i. Stated member education goals and strategies;

ii. The Contractor's plans for new member outreach and orientation;

iii. Details of proposed marketing and member education activities and events;

iv. A member education calendar, which begins with the date the signed Contract, between LDH and the Contractor, is approved by DOA/OSP: website development, printed materials, material distribution plans (including specific locations), outreach activities (health fairs, area events, etc.);

v. Distribution methods and schedules for all materials, including media schedules for electronic or print advertising (include date and station or publication);

vi. How the Contractor plans to meet the informational needs, relative to member education, for the physical and cultural diversity of the service area. This may include, but is not limited to: how the Contractor will meet the health literacy needs of membership and a description of provisions for non- English speaking individuals, language interpreter services, alternate communication mechanisms (such as sign language, braille, audio tapes);

vii. A list of all Subcontractors engaged in marketing or member education activities for the Contractor;

viii. The Contractor's plans to monitor and enforce compliance with all marketing and member education guidelines among internal staff and Subcontractors; and

ix. Copies of all marketing and member education materials (print and multimedia) the Contractor or any Subcontractor's plans to distribute that are directed at potential eligible members.

e. Any changes to the member education plan or included materials or activities must be submitted to LDH for approval at least thirty (30) days before the marketing or member education activity, unless the Contractor can demonstrate just cause for an abbreviated timeframe.

f. Written Materials Guidelines

a. The Contractor must comply with the following requirements as they relate to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.):

i. All member materials must be in a style and reading level that will accommodate the reading skills of members. In general the writing should be at no higher than a fifth grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to ensure accuracy:

1. Flesch – Kincaid;
2. Fry Readability Index;
3. PROSE The Readability Analyst (software developed by Educational Activities, Inc.);
4. Gunning FOG Index;
5. McLaughlin SMOG Index; or
6. Other computer generated readability indices accepted by LDH.

ii. LDH reserves the right to require evidence that member education materials have been tested against the fifth grade reading-level standard.

iii. All written materials must be clearly legible with a minimum font size of twelve-point, unless otherwise approved by LDH or required by 42 CFR §438.10.

iv. All written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.

v. Written materials critical to obtaining services, including information on how to request auxiliary aids and services, must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. Large print means printed in a font size no smaller than 18 point conspicuously-visible font size as defined in 45 CFR §92.8(f)(1).

vi. Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.

vii. All marketing activities should provide for equitable distribution of materials without bias toward or against any group.

g. Contractor Website Guidelines

a. The Contractor shall develop and maintain a customized website that provides online access to member service information. Prior written approval from LDH is required for all content appearing on the website. Web content shall be written in easily understood language at or below a fifth-grade reading level and shall follow the written materials guidance in this section.

i. The Contractor shall have a website established thirty (30) days prior to go-live. The Contractor must notify LDH when the approved website is available to the public and approved updates are made.

ii. The Contractor must remain compliant with HIPAA privacy and security requirements when providing member eligibility or member identification information on the website.

iii. The Contractor website should, at a minimum, be in

compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. The Contractor website must follow all written materials guidelines included in this section.

iv. Use of proprietary items that would require a specific browser is not allowed.

v. Forms on which members may file grievances, appeals, change in contact or address, feedback or recommendations to the Contractor shall be available and must be provided upon request of the member. The Contractor shall make all forms easily available on the Contractor's website.

vi. The Contractor must provide the following information on its website, and such information shall be easy to find, navigate, and understand by all members:

1. The most recent version of the member handbook;
2. Corporate and local telephone, mailing address and email contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number, with hours of operation;
3. A searchable list of network providers shall be updated in near real time, but at a minimum weekly, upon changes to the network;
4. Links to the LDH and CSoC websites;
5. The capability for members to submit questions and comments to the Contractor and receive responses;
6. Member eligibility information;
7. Information on how to access behavioral health services;
8. Explanation of available services, including crisis response services implemented through the Louisiana Crisis Response System;
9. Crisis response information and toll-free 24 hour Behavioral Health Crisis line telephone numbers;
10. General customer service information;
11. Information on how to file grievances and appeals;
12. Updates on emergency situations that may impact the public, such as natural and human-caused disasters that would require time sensitive action by members, such as evacuation from their homes or communities or other preparedness-related activities. The website shall include hyperlinks to state and Federal emergency preparedness websites;

13. Holistic health information and related links to health and wellness promotion articles and websites;

14. Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for members receiving services, their families/caregivers, providers, and stakeholders to become involved;

15. Information regarding advocacy organizations, including how members and other families/caregivers may access advocacy services;

16. Instructions on how to report suspected member or provider fraud and abuse;

17. Website address with direct links for the Integrated Medicaid Managed Care plan(s); and

18. Any other documents as required by LDH.

h. Member Communication/Education Required Materials and Services

a. The Contractor shall ensure all materials and services do not discriminate against Contractor members on the basis of their health history, health status or need, healthcare services, and any educational limitation (e.g., illiteracy). This applies to enrollment, materials and processes from the Contractor.

b. New Member Orientation

i. The Contractor shall have written policies and procedures to orient new members on the following, but not limited to:

1. What benefits and services are available;

2. How to utilize services;

3. What to do in an emergency or urgent medical situation;

4. How to report program integrity issues;

5. How to report critical incidents; and

6. How to a file a grievance and appeal.

ii. The Contractor shall submit a copy of the procedures to be used to contact members for initial member education in the Member Education Plan.

c. Welcome Letter

i. The welcome letter and member handbook shall be distributed to all new CSoC families through the WAAs by hard copy at the first face-to- face WAA/family meeting. A current, accurate hard copy provider directory will be provided to members upon request. This information shall also be available electronically through the website and comply with 42 CFR §438.10(c).

ii. The welcome letter and member handbook will be utilized by the Contractor throughout the Contract and during periods of transition if mandated by LDH.

iii. The Contractor shall adhere to the requirements for the member handbook and Provider Directory as specified in this Contract, its attachments/appendices, and in accordance with 42 CFR §438.10.

d. Additional Member Educational Materials and Programs

i. The Contractor shall prepare and distribute educational materials, including, but not limited to, the following:

1. Bulletins or newsletters distributed a minimum of once every six (6) months that provide information on preventive care, access to providers and other information that is helpful to members;

2. Literature, including brochures and posters, such as calendars, regarding all health or wellness promotion programs offered by the Contractor. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;

3. Identify and educate members who access the system inappropriately and provide continuing education as needed;

4. Notification to its members of any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date in accordance with 42 CFR §438.10(g); and

5. All materials distributed must comply with the relevant guidelines established by LDH for these materials or programs.

i. *Member Handbook*

a. The Contractor shall develop and maintain a Member Handbook, due to LDH at go-live, that adheres to the requirements in 42 CFR §438.10 and the written materials requirements listed in this section.

b. At a minimum, the Member Handbook shall include information required in 42 CFR §438.10(g)(2) and the following information:

i. Table of contents;

ii. A general description about how the Contractor operates, member rights and responsibilities, and appropriate utilization of services;

iii. CSoC eligibility requirements;

iv. Member's right to change providers within the Contractor (and how to);

v. The member's freedom of choice among Contractor providers and services and any restrictions;

vi. Member's rights and responsibilities, as specified in 42 CFR §438.100;

vii. Member's Bill of Rights;

viii. Information regarding the member call center and toll-free 24 hour Behavioral Health Crisis line;

ix. Information on how to report member or provider Fraud, Waste, and Abuse;

x. The amount, duration, and scope of benefits available to the Member under this Contract in sufficient detail to ensure that Members understand the benefits to which they are entitled;

xi. Procedures for obtaining benefits, including plan of care development and prior authorization requirements;

xii. Where to find medical necessity criteria on the Contractor's website and how to request hardcopies of medical necessity criteria;

xiii. Where and how to access behavioral health services, provider information (including emergency or crisis services), and a description of covered behavioral health services;

xiv. The extent to which, and how, after-hours, crisis and emergency coverage are provided, including:

1. What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a);

2. That prior authorization is not required for emergency services;

3. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;

4. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services, crisis response services, and post-stabilization services covered by the Contractor; and

5. That, subject to the provisions of 42 CFR Part 438 specific to emergency services, especially §438.114, which the Contractor shall summarize in the member handbook, the member has a right to use any hospital or other setting for emergency care.

xv. The post-stabilization care services rules set forth in 42 CFR §422.113(c);

xvi. That the member has the right to refuse to undergo any medical service or treatment or to refuse to accept any health service provided by the Contractor if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;

xvii. For counseling or referral services that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. The state shall provide information on how and where to obtain the service;

xviii. Grievance, appeal and fair hearing procedures that include the following:

1. The right to file grievances and appeals;

2. The requirements and timeframes for filing a

grievance or appeal;

3. The availability of assistance in the filing process;

4. The toll-free numbers that the member can use to file a grievance or an appeal by phone;

5. The fact that, when requested by the member:

    a. Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing;

    b. The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; and

    c. In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of LDH who has final authority to determine whether services must be provided as per LAC 50:I.3717.C.

6. For State Fair Hearing:

    a. The right to a hearing;

    b. The method for obtaining a hearing; and

    c. The rules that govern representation at the hearing.

xix. A description of advance directives which shall include:

1. The member's rights under state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the Member Handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;

2. Information that members can file grievances about the failure to comply with an advance directive with the LDH Health Standards Section;

3. Information about where a member can seek assistance in executing an advance directive and to whom copies should be given; and

4. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.

xx. How to make, change, and cancel appointments and the importance of canceling or rescheduling rather than being a "no-show";

xxi. A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;

xxii. Family's/caregiver's or legal guardian's role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families;

xxiii. Generic information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult's engagement, resilience, strength-based and evidence-based practice, and best/proven practices;

xxiv. Information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;

xxv. Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment;

xxvi. How to identify and contact the WAAs and FSO;

xxvii. How to obtain emergency and non-emergency medical transportation;

xxviii. Information about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services;

xxix. Instructions on how to request multi-lingual interpretation (oral) and written translation when needed at no cost to the member in accordance with the *Notice to Members of Provider Termination and Changes* section. This instruction shall be included in all versions of the handbook in English, Spanish and Vietnamese;

xxx. Names, locations, telephone numbers of, and non-English languages spoken by current network providers including identification of providers that are not accepting new patients. This may be a summary of information with reference to the website of the Contractor where an up-to-date listing is maintained and details on using the web-based provider directory;

xxxi. Information on the member's right to a second opinion at no cost and how to obtain it;

xxxii. Any additional text provided to the Contractor by LDH or deemed essential by the Contractor;

xxxiii. The date of the last revision;

xxxiv. The mechanism by which a member may submit, whether oral or in writing, a service authorization request for the provision of services; and

xxxv. Additional information that is available upon request, including the following:

1. Information on the structure and operation of the Contractor;

2. Pharmacy location or medication information availability;

3. Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and

4. Service utilization policies.

c. The Contractor shall review the Member Handbook at least annually. If the Contractor makes changes to the Member Handbook, the Contractor shall notify members of the revisions on a timely basis. Documentation of the handbook's distribution shall be included in the care management record. Updated hard copies will be provided to members upon request.

d. The Contractor shall provide members or their families/caregivers receiving services with written notice of significant changes related to member rights, advance directives, grievances, reconsiderations or state fair hearings at least thirty (30) days in advance of the intended effective date.

e. Unless otherwise instructed by LDH, the Contractor shall distribute, in sufficient quantities, the member handbook to WAAs and other CSoC system partners at least thirty (30) days prior to Contract go-live and when requested.

f. The Contractor shall provide the member with a member handbook within a reasonable time after receiving notice of the member's enrollment in accordance with 42 CFR §438.10(g) (1).

j. *Provider Directory for Members*

a. The Contractor shall develop and maintain a Provider Directory in a web-based, searchable, machine readable, mobile-enabled, online directory for members and the public in compliance with 42 CFR §438.10(h). The directory shall be made available to members in paper form upon their request.

b. The Contractor shall submit the file layout for the electronic directory to LDH for approval within thirty (30) days from the date the Contract is approved by DOA/OSP.

c. The hard copy directory for members shall be updated at least quarterly. Inserts shall be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in near real time, however no less than weekly. The electronic version shall be updated prior to each submission to the Medicaid Fiscal Intermediary. While daily updates are preferred, the Contractor shall, at a minimum, submit no less than weekly.

d. In accordance with 42 CFR §438.10(h), the Provider Directory shall include, but not be limited to:

i. Names, including any group affiliation, street address, locations, telephone numbers, website URL if applicable, including whether the provider or hospital is accepting new Medicaid patients, whether the provider offers covered services via telehealth, and cultural and linguistic capabilities by current network providers by each provider type specified in this Contract in the Member's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office;

ii. Indication of populations served by the provider (e.g., age range of clients) and specialties;

iii. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;

iv. Identification of any restrictions on the member's freedom of choice among providers;

v. Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours); and

vi. Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.

vii. Identification of providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.

viii. Identification of provider's gender, race, and ethnicity, if available.

e. LDH reserves the right to request in writing additional data needed for enhancements to the provider search function.

f. LDH reserves the right to conduct periodic audits to verify the accuracy of the Contractor's Provider Directory data. LDH will utilize full discretion in determining the audit type, criteria, and methodology. LDH may penalize the Contractor for inaccurate Provider Directories using one (1) or more remedies in the *Remediation* section

k. *Member Service and Call Center Staff*

a. Call center staff provide the single point of entry for all individuals that seek information about the Contractor's services. This includes members or others calling on behalf of members. Call center staff obtain demographic information and emergency contact information from members and their families/caretakers; gather insurance information, including Medicaid eligibility; and assist callers in accessing information on member rights and benefits, obtaining services, and filing grievances. The call center staff determines the reason for the call and transfers the call to the appropriate party within the Contractor's operations or provides contact information. For members seeking services or information related to their services or plan of care, the call center staff will transfer the call to a Care Manager.

b. Member services representatives must be trained in the geography of Louisiana as well as culture and correct pronunciation of cities, towns, and surnames.

c. The Contractor's member services department shall operate as the common single point of entry for all services and perform the following functions:

i. The Contractor shall maintain a toll-free member service call center, physically located in Louisiana, with dedicated staff to respond to member questions including, but not limited to such topics as:

1. Explanation of Contractor policies and procedures;

2. Prior authorizations;

3. Access information;
4. Information on specialists;
5. Referrals to Integrated Medicaid Managed Care Program Plans;
6. Resolution of service or service delivery problems; and
7. Member grievances and appeals.

d. The toll-free number must be staffed twenty-four (24) hours per day, seven (7) days per week for crisis response and service authorization by care managers.

e. The member line shall be answered by a live voice at all times.

f. There shall be twenty-four (24) hour access to an LMHP and board certified psychiatrist as required to provide clinical consultation.

g. The Contractor shall have sufficient telephone lines and staff available to answer incoming calls. LDH reserves the right to specify staffing ratio or other requirements if it is determined that the call center staffing/processes are not sufficient to meet member needs as verified by LDH through call management metrics, member surveys, unplanned call center assessments, or Contractor independent evaluation methods.

h. The Contractor must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain required call center access standards. The Contractor must develop and implement a plan to sustain call center performance in situations where there is high call/email volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.

i. The Contractor must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The Contractor shall submit any new telephone help line policies and procedures to LDH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The Contractor call center must have the capability to produce an electronic record to document a synopsis of all calls.

j. The Contractor shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll- free telephone line. The Contractor shall submit call center quality criteria and protocols to LDH for review upon request. The Contractor shall provide a member service approach that ensures working with all parties involved with the member to establish program eligibility. The Contractor shall interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner. The Contractor shall provide to LDH upon request copies of the member call center script and any screening, evaluation, and assessment tool used in coordinating any caller’s care or needs.

k. The Contractor shall work with individuals and their families/caregivers/guardians to obtain eligibility for other

support services, including but not limited to those available from Medicaid and community organizations. For complex eligibility matters, members should be referred to the Contractor's care management staff.

l. The Contractor shall assist and inform individuals and their families/caregivers about required eligibility documents or obtaining such documentation.

m. The Contractor shall provide general assistance and information to individuals and their families seeking to understand how to access care in either the private or public sector. For the CSoC eligible members, provide information to families about the specialized services available for this population.

n. The Contractor shall facilitate access to information on available service requirements and benefits.

o. The Contractor shall inform individuals or family members of required documents needed to prove citizenship for Title XIX and Title XXI eligibility, and assist in obtaining such documentation.

p. The Contractor shall refer reconsiderations, appeals and Quality of Care issues to Contractor's care manager or other designated staff to handle.

q. The Contractor's call abandonment rate shall not exceed five percent (5%) monthly.

r. The call center shall utilize a language line translation system for callers whose primary language is not English. Assistance should include, but not be limited to, use of qualified peer support for this service. This service shall be available twenty-four (24) hours a day, seven (7) days a week, and three hundred and sixty- five (365) days a year.

s. The Contractor shall have available, at all times, a Telecommunications Device for the Deaf (TDD) or relay systems.

t. LDH shall own the rights to the toll-free call center number. It is anticipated that this number will be transitioned from the incumbent Contractor to a new Contractor, or to the State, at the end of the Contract term.

u. The Contractor shall ensure the toll-free number is publicized throughout Louisiana. All costs of publication shall be paid by the Contractor.

v. The Contractor shall assist and triage callers who may be in crisis by effectuating an immediate transfer to a care manager. The call shall be answered by the care manager within sixty (60) seconds and only transferred via a warm line to a care manager. The Contractor shall respect the caller's privacy during all communications and calls.

w. The Contractor shall provide general information and orientation regarding all aspects of the program and operations. The Contractor shall have in place a comprehensive program through the call center to provide all members, not just those who access services, with appropriate information, such as information about behavioral health services, available providers, and education related to recovery, resilience and best practices, as well as member rights.

x. The Contractor shall supply LDH, upon request, a call center report with call management metrics in a format determined by LDH.

I. 24-Hour Behavioral Health Crisis Line

a. The Contractor shall maintain a twenty-four (24)-hour toll-free crisis response center to respond to specialized behavioral health needs. The call center may be combined with the Contractor's member service call center line or may be a separate line, but must:

   i. Provide access to staff Twenty-four (24) hours a day, seven (7) days a week;

   ii. Answer with a live voice at all times within thirty (30) seconds;

   iii. Have sufficient telephone lines to answer incoming calls and meet performance standards set forth in this Contract;

   iv. Assist and triage callers who may be in crisis by effectuating an immediate transfer via a warm line to an LMHP for those who need a higher level of clinical skill, or a Recognized Peer Support Specialist (RPSS) or Recognized Family Peer Support Specialist (RFPSS).

   v. Be staffed with an adequate number of LMHPs overseeing clinical triage and other trained staff to handle to all calls received;

   vi. Coordinate connections to crisis mobile response team services closest to the Enrollee's location at the time of crisis;

   vii. Schedule outpatient follow-up appointments via a warm handoff to support connection to ongoing care following a crisis episode; and

   viii. Connect Enrollees to facility-based care through warm handoffs and coordinate transportation as needed.

b. During each call, behavioral health crisis line staff shall:

   i. Try to resolve the crisis over the phone, and if needed will provide assistance in accessing face-to- face intervention, arranging an urgent outpatient appointment, or providing phone consultation with an LMHP if a higher level of clinical skill is needed.

   ii. Engage individuals in a respectful and rapport-building manner providing assessment of risk of suicide for every call in a manner that meets National Suicide Prevention Lifeline standards and minimizes danger to others;

   iii. Initiate emergency response services when needed to secure the immediate safety of the Enrollee if the Enrollee is in need of medically necessary rescue services for an emergency medical need or when there is a concern for public safety;

   iv. Use call processing protocols (e.g., Robert's Model of Crisis Intervention), standardized risk assessments/instruments, and triage protocols to determine level of response for each call;

   v. Use de-escalation and resolution techniques by engaging Enrollees in brief phone-based counseling and intervention to de-escalate the crisis with the goal of determining appropriate level of need and resolving the situation so that higher levels of care

are not necessary;

vi. Practice active engagement with persons calling on behalf of an Enrollee to determine the least invasive, most collaborative actions to best ensure the safety of the person at risk; and

vii. Connect Enrollees to clinically appropriate additional care that uses the least invasive intervention and considers involuntary emergency interventions as a last resort.

c. The Contractor should use workforce management technology and tools to ensure adequate coverage of call volume and efficiencies and require internal monitoring of behavioral health crisis call processes. This can include coordinating overflow coverage with a resource that meets all 24-hour behavioral health crisis line expectations as outlined within the *Louisiana Crisis Response Companion Guide* when implemented.

d. In addition to standard call center reporting metrics, the Contractor shall report on 24-hour behavioral health crisis line specific functions, including, but not limited to, service level, call resolution, crisis mobile response team dispatch, and involvement of law enforcement or EMS, as specified by LDH.

e. For the 24-hour behavioral health crisis line, the Contractor shall incorporate Caller ID functionality in collaboration with partner crisis mobile response teams to more efficiently dispatch care to Enrollees in need.

f. The Contractor must have an after-hours system to route emergent and crisis behavioral health calls outside of its Enrollee services hours of operation in order to ensure Enrollees in crisis are able to access crisis services necessary to meet their needs.

m. *Automated Call Distribution (ACD) System*

a. The Contractor shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:

i. Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;

ii. Transfer calls to other telephone lines;

iii. Provide detailed analysis as required for the reporting requirements including but not limited to: the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred, hold time, abandonment rate, wait time, busy rate, response time, and call volume;

iv. Provide a message that notifies callers that the call may be monitored for quality control purposes;

v. Measure the number of calls in the queue at all times, particularly peak times;

vi. Measure the length of time callers are on hold;

vii. Measure the total number of calls and average calls handled per day/week/month;

viii. Measure the average hours of use per day;

ix. Assess the busiest times and days by number of calls;

x. Record calls to assess whether answered accurately;

xi. Measure and report average speed to answer;

xii. Establish separate call tracking and record keeping for tracking and monitoring provider and member phone lines;

xiii. Track and report on nature of calls;

xiv. Track and monitor call abandonment rates, which shall not exceed five percent (5%) monthly;

xv. Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines are not disrupted;

xvi. Record types of calls and call responses (e.g., where the member was referred); and

xvii. Inform the member to dial 911 if there is an emergency.

b. The Contractor must conduct ongoing quality assurance to ensure these standards are met.

c. If LDH determines that it is necessary to conduct onsite monitoring of the Contractor's member call center functions, the Contractor is responsible for all reasonable costs incurred by LDH or its authorized agent(s) relating to such monitoring.

n. *Members' Rights and Responsibilities*

a. Member Rights

i. The rights afforded to current members are detailed in the Member's Bill of Rights. A Member's Bill of Rights shall be provided to members or their families/caregivers/guardians as part of the new member information in the welcome letter and in the member handbook, and upon request by a member or his/her family/caregiver/guardian. The information shall be written at a reading comprehension level no higher than a fifth grade level, or as determined appropriate by LDH. The minimum written information shall address 42 CFR §438.100 and include:

1. The right to diagnosis, arrangement of plan of care, and appropriate treatment and services to the fullest extent possible; these services should be provided timely and with written documentation.

2. The right to receive information as described in 42 CFR §438.10 and as outlined in this Contract.

3. The right to be treated with respect and with due consideration for his or her dignity and privacy.

4. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the

member's condition and ability to understand.

5. The right to receive rehabilitative services in a community or home setting.

6. The right to participate in decisions regarding his/her care, or decisions for care of someone for whom they serve as legal guardian, including the right to refuse treatment, and the right to the following:

    a. Complete information about his/her specific condition and treatment options, regardless of cost or benefit coverage, and the right to seek second opinions;

    b. Information about available experimental treatments and clinical trials and how such research can be accessed; and

    c. Assistance with care coordination.

7. The right to be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation, or convenience. Restraint and seclusion may only be utilized by facilities in emergency situations to prevent an imminent threat of extreme violence or self-destructive behavior.

8. The right to appeal or express a concern about the Contractor, or the care it authorizes, and receive a response in a reasonable period of time.

9. The right of the member or his/her legal guardian to receive a copy of treatment records, including the right to request that the records be amended or corrected as allowed in 45 CFR Part 164.

10. The right to determine to whom and what portions of his or her treatment records are released to a third party.

11. The right to access one's attorney or legal representatives, including access to facilities for private communication.

12. The right to implement an advance directive as required in 42 CFR §438.10(g)(2); update written information as required in 42 CFR §438.6(i)(3) and (4), which specifies that the written information shall reflect changes in state law as soon as possible, but no later than ninety (90) days after the effective date of change; and the right to file a grievance concerning noncompliance with the advance directive requirements to LDH or other appropriate certification or licensing agencies, as allowed in 42 CFR Part 438 Subpart I.

13. The right to choose his or her provider to the extent possible and appropriate, in accordance with 42 CFR §438.6(m).

14. The right to be furnished behavioral

healthcare services in accordance with 42 CFR §438.206 through §438.210.

15. Freedom to exercise the rights described herein without any adverse effect on the Member's treatment by LDH, the Contractor, Subcontractors, or network providers.

16. The right to be treated with dignity and respect by a professional, competent, and ethical work force in the least restrictive manner as possible.

17. The right to a safe treatment environment that affords protection from harm and appropriate personal privacy.

18. The right to be given the opportunity to practice one's spirituality on a voluntary basis, limited only when inconsistent with safety and order of operations for the facility.

19. The right to engage in appropriate leisure, recreational, and other activities.

20. The right to refuse treatment or services unless ordered by a court to participate, or unless such refusal would pose a danger to self or others.

21. The right to receive reasonable accommodations in accordance with the Americans with Disabilities Act including but not limited to provision of supports and services.

22. The right to exercise the entitlements described in this Member Bill of Rights without punishment, including punishment in the form of denial of any appropriate, available treatment.

23. In accordance with La. R.S 28:171, the right to not be presumed incompetent or held incompetent except as determined by a court of competent jurisdiction. The determination of incompetence shall be separate from the judicial determination of whether the person is a proper subject for involuntary commitment.

24. The right to be informed of the aforementioned rights both orally and in writing upon admission and upon request.

ii. The Member Bill of Rights shall be in addition to, and not in place of, any other statutory rights.

iii. The Member Bill of Rights shall not be interpreted so as to contradict or conflict in any way with any applicable provision of Federal or state laws, rules, or regulations.

b. Member Responsibilities

i. The Contractor shall encourage each member to be responsible for his/her healthcare by becoming an informed and active participant in his/her care, including parents/caretakers/guardians for child and youth members. Members have the responsibility to cooperate fully with providers in following mutually

acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their healthcare provider promptly if serious side effects and complications occur, or worsening of the condition arises.

ii. The Contractor shall furnish members with both verbal and written information about the nature and extent of the responsibilities as a member of the Contractor. The Contractor must have written policies on member rights.

iii. The Contractor members' responsibilities shall include but are not limited to:

1. Being familiar with Contractor procedures to the best of the member's abilities;

2. Calling or contacting the Contractor to obtain information and have questions answered;

3. Providing participating network providers with accurate and complete medical information;

4. Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;

5. Living healthy lifestyles and avoiding behaviors known to be detrimental to their health;

6. Following the grievance and appeals process established by the Contractor if they have a disagreement with a provider or the Contractor;

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

8. Keeping any agreed upon appointments, follow-up appointments, accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.

iv. The Contractor shall have written policies regarding member rights and responsibilities. The Contractor shall comply with all applicable state and Federal laws pertaining to member rights and privacy. The Contractor shall further ensure that the Contractor's employees, Contractors and Contractor providers consider and respect those rights when providing services to members.

o. *Notice to Members of Provider Termination and Changes*

a. Provider Contract Termination and Changes

i. If a member has been receiving a prior authorized course of treatment, the Contractor shall provide notice to the member or the parent/legal guardian as appropriate or the custodial state agency if

applicable when the treating provider becomes unavailable or is terminated.

ii. The Contractor shall provide notice to the member, if a member has been receiving a prior authorized course of treatment, to the later of thirty (30) calendar days prior to the effective date of the termination or fifteen (15) calendar days after the receipt or issuance of the notice, of the Contractor becoming aware of a provider becoming unable to care for members for reasons including but not limited to an illness, death, relocation from the service area, when a provider fails credentialing or when a provider is displaced as a result of a natural or man-made disaster.

iii. When the termination was initiated by the provider, once the Contractor becomes aware, to the later of thirty (30) calendar days prior to the effective date of the termination or within fifteen (15) calendar days after the receipt or issuance of the notice, the Contractor shall make a good faith effort to give written notice of a provider's termination to each member who received care from or was seen on a regular basis by the provider.

p. *Oral and Written Interpretation Services*

a. In accordance with 42 CFR §438.10(c) and (d), the Contractor must make real-time oral and signing interpretation services (bilingual staff and licensed sign language interpreters to deliver oral interpretation, translation, sign language, disability- related services, provide auxiliary aids and alternative formats) available free of charge to each member and member's family. This applies to all non-English languages, not just those that Louisiana specifically requires in written translation (Spanish and Vietnamese). The Contractor must notify its members that oral and signing interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.

b. Member education materials shall be available in English, Spanish, and Vietnamese. In addition, the Contractor shall ensure that translation services are provided for written member education materials and provided in any language that is spoken as a primary language by at least five percent (5%) of Contractor members. LDH-BHSF will provide the Contractor with a list of prevalent non- English languages spoken by members by parish via the Preferred Language Statewide by Parish link. Written materials must also be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Within ninety (90) calendar days of notice from LDH, materials must be translated and made available. Materials must be made available at no charge in that specific language to afford a reasonable chance for all members to understand how to access the Contractor and use services appropriately.

c. Contractor must notify members, in writing, that alternative formats are available and how to access them. The Contractor website must follow all written materials guidelines included in this section.

2. Provider Network Requirements

a. *General Provider Network Requirements*

a. The Contractor must maintain a network of qualified Medicaid behavioral health providers and waiver service providers that is supported by written network provider agreements and that is sufficient in numbers and locations to provide adequate access to all services covered under this Contract for all members, including those with limited English proficiency or physical disabilities.

b. The Contractor is expected to maintain and enhance its existing network that provides a comprehensive array of behavioral health services with a geographically convenient flow of members among culturally-competent, qualified network providers as necessary to meet their identified needs. The provider network shall be designed to reflect the needs and service requirements of the CSoC member population.

   i. The Contractor shall be required to contract with at least one Federally Qualified Health Center (FQHC) in each LDH region if there is an FQHC which can provide substance use disorder services or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications. Contractor will notify LDH if there are any barriers or issues with contracting with FQHCs.

   ii. The Contractor shall be required to maintain within its network a sufficient number of Wraparound agencies and providers of specialized CSoC services including Family Support Organization(s) which provide Youth Support and Training (YST), Parent Support and Training (PST), as well as providers of Independent Living/Skills Building (ILSB) and Short Term Respite (STR).

   iii. The Contractor shall be required to contract with State Opioid Treatment Authority-approved Opioid Treatment Programs (OTP) for the administration of Methadone and clinical treatment services for members in accordance with State and Federal regulations.

c. The Contractor is expected to begin the contract with a provider network that, at a minimum, will include all eligible behavioral health service providers meeting Federal and state rules, laws and regulations, who were contracted to participate in the CSoC provider network on November 1, 2018.

d. The Contractor shall maintain and expand its provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital admissions. The Contractor will notify LDH when barriers to expansion are encountered.

e. The Contractor will work with the providers offering services as necessary to address the needs of those eligible for the CSoC. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.

f. The Contractor shall ensure its provider network offers an appropriate range of specialty behavioral health services that is adequate for the anticipated number of members for the service area, including compliance with the waivers and Medicaid State Plan requirements.

g. The Contractor is required to contract with providers of behavioral health services who:

   i. Are appropriately licensed or certified;

   ii. Meet the certification and applicable licensing criteria;

   iii. Meet accreditation and other Federal and state requirements, inclusive of requirements and qualifications established in the Medicaid Behavioral Health Services Provider Manual, as applicable;

   iv. Agree to the standard contract provisions; and

   v. Elect to participate.

h. The Contractor shall ensure that within the provider network, recipients have a choice of providers, which offer the appropriate Level of Care (LOC) and may change providers in accordance with 42 CFR §438.3(l) and the Medicaid home and community-based waiver requirements pertaining to Freedom of Choice (FOC).

i. The Contractor shall maintain a directory of qualified providers divided into specific types of services and types of members the provider serves. The directory will continue to be made available to the public in near real time through the Contractor website and to members, the member's family/caregiver, and referring providers in electronic format. The Contractor provider types shall match the provider types approved in Louisiana and be delineated by zip code.

j. The Contractor shall ensure that the network has a sufficient number of prescribers and other qualified service providers to deliver services during evenings and weekends. The Contractor shall ensure that services included in this contract are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary.

k. The Contractor shall provide technical assistance and network development training (e.g., billing, CSoC services and authorization, linguistic/cultural competency, etc.) for its providers and maintain records of such training, which shall be made available to LDH upon request.

l. The Contractor shall respond to provider inquiries by coordinating with, or expeditiously referring inquiries to, persons within the Contractor's organization that can provide a timely response and shall be responsible for:

   i. Expeditiously developing network provider agreements and enforcing the agreement terms.

   ii. Managing the seamless transition of services or providers for members because of a change in network composition.

   iii. Performing credentialing of qualified service providers consistent with 42 CFR §438.214 and applicable state regulations, including credentialing of prescribers, practitioners, facilities, providers and WAAs. The process the Contractor uses to conduct credentialing and re-credentialing shall be submitted to LDH for approval within thirty (30) business days of Contract approval by DOA/OSP.

   iv. Ensuring that provider complaints are acknowledged within three (3) business days of receipt; resolve or state the result communicated to the provider within

thirty (30) calendar days of receipt (this includes referrals from LDH). If not resolved in thirty (30) calendar days, the CSoC Contractor must document why the issue goes unresolved; however, the issue must be resolved within ninety (90) calendar days.

m. The Contractor shall evaluate every prospective provider's qualifications and ability to perform the activities to be delegated prior to contracting with any provider. The Contractor must ensure the provider has not been found to have committed fraud as per the requirements in the *Program Integrity* section of this Contract.

n. All network providers shall be in compliance with Americans with Disabilities Act (ADA) requirements and provide physical access for members with disabilities.

o. The Contractor is not obligated to continue to contract with a provider that:

    i. Does not meet the contractual standards (e.g., fails to meet all health and safety standards and maintain all required Health Standards licenses),

    ii. Does not meet provider qualifications and requirements as established by the Medicaid Behavioral Health Services Provider Manual,

    iii. Does not meet provider qualifications and requirements as established by Federal and state rules, laws and regulations,

    iv. Does not provide high quality services, or

    v. Demonstrates outlier utilization of services compared to peer providers with similarly acute populations based on the expectations of the Contractor and LDH.

p. The Contractor shall not discriminate.

    i. The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

    ii. The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification in compliance with 42 CFR §438.12.

    iii. The prohibition of provider discrimination found in 42 CFR §438.12(a) may not be construed to:

        1. Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members.

        2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

        3. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members.

q. If the Contractor declines to include individuals or groups of providers in its provider network, it must notify LDH and give the affected providers written notice of the reason for its decision within fourteen (14) calendar days of its decision.

r. The Contractor shall at least semi-annually validate provider demographic data to ensure that current, accurate, and clean data is on file for all network providers.

s. The Contractor shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty- four (24) hours per day, seven (7) days per week. Crisis services shall include an on-call, 24-hour crisis hotline, crisis counseling, mobile crisis response teams, community brief crisis support, crisis intervention and follow up, linkage to ongoing behavioral health management and intervention, and crisis stabilization for children. Crisis services will be delivered in the least restrictive setting using approaches that minimize the use of coercive interventions. These crisis services will allow Enrollees to receive services in the community rather than in EDs when there are no medical or other contraindications to doing so. The Contractor shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. This includes utilizing standardized processes for the 24-hour behavioral health crisis line and referral to crisis response services developed through the Louisiana Crisis Response System and as outlined within the Louisiana Crisis Response System Companion Guide.

t. The Contractor shall develop, maintain and provide LDH and members access to an electronic provider directory that contains near real time information identifying, according to zip code and by provider type, provider availability, and any member parameters for service population (e.g., child, Spanish-speaking, etc.).

u. The Contractor shall not subcontract network management, network reporting, or assurance of network sufficiency.

v. If shortages in provider network sufficiency are identified, the Contractor shall perform outreach and recruiting efforts to enhance and further develop needed access to providers. The Contractor will execute single case agreements when a clinical need is identified for a member and no network provider is available to meet that particular need.

w. The Contractor shall comply with network and payment requirements for members who are identified as Indians in accordance with 42 CFR §438.14.

x. The Contractor shall also coordinate with community resources, including but not limited to, law enforcement, emergency departments, statewide and regional crisis coalitions, dispatch call centers, and emergency management service organizations personnel, to expand the crisis response. The community-based crisis response system may include other innovative approaches to crisis services beyond that which is established as reimbursable through the Louisiana Medicaid Program. The Contractor shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.

y. The Contractor will work with LDH on strategies to reduce the need for services delivered in EDs, or the involvement of law enforcement in crisis response when it can be safely

avoided. This includes the use of law enforcement for transportation.

z. The Contractor shall educate Enrollees on the availability of crisis services, and the statewide phone number for accessing the services.

aa. The Contractor shall work with LDH and other entities as identified by LDH to develop a robust continuum of behavioral health crisis responses that includes services ranging across the crisis continuum to include the following:

i. Crisis prevention and crisis planning by outpatient treatment providers;

ii. Early crisis intervention by outpatient treatment Providers;

iii. Acute crisis intervention;

iv. Crisis treatment (including alternatives to inpatient treatment); and

v. Post-crisis supports and strategies to prevent need for extended inpatient or admission to other congregate living.

bb. The Contractor will also be responsible for facilitating or participating in state/local crisis system of care collaborative/workgroups with a focus on care coordination, review of performance data, assessment and remediation of gaps and needs, and other crisis system improvement strategies.

cc. The Contractor must ensure that Contractor's staff who have direct Enrollee contact know the continuum of community resources for behavioral health crisis services, including crisis lines and the appropriate crisis services available within each region.

dd. The Contractor must train Contractor's staff who interface with the public or have direct Enrollee contact how to connect (through direct linkages) Enrollees in need of behavioral health crisis services to the appropriate crisis services.

ee. The Contractor must track and document behavioral health crisis contacts from Enrollees and ensure that this information is shared as soon as possible and no later than the next Business Day with the Contractor case manager, community case management Provider, Assertive Community Treatment (ACT) Team if appropriate or other behavioral health Provider for appropriate follow-up.

ff. The Contractor will perform Timely authorization, if required, for crisis services in order to minimize wait time before those services can commence and to assure the efficient operation of the crisis system of care.

gg. The Contractor must contract with all Providers identified by LDH as eligible to provide crisis services. When there are instances of quality concerns that place the provider’s contract in jeopardy, the Contractor must immediately notify LDH if it is not willing to contract with a particular crisis Provider and must collaborate with LDH on next steps, which must include a plan to assure Timely delivery of services in the geographic area covered by the Provider of concern.

hh. The Contractor must monitor crisis Providers for compliance with LDH's standards and guidance using a standardized

protocol as specified by LDH. As directed by LDH, the Contractor must coordinate monitoring activities with other Contractors.

b. *Network Development and Management Plan*

a. The Contractor shall develop, implement and maintain a provider Network Development and Management Plan. Contractor will address barriers to CSoC waiver and non-waiver service development with the goal of ensuring that the provision of specialized behavioral health and waiver services to CSoC children/youth will occur consistent with the goals and principles of LDH [42 CFR §438.207(b)].

b. The Network Development and Management Plan shall be submitted to LDH when significant changes to the network occur as defined in 42 CFR §438.207(c)(3). The Plan shall include the Contractor's process to develop, maintain, manage and monitor the provider network that is supported by written agreements and is sufficient to provide adequate access to all required services included in the Contract. A Network Development and Management Plan for purposes of implementation shall be submitted to LDH within thirty (30) days of Contract approval by DOA/OSP, if requested by LDH, and annually thereafter.

c. The plan shall contain separate sections for each provider type for covered services described in this Contract.

i. In establishing and maintaining the network and in developing the network plan, the Contractor shall consider and report on the following:

1. CSoC enrollment.

2. Utilization of services, taking into consideration the characteristics and behavioral healthcare needs of Members.

3. The numbers of network providers who are not accepting new Medicaid patients.

4. The geographic location of providers and Medicaid enrollees, considering distance, the means of transportation ordinarily used by Medicaid enrollees, waiver requirements, and whether the location provides physical access for Medicaid enrollees with disabilities.

5. Development of network capacity in collaboration with state agencies, with the understanding that the network capacity requirements may change due to the needs of individual children.

6. Development and implementation of policies and procedures to monitor and demonstrate that the network is of size, scope, and types of providers to deliver all covered behavioral health services and satisfy all the service delivery requirements of this Contract and the Medicaid Behavioral Health Services Provider Manual.

7. If the Contractor is not able to deliver a medically necessary covered behavioral health service, the Contractor must adequately and timely cover these services utilizing an out-of-network provider to deliver

the same service via a provider with at least the same type of training, experience, qualifications and specialization as within the provider network. The Contractor shall authorize services in accordance with the *Care and Utilization* section and reimburse the out-of-network provider in these circumstances in accordance with the *Provider Payment*s section.

8. Out-of-network providers shall meet at least a minimum standard of qualification. Out of state providers shall have proof of the equivalent of Louisiana licensing requirements. In state providers shall be licensed with HSS or the respective state board or agency. All out-of- network providers shall have applicable accreditations. Upon request, the Contractor shall submit proof to LDH of the out-of- network provider meeting these requirements.

9. If a member needs a specialized service that is not available through the network, the Contractor will arrange for the service to be provided outside the network if a qualified provider is available. Transportation will be provided and reimbursed through Medicaid when eligible.

d. The Network Development and Management Plan shall also include the following requirements:

i. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted behavioral health services and CSoC services, including providers specializing in services (e.g., Developmentally Disabled (DD) population, sexual offending behaviors, and early childhood development) that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated enrollees.

ii. An annual needs assessment to identify unmet service needs in the service delivery system. The needs assessment shall analyze and include:

1. Volume of single case agreements and out-of-network referrals;

2. Specialized service needs of members; and

3. Growth trends in eligibility and enrollment, including:

a. Barriers to sufficiently addressing unmet needs;

b. What has been done to address unmet needs; and

c. Current and desired service utilization trends, including prevalent diagnoses; age, gender, and race/ethnicity and cultural characteristics of the enrolled population by CSoC region; best practice approaches; and network and contracting models consistent

with LDH, CSoC, and Wraparound Goals and Principles.

iii. What has been done to address unmet needs, accessibility of services, including:

1. The number of current network providers by individual service in the network who are not accepting new referrals or new Medicaid members and plan for updating on a regular, reoccurring basis as close to real time as possible.

2. The geographic location of providers and members considering distance, and available means of transportation.

3. Availability of services and appointments with physical access for persons with disabilities.

4. Any service access standards detailed in a SPA or waiver.

iv. GEO mapping and coding of all network providers for each provider type to LDH quarterly, upon material change or upon request.

v. The Network Development and Management Plan shall state that the CSoC Contractor‘s provider network meets the requirements with regard to cultural competence and linguistics as follows:

1. Cultural competence and linguistic needs, including the member’s prevalent language(s) and sign language in accordance with 42 CFR §438.206 and §440.262

2. Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by:

a. Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required);

b. Assessing the cultural competence of the providers on an ongoing basis, at least annually;

c. Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.;

d. Assessing provider satisfaction ofthe services provided by the CSoC Contractor at least annually; and

e. Requiring and providing training on cultural competence, including tribal awareness, by obtaining proof of attendance at trainings to CSoC Contractor staff and network providers for a minimum of three (3) hours per year and as directed by the needs assessments.

3. For the purpose of effective communication, the Contractor will ensure people with vision, hearing, or speech disabilities can communicate with, receive information from, and convey information to, the Contractor and those with whom the Contractor subcontracts or enters into a network provider agreement. The covered entity must provide appropriate services when needed to communicate effectively with people who have communication disabilities with regard to the nature, length, complexity, and context of the communication and the person's normal method(s) of communication. Effective communication applies to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, caregiver, custodian, spouse, or companion, in appropriate circumstances.

vi. The Contractor shall include in the plan strategies for continued transformation of service delivery into a comprehensive system that:

1. Includes network providers designed and contracted to deliver care that is strength-based, family-driven, community-based, and culturally competent.

2. Is of sufficient size and scope to offer members a choice of providers for all covered behavioral health services.

3. Develops and expands the use of evidence-based models to deliver covered services. Evidence-based practice (EBP) models may be used by providers to deliver covered services such as LMHP services, CPST services, and PSR services. To develop and expand the use of EBP models, the Contractor may use strategies inclusive of UM and CM protocols that link members to providers using EBP models, recruiting providers trained in EBP models into the network, Contractor-provided workforce development to increase the percentage of network providers who are trained in EBP models, or value- based payment strategies to support both the recruitment and retention of trained EBP providers in the network.

4. Includes specific services for children eligible for CSoC as defined in this Contract.

5. Targets the development of family and community-based services for children/youth

in out-of-home placements based on services as defined in the Medicaid Behavioral Health Services Provider Manual.

6. Contractor will work with WAA providers to increase access to family and community-based services, optimizing the use of natural and informal supports and reducing reliance on out-of-home placements.

7. Improves and increases services available for individuals with behavioral health and developmental disabilities, including autism spectrum disorders, which incorporates reducing health disparities and includes long-range fiscal planning to promote training and fiscal sustainability.

8. Assesses annually the number of providers serving members with behavioral health and developmental disabilities and if the needs are being met for this population in the state. This assessment shall include:

    a. How many members being served out-of- state due to lack of appropriate services in- state;

    b. If these providers have waiting lists; and

    c. If access to care standards are being met by these providers.

vii. Maintain minimum standards for certified peer and family support as set by LDH.

viii. Documentation of accessibility to a sufficient number of qualified oral interpreters, bilingual staff, and licensed sign language interpreters to deliver oral interpretation, translation, sign language, disability-related services, provide auxiliary aids and alternative formats, including formats accessible to the visually impaired.

ix. A process for expedited and temporary credentials for out of network providers. Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management, utilization, administrative and onsite audits and provider profiling.

x. An evaluation of the initial Network Development and Management Plan, including evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions.

e. Upon request and as part of its Network Development and Management Plan, the Contractor shall submit provider profiling data to LDH that includes:

    i. Eligibility/enrollment data;

    ii. Utilization data;

    iii. The number of single case agreements by service type;

    iv. Treatment and functional outcome data;

    v. Members diagnosed with developmental/cognitive

disabilities;

vi. Number of prescribers required to meet behavioral health members' medication needs;

vii. Provider complaint data; and

viii. Issues, concerns, and requests identified by other state agency personnel, local agencies, and community stakeholders.

f. Contractor Network Development and Management policies shall be subject to approval by LDH.

c. Network Standards and Guidelines

a. Access Standards

i. The Contractor shall ensure access to healthcare services (distance traveled, waiting time, length of time to obtain an appointment, after- hours care, facility wait list) in accordance with the provision of services under this Contract and in accordance with 42 CFR §438.206(c). The Contractor shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, and professional personnel for the provision of services, including all specialized behavioral health emergency services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:

1. Geographic Access Standards

a. Travel distance to behavioral health specialists (i.e. psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in rural parishes shall not exceed thirty (30) miles for ninety percent (90%) of members.

b. Travel distance to behavioral health specialists (i.e. psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in urban parishes shall not exceed fifteen (15) miles for ninety percent (90%) of members.

c. Travel distance to specialized behavioral health outpatient non-MD services (excluding behavioral health specialists) shall not exceed sixty (60) miles for urban members and ninety (90) miles for rural members for ninety percent (90%) of members. Maximum time for appointments shall not exceed appointment availability requirements for specialized behavioral health emergent, urgent and routine care.

2. The Contractor shall report on service accessibility in a manner which allows for comparisons to the industry standards.

Calculations for access to behavioral healthcare shall include distance, population density, and provider availability variables.

3. Requests for exceptions as a result of prevailing community standards for geographic accessibility standards must be submitted in writing to LDH for approval.

4. There shall be no penalty if the member chooses to travel further than established access standards in order to access a member's provider of choice. The member shall be responsible for travel arrangements and costs.

ii. Scheduling/Appointment Waiting Times

1. The Contractor shall have policies and procedures for appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The Contractor shall disseminate these appointment standard policies and procedures to its network providers and to its members and include this on its website, in member and provider handbooks, in provider contracts and shall be made available to LDH for review upon request. The Contractor shall monitor compliance with appointment standards and shall have a CAP when appointment standards are not met.

2. The Contractor shall require all participants in the provider network to have an appointment system for contracted services that is in accordance with prevailing behavioral health community standards as specified below:

a. Provisions must be available for obtaining emergent care twenty-four (24) hours per day, seven (7) days per week. Emergent, crisis or emergency services must be available at all times. An appointment shall be available within one (1) hour of request.

b. Provisions must be available for obtaining urgent care twenty-four (24) hours per day, seven (7) days per week. An appointment shall be available within forty-eight (48) hours of request.

c. Routine, non-urgent behavioral healthcare shall be available with an appointment within fourteen (14) days of request.

iii. None of the above access standards shall supersede the requirements in the waivers or Medicaid State Plan.

b. The Contractor shall submit an attestation ensuring adequate capacity as defined by the contractual GEO Access Standards and services upon execution of the Contract and at any time there has been a change in the Contractor's operations that would potentially impact adequate capacity and services (e.g., changes

in services, benefits, payments, or enrollment of a new population).

a. Other Network Reports

a. Network Status Reports

i. Contractor shall submit written Quarterly Network Status reports in a format approved by LDH that substantially mirrors the annual Network Development and Management Plan as referenced in the *Network Development and Management Plan* section.

ii. The Contractor's Quarterly Network Status reports shall include separate sections reporting changes in network providers (organized by provider type), by LDH regions and CSoC designated regions. GEO mapping shall be included in this report to identify compliance with urban and rural access standards unless otherwise approved by LDH. Each section shall include identification of providers lost and gained, prescribers lost and gained and prescriber sufficiency analysis, the name and address of each provider, provider type, contracted capacity, provider identification number, populations served, whether or not the provider is accepting new Medicaid patients and an analysis of the effect on network sufficiency.

iii. Semi Annual Network Status reports shall include credentialing and contracting outlier data associated with CSoC and behavioral health providers, with the expectation that barriers or issues negatively impacting completion of the process within ninety (90) calendar days are documented and addressed, ensuring timely provider contracting and beginning of service delivery. A mutually agreed upon template will be provided to the Contractor for the above reporting purposes.

iv. Contractor shall provide to LDH semi-annually in a format prescribed by LDH written documentation of provider status throughout the contracting process, to include credentialing applications, and contract processing dates, in an effort to ensure provider enrollment process efficiency.

v. Contractor shall report to LDH semi-annually in writing regarding areas of need for cultural competency, the training topics and materials provided, dates of trainings, and numbers of individuals and organizations trained specific to cultural competency. Cultural competency training completion records or transcripts shall be maintained for each network provider and shall be made available to LDH and its monitoring teams on request.

vi. Contractor shall maintain and provide written reports to LDH quarterly on the number of non-licensed providers of CSoC and behavioral health services (including non-licensed staff of organizational providers) that meet LDH minimum qualifications and standard training requirements within the prescribed time requirement. This shall be reported as the number of non-licensed providers meeting training requirements (numerator) as compared to the total number required to complete training within the given time period (denominator).

vii. Contractor shall at least semi-annually validate provider demographic data to ensure that current, accurate, and clean data is on file for all network providers, which shall be provided in writing to LDH.

b. Monthly Network Status Reports

i. Contractor shall report monthly to LDH in writing via a format approved by LDH on the number and type of out-of-network providers entered via an Out-of-Network Provider Report. Contractor shall include in the report, at minimum, the number and location of all members placed in out-of-network treatment by provider type, service and LDH and CSoC designated regions.

ii. Contractor shall report monthly on the number of out of state placements for treatment services. This report shall include the type of placement, location of placement and evidence of what efforts are being made to return these youth to the state and their homes.

c. Provider Performance Review Report

i. Contractor shall submit a Provider Performance Review to LDH in writing annually and at additional periodic intervals as requested and approved by LDH. The report shall include a formalized monitoring review process of all network providers' performance on an ongoing basis including a procedure for formal review with site-visits according to a periodic schedule determined by the Contractor and approved by LDH.

ii. As part of its monitoring activities, member and provider surveys and regular member and provider interviews shall be included in the annual Provider Performance Review report. The report shall include aggregate results; however upon LDH request the Contractor shall supply the individual member and provider reports.

iii. The Provider Performance Review report shall include a description of any deficiencies providers have demonstrated. Contractor will provide detailed information regarding these deficiencies including findings, improvement actions taken, and the effectiveness of said actions. A deficient finding in a youth residential facility that affects the health and safety of the youth shall be reported within twenty-four (24) hours of the finding to LDH and any state custodial agency that has youth receiving services from said facility.

b. Provider Enrollment

a. During the term of this Contract, LDH shall publish in the *PIHP CSoC Systems Companion Guide*, available at https://ldh.la.gov/assets/docs/BayouHealth/CompanionGuides/PIHP_CSoC_Systems_Companion_Guide_September_2024_V23.pdf, that lists the Louisiana Medicaid provider types, specialty, and sub-specialty codes, which may be updated periodically to incorporate necessary changes. The Contractor shall utilize the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with LDH. The Contractor shall provide the following:

i. Provider name, business address, service location

address, licensing information, Tax ID, National Provider Identifier (NPI), taxonomy and all other information as required in the MCE System Companion Guide; and

ii. All relevant provider ownership information as prescribed by LDH, Federal or state laws.

b. Provider enrollment systems shall be Affordable Care Act-compliant and include, at minimum, the following functionality:

i. Audit trail and history of changes made to the provider file;

ii. Automated interfaces with all licensing and medical boards, when feasible;

iii. Automated alerts and system generated letters to providers when their licenses are within thirty (30) days expiration;

iv. Retention of NPI requirements;

v. Linkages of individual providers to groups;

vi. Credentialing information;

vii. Provider office hours; and

viii. Provider languages spoken.

c. In accordance with 42 CFR §438.602(b) and upon LDH implementation of a provider management system, the Contractor shall not enter into a network provider agreement with a provider to provide services to Medicaid beneficiaries when the provider is not otherwise appropriately screened by and enrolled with the State according to the standards under 42 CFR §455 Subparts B and E and upon implementation of appropriate systems. Such enrollment includes providers that order, refer, or furnish services under the State Plan and Waivers. Such enrollment does not obligate providers to participate in the FFS healthcare delivery system.

d. Once providers are screened and enrolled with the State, the Contractor may credential providers to verify they are qualified to perform the services they are seeking to provide and execute written network provider agreements.

e. The Contractor may execute network provider agreements pending the outcome of the State screening, enrollment, and re-validation process of up to one hundred twenty (120) calendar days, but upon notification from the state that a provider's enrollment has been denied or terminated, or the expiration of the one hundred twenty (120) calendar day period without enrollment of the provider, the Contractor shall terminate such network provider immediately and notify affected members that the provider is no longer participating in the network.

f. LDH reserves the right to contract with a single National Committee for Quality Assurance (NCQA)-certified Credential Verification Organization (CVO). If this option is pursued, the Contractor and its Subcontractors shall agree to use the CVO for the credentialing and re-credentialing of all Network Providers. The Contractor will be given at least ninety (90) Calendar Days' notice before implementation of any CVO contract. When LDH implements a CVO, the Contractor shall.

i. Accept the final credentialing decisions of the CVO

ii. Within thirty (30) Calendar Days of receipt of an approved credentialing decision, load providers in its Claims processing system.

iii. Provide information to the State's provider management contractor on Network Providers.

iv. Participate on the CVO's Credentialing Committee to evaluate provider credentialing files (including re-credentialing files) using a peer review process. The credentialing committee is responsible for credentialing decisions which shall be accepted by the Contractor.

g. Prior to contracting with a network provider or paying a provider's claim, the Contractor shall ensure that the provider has a valid National Provider Identifier (NPI) Number, where applicable, has a valid license or certification to perform services, is accredited by an LDH approved accrediting organization, if applicable, has not been excluded or barred from participation in Medicare, Medicaid, or CHIP, or any other government healthcare program and has obtained a Medicaid provider number from LDH upon implementation of appropriate systems.

h. The Contractor shall comply timely with all sanctions imposed by the State on network providers, including enrollment revocation, termination, and mandatory exclusions.

i. The Contractor shall comply with any additional requirements established by LDH.

j. The Contractor shall require unlicensed staff of provider organizations rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services to obtain and submit National Provider Identifier (NPI) numbers to the Contractor, as well as documentation verifying the unlicensed staff meets all qualifications and requirements for providing MHR services established by law, rules, regulations and the Medicaid Behavioral Health Service Provider Manual, inclusive of Evidence- Based Program (EBP) MHR services, prior to reimbursing agencies for services provided by these staff. Claims submitted for MHR services shall include rendering provider NPIs and other Contractor required identifiers regardless of whether the rendering staff is licensed or unlicensed. The Contractor shall configure systems to deny claims for services when rendering providers and NPIs are denoted on claims for service that have not been credentialed and approved by the Contractor. The Contractor shall submit its policies, procedures and work plan associated with this requirement to LDH for approval within thirty (30) days of Contract execution.

c. Material Change to Provider Network

a. The Contractor shall provide written notice to LDH, no later than seven (7) business days of any network provider contract termination that materially impacts the Contractor's provider network, whether terminated by the Contractor or the provider, and such notice shall include the reason(s) for the proposed action.

b. A material change is defined as one which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and network standards as described in this Contract, including but not limited to the following:

i. Any change that would cause more than five percent (5%) of members in a parish to change the location where services are received or rendered;

ii. A decrease in provider type by more than five percent (5%);

iii. A loss of any participating specialist which may impair or deny the members' adequate access to providers;

iv. A loss of residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by LDH; or

v. Other adverse changes to the composition of the Contractor provider network which impair or deny the members' adequate access to providers.

c. The Contractor shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.

d. When the Contractor has advance knowledge that a material change will occur, the Contractor must submit a request for approval of the material change in its provider network to LDH including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.

i. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including:

1. Detailed information identifying the affected provider;

2. Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category (e.g., children eligible for the CSoC, etc.);

3. Location and identification of nearest providers offering similar services; and

4. A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.

ii. A material change in the Contractor's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, LDH will expedite the approval process.

e. The Contractor shall notify LDH within one (1) business day of the Contractor becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, provider death, relocation from the service area and fails to notify the Contractor, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include:

i. Information about how the provider network change will affect the delivery of covered services, and

ii. The Contractor's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

f. The Contractor shall give providers ninety (90) days' notice prior to a contract termination without cause. Contracts between the Contractor and single practitioners are exempt from this requirement.

g. The Contractor shall notify LDH in writing within five (5) business days prior to the effective date if a network provider fails to meet licensing criteria, or if the Contractor terminates, suspends, limits, or materially changes a network provider. When the Contractor recommends to terminate, suspend, limit or materially change a WAA network provider agreement, the Contractor shall obtain written approval from LDH.

h. The Contractor shall concurrently notify LDH/OBH and the LDH Health Standards Section of its decision to terminate a provider.

i. If a provider loss results in a material gap or network deficiency, the Contractor shall submit a plan to LDH within thirty (30) days with time frames and action steps for correcting the gap or deficiency that includes the transitioning of members to appropriate alternative service providers in accordance with the network notification requirements.

j. The Contractor shall track all members transitioned due to a network provider's suspension, limitation, termination, or material change to ensure service continuity and provide member information as requested by LDH (e.g., name, Title XIX or Title XXI status, date of birth, services member receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider). LDH will require the Contractor and its providers, where applicable, to use data elements which match current data systems requirements specified by LDH.

d. Credentialing and Re-credentialing of Providers

a. The Contractor will certify any new WAA(s) and FSO(s). The Contractor will also recertify existing WAA(s) and FSO(s) annually. In the event a WAA or FSO is denied certification or credentialing by the Contractor, the Contractor will provide to LDH electronically a reason for the denial as well as applicable data exclusive of peer review protected information supporting the denial.

b. The Contractor shall completely process credentialing applications, through the credentialing committee decision, from all provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed Network Provider Agreement, per application. "Completely process" means that the Contractor shall:

i. Provide written confirmation, electronically or by mail, of receipt to the provider within five (5) Business Days of receipt of the application.

ii. If the application is deemed incomplete, send a written request within thirty (30) Calendar Days of receipt of the application to the provider for all

missing information.

iii. Review, approve and load approved applicants to its provider files in its Claims processing system; and

iv. Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or

v. Deny the application and assure that the provider is not used by the Contractor.

c. The Contractor shall not delegate credentialing of providers.

d. The Contractor must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12; §438.206, §438.214, §438.224, §438.230, and §438.602(b) and NCQA Health Plan Accreditation Standards for the review, credentialing and re- credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the Contractor selects and directs its Enrollees to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) days after Contract execution, when a substantive change in content is made, and annually thereafter by Contract year.

e. The Contractor shall develop and implement policies and procedures for the acceptance of new providers screened, enrolled, and approved in writing by the State, and termination or suspension of providers to ensure compliance with the Contract.

f. The Credentialing Application Form and Re-Credentialing Application Form will be submitted to LDH for approval prior to Contract execution and at any time of a requested substantive change in content.

g. Contractor shall follow NCQA guidelines for the re-credentialing of its providers. Unless NCQA guidelines determine more stringent timelines, Contractor shall ensure providers are re-credentialed within thirty-six (36) months of the date of the previous credentialing decision. The credentialing date of the Credentialing Committee shall be used to determine the date by which Contractor must re-credential the provider. In instances where the Contractor or LDH determines significant quality issues with a provider or a cause for provider termination, the provider may need to re-credential on a more frequent basis.

h. Prior to contracting with the Contractor, providers must be credentialed according to standards and requirements of the Contractor and LDH.

i. Prior to contracting or subcontracting with a provider via a provider agreement or single case agreement (SCA), or prior to reimbursing for specialized behavioral health services (SBHS), the Contractor shall credential providers to ensure individual practitioners, provider facilities, organizations, and staff meet all qualifications and requirements established by LDH policy including but not limited to the Medicaid Behavioral Health Provider Manual, as well as state and Federal rules, laws and regulations. The Contractor's credentialing files on providers shall include verification of meeting said requirements. This shall include that agencies offering mental health rehabilitation services (i.e. CPST, PSR or CI), Assertive Community Treatment (ACT), Crisis Services (MCR, CBCS), or Opioid Treatment Programs supply proof of accreditation by an LDH approved

accrediting body, which shall be made part of the agency's credentialing file with the Contractor. Agencies not accredited at the time of credentialing shall supply proof that the agency applied for accreditation and paid the initial application fees prior to contracting with the Contractor. Agencies must attain and present the Contractor with proof of full accreditation within the required timeframe established by LDH policy, including, but not limited to, the Medicaid Behavioral Health Provider Manual, unless otherwise established by state or Federal rules, laws or regulations. LDH approved national accrediting bodies include:

i. The Council on Accreditation (COA);

ii. The Commission on Accreditation of Rehabilitation Facilities (CARF); and

iii. The Joint Commission (TJC)

j. Contractor shall conduct site visits as needed or requested by LDH to providers for the purpose of ensuring its providers meet minimum qualifications and requirements, its providers' service delivery sites meet all applicable requirements of Louisiana law, and meet the credentialing and re-credentialing requirements to which they have attested.

k. Contractor shall be required to utilize the Council for Affordable Quality Healthcare (CAQH) secure online provider repository for the credentialing of individual practitioners.

l. All service providers with a network provider agreement with the Contractor or a Single Case Agreement (SCA) shall meet minimum qualification requirements in accordance with the Medicaid Behavioral Health Services Provider Manual, inclusive of any required certification and licensure, as well as all Federal and state rules, laws and regulations, and credentialing requirements in accordance with the process submitted by the Contractor for LDH approval.

i. When selecting qualified service providers for a network provider agreement, the Contractor shall evaluate information from the following sources: quality management data, including at a minimum, appointment availability data; grievances; patterns of concerns reported by eligible or enrolled members; performance on current and previous provider agreements, including outcomes; behavioral health member satisfaction survey data; results from independent case reviews and other reviews/audits; unmet needs data which shall include, but not be limited to, the number of members denied services by the providers, the number of members receiving services out of the network within the state, the number of complaints regarding service availability, the number of referrals for all service types, the number of members in the service types, network access (including geographic access, appointment availability, and access to qualified providers of each service type), and the number of members receiving services outside of the State; grievance and appeals data; network management and contracting data (for example, geographic location and cultural or unique service delivery considerations); and issues, concerns, and requests from state agency personnel or system stakeholders. When selecting providers for a

network provider agreement, the Contractor shall require providers to:

1. Obtain a unique national provider identifier (NPI);
2. Operate within their license and scope of practice; and
3. Obtain and maintain all applicable insurance coverage, in accordance with the Terms and Conditions of this Contract.

ii. As part of the contracting process, network providers are required to disclose the health-related criminal conviction information that is required from FFS providers under 42 CFR §455.106, or any legal actions brought against them in the last five (5) years regardless of provider accreditation.

iii. The Contractor network provider application shall include all information outlined in 42 CFR §455.104 for disclosure by Medicaid providers and fiscal agents regarding information on ownership and control interests. The application shall include information sufficient for the Contractor to make a determination of compliance with program integrity related requirements in the Contract.

iv. The Contractor shall make any collected information on providers through the credentialing process available to LDH upon request in an LDH approved format.

v. The Contractor will comply with NCQA standards for validation of malpractice insurance for each qualified network provider and shall make available these certificates to LDH upon request.

vi. The Contractor shall evaluate and make a determination to retain providers utilizing performance and QI data acquired while delivering services under the Contract.

vii. The Contractor shall clearly describe and disseminate the process and criteria to be used for terminating provider participation. If the Contractor declines to enter into an agreement with individuals or groups of providers as part of the network, it shall give the affected providers prior written notice of the reason for its decision.

viii. The Contractor shall conduct credentialing in accordance with Federal and state rules, laws and regulations, and as established by the Medicaid Behavioral Health Services Provider Manual, ensuring that providers and individuals rendering services for provider agencies meet the documented qualifications for the services provided, abide by the service limitations and exclusions, meet any additional service criteria listed, and serve those individuals listed under eligibility criteria.

ix. The Contractor's credentialing process will include verification of provider's use of LDH approved curriculum or equivalent standards, compliance with EBP fidelity monitoring as appropriate, and provider compliance with training requirements as documented in the Medicaid Behavioral Health Services Provider Manual for select services.

1. The providers of Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), Homebuilders and Assertive Community Treatment Act (ACT) maintain fidelity monitoring as part of their certification/credentialing process. The MCO shall maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for FFT, MST, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports.

x. The Contractor shall maintain a sufficient number of qualified staff to expeditiously process the credentialing and privileging of qualified service providers.

xi. The Contractor shall give all network providers and subcontracts access to the Medicaid Behavioral Health Services Provider Manual and the Contractor's Provider Manual, and any updates, either through the Contractor's website, or by providing paper copies to providers who do not have Internet access.

xii. The Contractor shall provide, in accordance with national standards, claims inquiry information to network providers and subcontracts via the Contractor's website.

1. The Contractor shall not restrict or inhibit providers in any way from freely communicating with or advocating for a member regarding behavioral healthcare, medical needs, and treatment options, even if the person needs services that are not covered or if an alternate treatment is self-administered. The Contractor may not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:

    a. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self- administered;

    b. For any information the member needs in order to decide among all relevant treatment options;

    c. For the risks, benefits, and consequences of treatment or non-treatment; and

    d. For the member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

xiii. The Contractor shall require providers to communicate information to assist a member to select among relevant treatment options, including the risks, benefits, and consequences of treatment

or non-treatment; the right to participate in decisions regarding his or her behavioral healthcare; and the right to refuse treatment and to express preferences about future treatment decisions.

xiv. The Contractor shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to ensure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.

xv. The Contractor shall notify LDH when it denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

xvi. The Contractor shall develop and implement a mechanism, with LDH approval, for reporting quality deficiencies, which result in suspension or termination of a network provider(s). This process shall be submitted for review and approval thirty (30) days from the date the network provider agreement or subcontract is signed and at the time of any change.

m. The Contractor shall develop and implement a provider dispute and appeal process, with LDH's approval, for sanctions, suspensions, and terminations imposed by the Contractor against network provider or Subcontractor(s) as specified in the contract. This process shall be submitted for review and approval thirty (30) days from the date the network provider agreement or subcontract is signed and at the time of any change.

e. Network Provider Agreements

a. The Contractor shall enter into written network provider agreements with qualified service providers to deliver covered behavioral health services to members. The Contract shall specify the activities and reporting responsibilities delegated to the provider; and provide for revoking delegation, terminating agreements, or imposing other sanctions if the provider's performance is inadequate.

b. Upon request, LDH shall be given copies of any network provider agreements entered into by the Contractor regarding the CSoC. Any proprietary information regarding rate setting may be redacted by the Contractor prior to submission to LDH.

c. The Contractor shall have written policies and procedures for the selection and retention of providers in accordance with 42 CFR §438.214.

d. The Contractor shall develop and maintain methods to communicate policies, procedures and relevant information to providers through its website, including a Provider Manual developed to disseminate all relevant information to network providers.

e. All network provider agreements shall include the following provisions:

i. The name and address of the network provider.

ii. The method and amount of compensation, reimbursement, payment, and other considerations provided to the provider.

iii. Identification of the population to be served by the provider.

iv. Requirement that the provider's treatment site be a smoke free environment.

v. The amount, duration, and scope of covered behavioral health services to be provided.

vi. The term of the provider's network provider agreement, including beginning and ending dates, and procedures for extension, termination, and renegotiation.

vii. Requirement that provider meets LDH Appointment Availability Standards.

viii. Requirement that the provider submits results of all accreditation surveys to the Contractor within one (1) business day of receipt of results, if required to be accredited.

ix. Requirement that provider reports loss of accreditation, whether preliminary, provisional, full or other accreditation, suspension or action taken that could result in loss of accreditation to Contractor, inclusive of all documentation from the accrediting body, within one (1) business day of receipt of notification, if required to be accredited.

x. Requirement that provider report cancellation of any required insurance coverage, licensure or certification to the Contractor within one (1) business day of receipt of notification.

    1. Upon receipt of this report, the Contractor shall immediately notify the Provider that it is prohibited from performing any work under the Contract unless and until the Provider provides written documentation to the Contractor indicating that the Provider has reinstated all required insurance coverage, licensure, or certification.

xi. Specific network provider agreements duties relating to coordination of benefits and determination of third-party liability.

xii. Identification of Medicare and other third-party liability coverage and requirements for seeking Medicare or third-party liability payments before submitting claims or encounters to Contractor, when applicable.

xiii. Uniform terms and conditions of the contract.

xiv. Maintenance of an appropriate clinical record keeping system that ensures appropriateness of billing.

xv. Compliance with the requirements in the Contractor QAPI and UM plans/program including Performance Improvement Project (PIP) and CAPs.

xvi. Language that requires a written network provider agreement amendment and prior approval of LDH, if the provider participates in any merger, reorganization, or changes in ownership or control, that is related to or affiliated with the Contractor.

xvii. Assumption of full responsibility for all tax

obligations, worker's compensation insurance, and all other applicable insurance coverage obligations required in this network provider agreement, for itself and its employees, and that LDH shall have no responsibility or liability for any taxes or insurance coverage.

xviii. Incorporation by reference of the Medicaid Behavioral Health Services Provider Manual and the Contractor's Provider Manual and language that the network provider agreement complies with all requirements stated in this Contract, CMS waiver and SPA and all applicable state and Federal laws, rules and regulations.

xix. A requirement that provider notify the Contractor within two (2) business days when it is not accepting new Medicaid clients, or if it does not accept a client and the associated cause.

xx. Requirement that the provider must provide crisis mitigation services, which provides 24-hour on call assistance to members.

xxi. The right of a provider to appeal a claims dispute in accordance with this Contract (to be detailed in the Contractor's Provider Manual).

xxii. Compliance and cooperation by the provider with audits, inspections, requests for information, document reviews, trainings, coaching, meetings, presentations, as well as requests for representation and participation in workgroups, taskforces, and committees including any reviews the Contractor may conduct.

xxiii. Compliance and cooperation by the provider with audits, inspections, requests for information, document reviews, trainings, coaching, meetings, presentations, as well as requests for representation and participation in workgroups, taskforces, and committees including any reviews LDH may conduct.

xxiv. Cooperation of the provider with the Contractor, other providers or state employees in scheduling and coordinating its services with other related service providers that deliver services to members.

xxv. Facilitation by the provider of another provider's reasonable opportunity to deliver services, and the prohibition of any commission or condoning of any act or omission by the provider or by state employees that interferes with, delays, or hinders service delivery by another provider.

xxvi. Timely implementation of LDH or Contractor decisions related to a grievance, member appeal, claims dispute or adverse incident mitigation recommendations.

xxvii. Compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any behavioral health member, according to 42 CFR §438.210(e).

xxviii. Members reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in providers.

xxix. Incorporation by reference of the LDH definition of medically necessary covered behavioral health services and the LDH levels of care.

xxx. A requirement that the providers assess the cultural and linguistic needs of the service area, and deliver services that address these needs to the extent resources are available.

xxxi. Information sufficient for the Contractor to conduct required program integrity related database checks. This information may include Social Security number or date of birth.

f. The Contractor shall be responsible to oversee all providers' performance and shall be held accountable through LDH issued compliance actions including corrective action mandates or sanctions for any function and responsibility.

i. All network provider agreements must fulfill the requirements of 42 CFR Part 438, and specifically 42 CFR §438.230, that are appropriate to the service or activity delegated under the network provider agreement;

ii. The Contractor must evaluate the prospective provider's ability to perform the activities to be delegated;

iii. The Contractor must have a written agreement between the Contractor and the provider that specifies the activities and reporting responsibilities delegated to the provider; and provides for revoking delegation or imposing other sanctions if the provider's performance is inadequate;

iv. The Contractor shall conduct audits, including but not limited to on-site provider visits, of provider compliance with contract terms;

v. The Contractor shall monitor the provider's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards and waiver and Medicaid State Plan requirements. Contractor's monitoring and evaluation plans shall be subject to LDH approval;

vi. The Contractor shall identify deficiencies or areas for improvement, and take corrective action; and

vii. LDH shall have the right to review and approve or disapprove any and all network provider agreements entered into for the provision of any services under the Contract.

g. Notification of amendments or changes to any network provider agreement which materially affects the network shall be provided to LDH prior to the execution of the amendment in accordance with the *Material Change to Provider Network* section.

h. The Contractor shall not execute network provider agreements with providers who have been excluded from participation in the Medicare or Medicaid program pursuant to §1128 (42 U.S.C. §1320a-7) or §1156 (42 U.S.C. §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid or Medicare program. The Contractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non- procurement activities

under regulations issued under Executive Orders. The Contractor shall conduct regular checks as per 42 CFR §455.436 and notify LDH of providers found.

i. The Contractor shall give written notice of termination of a provider, within fifteen (15) days after receipt of issuance of the termination notice, to each CSoC member who received his or her care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f).

j. The Contractor shall report to LDH and the LDH Program Integrity Unit any program integrity-related (fraud, integrity, or quality) adverse action taken on provider participation in its network. These reportable actions will include denial of credentials, enrollment, or contracts. Additionally, when the State executes permissive exclusions to terminate a provider for program integrity issues, the public will be notified as required by 42 CFR §1002.212.

k. All network provider agreements executed by the Contractor pursuant to this section shall, at a minimum, include the terms and conditions listed in the *Program Integrity* section of this Contract. No other terms or conditions agreed to by the Contractor and Subcontractor shall negate or supersede the requirements in *Program Integrity* section.

l. All Network Provider Agreements shall provide that the provider shall comply, within a reasonable time, with any information, records or data requests from any healthcare oversight agency, including the Louisiana Department of Justice, MFCU, related to any services provided under this Contract. When requested by the MFCU, the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The provider shall agree that its Network Provider Agreement creates for any healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

m. Single Case Agreement

i. Single case agreements (SCA) are written agreements between the Contractor and a provider that are member specific arrangements for a service or set of services. The Contractor shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. The Contractor shall not utilize SCAs as a substitute for network adequacy. The Contractor must address network deficiencies by developing its network of providers and specialists to meet the needs of its members. A gap analysis and network development plan shall be made available to LDH upon request.

ii. The Contractor shall have in place policies and procedures around negotiation, development and execution of single case agreements. Policy and procedures shall address all requirements listed in this section for SCA. SCA policies and procedures shall be made available to LDH upon request.

iii. Providers with which the Contractor negotiates an SCA shall meet at least the minimum standards of qualifications. Out of state SCA providers shall have

proof of the equivalent of Louisiana licensing and accreditation requirements, if required to be accredited. In state providers with SCA should be licensed with HSS or the respective state board or agency. All SCA providers shall have applicable accreditations. Upon request, the Contractor shall submit proof of the SCA provider meeting these requirements. The Contractor must be in compliance with any NCQA Health Plan Accreditation standards and all applicable state laws, if applicable, to SCA.

iv. LDH shall have the right to review and approve or disapprove any and all provider SCAs entered into for the provision of any services under this Contract.

f. Provider-Member Communication Anti-Gag Clause

a. Subject to the limitations described in 42 CFR §438.102(a)(1) the Contractor shall not prohibit or otherwise restrict a healthcare provider acting within the lawful scope of practice from advising or advocating on behalf of a Member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under this Contract, for the following:

i. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii. Any information the member needs in order to decide among relevant treatment options;

iii. The risks, benefits and consequences of treatment or non-treatment; and

iv. The member's right to participate in decisions regarding the member's healthcare, including, the right to refuse treatment, and to express preferences about future treatment decisions.

b. Any Contractor that violates the anti-gag provisions set forth in 42 CFR §438.102(a)(1) shall be subject to remediation.

c. The Contractor shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.

g. Mainstreaming

a. LDH considers mainstreaming of CSoC members into the broader health delivery system to be important. The Contractor therefore must ensure that all CSoC providers accept members for treatment and that Contractor providers do not intentionally segregate members in any way from other persons receiving services.

b. To ensure mainstreaming of members, the Contractor shall take affirmative action so that members are provided covered services without regard to race, color, creed, gender, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or intellectual/developmental, physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i. Denying or not providing to a member any covered service or availability of a facility;

ii. Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large; and

iii. Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay members.

c. Once the Contractor becomes aware of a provider's failure to comply with this section, the Contractor shall develop a formal CAP with the provider within thirty (30) calendar days and notify LDH.

d. If the Contractor knowingly executes a contract with a provider with the intent of allowing or permitting the provider to implement barriers to care, LDH shall consider the Contractor to have breached the provisions and requirements of the Contract.

e. The Contractor shall ensure that providers do not exclude treatment or placement of members for authorized CSoC services solely on the basis of state agency (DCFS, LDOE, and OJJ) involvement or referral.

3. Care and Utilization Management

a. *Care Management Requirements*

a. Care management is the overall system of medical and psychosocial management encompassing, but not limited to, UM, care coordination, discharge planning following restrictive levels of care, continuity of care, and care transition. Care management also refers to the Contractor's overall responsibility to assess and achieve good health and social outcomes for all of its members. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for members requiring behavioral health services and linkages to primary medical care services as needed. These activities shall include scheduling assistance, monitoring, and follow-up for member(s) requiring behavioral health services.

b. The Contractor shall develop and maintain a care management function that ensures covered behavioral health services are available when and where individuals need them. The Contractor shall provide services that are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and be in compliance with 42 CFR §438.210. The care management system shall have LMHP care managers (CMs) that respond twenty-four (24) hours per day, seven (7) days per week, and three hundred and sixty-five (365) days per year to members, their families/caregivers, legal guardians, or other interested parties calling on behalf of the member. Failure to meet this standard as verified by LDH will subject the Contractor to remediation outlined in the *Remediation* section of this Contract.

c. The Contractor shall develop and implement a care management program through a process, which provides that clinically appropriate and cost-effective behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon clinically appropriate and cost-effective service

plan that meets the behavioral health needs of the member.

d. Care Management program functions shall include but not be limited to the following, all of which must be addressed in the Contractor's Care Management policies and procedures:

i. Early identification of members who have or may have special needs. For enrollees with special health care needs determined through an assessment to need a course of treatment, Contractor shall have in place a mechanism in place to directly access a specialist as appropriate for the enrollee's condition and identified needs in accordance with 42 CFR §438.208;

ii. Assessment of a member's current health status, risks, current service utilization and gaps in care initially and on an ongoing basis to ensure member health and safety using the required CANS and IBHA, and as appropriate, other assessment tools as deemed appropriate by the Contractor or required by LDH;

iii. Development of an individualized comprehensive plan of care by the Wraparound Facilitator which must be in compliance with applicable Federal waiver requirements, based on the results of the member's individual assessment and System of Care principles and values, and shared timely with service providers. The Wraparound Facilitator shall collaborate with the member and his/her family to identify who should be involved in the plan of care planning process and develop and implement the plan through a person-centered process by which the member and his/her family has a primary role. The plan of care must include the following elements at a minimum:

1. Member demographics;

2. Identification of the member's providers;

3. Member's goals, identified strengths and needs, and identified barriers to treatment;

4. Supports and services, including type, frequency, amount and duration needed to meet the member's needs; and

5. Plan for addressing crisis to prevent unnecessary hospitalization, incarceration, or out-of-home placement. The crisis plan must identify resources and contact information, including 988 and LA-CRS services such as MCR.

iv. Documentation that freedom of choice of services and providers were offered to the member and his/her caregiver by the Wraparound Facilitator;

v. Referrals and assistance to ensure timely access to providers within the LDH access standards;

vi. Actively linking member to providers and coordinating with medical services, residential, social, community and other support services where needed;

vii. Monitoring to identify early changes in the health status of members, ensure members are receiving

needed services and supports, and ensure member progress and safety;

viii. Continuity of care, including managing transitions between levels of care;

ix. Timely follow-up for members who miss appointments or who are discharged from a 24-hour facility;

x. Developing and implementing strategies to reduce risk to members and families/caretakers or legal guardians, including, at a minimum:

1. Identifying members who are in need of more intensive monitoring or support, or that have high-risk needs that have not been addressed.

2. Offering alternative services when requested services are denied when appropriate.

xi. Collaborating with the appropriate WAA to review members' individual plan of care and adjust services to address over reliance on crisis, ER or inpatient services; and

xii. Documentation of care management activities on an individual member level.

b. *Care Coordination, Continuity of Care, and Care Transition*

a. The Contractor shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a holistic approach to providing behavioral healthcare services for all CSoC members. The Contractor shall establish a process and shall coordinate the delivery of behavioral health services and care with the primary care services or other services that are provided under the Integrated Medicaid Managed Care Program or Fee for Service Medicaid (or other PIHP, PAHP or MCO if applicable). Continuity of care activities shall ensure the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. These activities shall be demonstrated via work flows with specific decision points, and included in the Contractor's Care Management policies and procedures.

b. Continuity of care activities shall provide processes by which members and network or non-network provider interactions are effective and shall identify and address those that are not effective. The Contractor shall ensure that service delivery is properly monitored through member surveys, treatment record reviews and Explanation of Benefits (EOB) to identify and overcome barriers to care that a member may encounter. Corrective action shall be undertaken by the Contractor on an as needed basis and as determined by LDH.

c. The Contractor shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208.

d. The Contractor is responsible for coordinating with the Office for Citizens with Developmental Disabilities (OCDD) for the behavioral health needs of the I/DD co- occurring population.

e. The Contractor shall implement care coordination and continuity of care policies and procedures that meet or

exceed the following requirements:

i. Ensure that each member has an ongoing source of care appropriate to the member's needs.

ii. Ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the member. The Contractor shall document the individual's PCP in the care management record, or if none, follow-up on the PCP referral as part of the ongoing care management process. The Contractor shall attempt to obtain signature for release of information from the member or the family/caregiver or legal guardian, as appropriate, to coordinate care with the PCP and other healthcare providers. If the member refuses consent, that shall be documented.

iii. Require all network providers to request a standardized release of information from each member to allow the network provider to coordinate treatment with the member's PCP, and that network providers, having received such a release, provide timely notification, as necessary, to PCPs of the member's treatment throughout the time the member receives behavioral health treatment from the network provider. Special emphasis shall be placed on notifying the member's PCP of the initiation of, or change in, psychotropic medication.

iv. Ensure the WAA will provide quick access to Wraparound care coordination. It is expected that the WAA will attempt to contact the youth/family within forty-eight (48) hours of the date of referral to the WAA. This will be measured through documentation on the monthly CSoC data spreadsheet. The WAA staff will make face-to-face contact with the youth/family within seven (7) calendar days of WAA referral, which will be tracked through the CSoC data spreadsheet or as required in the CSoC Quality Improvement Strategy (QIS).

v. Coordinate care for out-of-network services.

vi. Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.

vii. Coordinate timely with Integrated Medicaid Managed Care Programs and the member's family following an inpatient, PRTF, nursing facility, or other residential stay for members when a return to home placement is not possible.

viii. Share with other healthcare entities serving the member the assessment, results and other information necessary to prevent duplication of activities.

ix. Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 42 CFR Part 2, 45 CFR Parts 160 and 164, and other applicable state or Federal laws.

x. Maintain and operate a formalized discharge planning program, including planning for discharges against medical advice.

1. Provide information to members regarding walk-in clinics and crisis services prior to discharge from a facility providing 24-hour levels of care.

2. Expedite approval of services for members being discharged from a 24-hour facility.

3. Ensure the discharge planning process is initiated at admission and finalized at least twenty-four (24) hours before the scheduled discharge.

4. Coordinate discharge and transition of members in an out- of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community including the referral to necessary providers.

5. Ensure members receive follow-up appointment within seventy-two (72) hours with the appropriate behavioral health provider following discharge.

6. Follow-up with members who are discharged from facilities providing 24-hour levels of care within seventy-two (72) hours post- discharge to ensure access to and attendance at aftercare appointments.

xi. Identify members using emergency department (ED) and inpatient psychiatric services inappropriately to assist in scheduling follow-up care with appropriate providers.

xii. Provide active assistance to members receiving treatment for behavioral health conditions to transition to another provider when their current provider has terminated participation with the Contractor. The Contractor shall provide continuation of such services for at least ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less.

xiii. Refer members to appropriate network providers or community resources offering tobacco cessation treatment or problem gaming services, if the Contractor becomes aware of problem gaming and tobacco usage during an individual needs assessment or case review.

xiv. Document referrals in Contractor's system.

f. Coordination with the Integrated Medicaid Managed Care Plans

i. The Contractor shall coordinate care with the member's Integrated Medicaid Managed Care Program Plan to promote overall health and wellness, including:

1. Coordination of services the Contractor furnishes to the member with the services the member receives through the Integrated Medicaid Managed Care Program including access to pharmacy needs.

2. Timely sharing of clinical information relative to the member's needs with Integrated

Medicaid Managed Care Program Plan in order to prevent duplication of activities.

ii. The Contractor shall support the integration of physical and behavioral health services and will work in conjunction with the Integrated Medicaid Managed Care Program.

1. The Contractor shall coordinate care for members with both medical and behavioral health disorders, including care transition between inpatient services and outpatient care for members with co-existing medical-behavioral health disorders.

2. The Contractor shall assist members with a newly diagnosed chronic medical disorder, who would benefit from psychosocial guidance.

3. The Contractor shall communicate and consult with PCPs or Integrated Medicaid Managed Care Program plan on co-enrolled members with co-existing medical and behavioral health disorders requiring co-management.

iii. The Contractor shall implement measures that ensure effective co- management and information sharing between Integrated Medicaid Managed Care Program Plans and the Contractor, including:

1. Educating members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, when available and appropriate;

2. Identifying members who use emergency department (ED) services for specialized behavioral health needs to assist in scheduling follow-up care with appropriate behavioral health specialists; and

3. Ensuring referral, continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow- up for member(s) requiring medical services.

iv. The Contractor and the Integrated Medicaid Managed Care Program Plans shall work together to develop a process for bidirectional information exchange related to shared members. The process will delineate the necessary information to be exchanged, timelines for information exchange, events and conditions that will trigger information exchange, data sharing format(s) and Information Technology (IT) requirements. The process and any changes to the process must be approved by LDH prior to implementation.

v. The Contractor shall accept direct referral calls from the community and other stakeholders and apply the initial risk screen for CSoC eligibility. The Contractor will also accept transferred calls as a seamless

"warm transfer" from the Integrated Medicaid Managed Care Program Plans for members who are identified as potentially eligible for CSoC through the application of the initial CSoC risk screen.

vi. The Contractor will apply the Brief Child and Adolescent Needs and Strengths (CANS) assessment tool to assess for CSoC presumptive eligibility. Upon completion of the Brief CANS before the call is terminated, the Contractor Care Manager shall inform the caller of the child/youth's CSoC eligibility status.

1. If the child/youth is presumptively eligible for CSoC and agrees to be referred, the Contractor Care Manager will make referrals for CSoC assessment and enrollment.

2. If the child/youth is presumptively eligible for CSoC and does not agree to be referred, the Contractor Care Manager will transfer the caller back to the member's Integrated Medicaid Managed Care Program Plan using a seamless "warm transfer."

3. If the child/youth is not presumptively eligible for CSoC, the Contractor Care Manager will transfer the caller back to the member's Integrated Medicaid Managed Care Program Plan using a seamless "warm transfer."

vii. The Contractor shall document the following information in the child's health record for Contractor's management system: the date of referral, Brief CANS results, date of referral to the Wraparound Agency (WAA) and Family Support Organization (FSO), date and result of Comprehensive CANS, date the Freedom of Choice (FOC) was signed or declined, reason given if FOC is declined.

viii. The Contractor Care Managers shall utilize secure email to provide notice to referring Integrated Medicaid Managed Care Program Plan Care Manager that information was received, and will contact the Integrated Medicaid Managed Care Program Plan Care Manager within three (3) business days of receipt of referral for routine referrals and within one business day, if referral is marked "urgent;"

ix. The Contractor shall document the member's PCP in the Care Management record or, if none, follow up on the PCP referral as part of the ongoing care management process, thus ensuring that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the member;

x. The Contractor shall distribute Release of Information forms as per 42 CFR §431.306, and provide training to Contractor providers on its use;

xi. The Contractor shall conduct Case Management rounds at least monthly with each Integrated Medicaid Managed Care Program plan;

xii. The Contractor shall develop and implement a case

management program through a process which coordinates appropriate and cost- effective medical services, social services, and behavioral health services that are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs; and

xiii. The Contractor shall participate in regular collaborative meetings as requested by LDH which may include Integrated Medicaid Managed Care Program Contractors, BHSF, OBH, Office for Citizens with Developmental Disabilities (OCDD), WAAs and other entities as determined by LDH.

g. When the Contractor becomes aware that a child/youth will be discharged or disenrolled from CSoC, the Contractor shall notify the member's Integrated Medicaid Managed Care Program Contractor that a youth will be disenrolled from CSoC, and shall coordinate discharge planning with the Integrated Medicaid Managed Care Program Contractor to ensure smooth transition of care management of specialized behavioral healthcare services, such that the youth's specialized behavioral healthcare needs will be transitioned seamlessly from management by the CSoC Contractor to management by the Integrated Medicaid Managed Care Program Contractor. Contractor shall provide the results to the Integrated Medicaid Managed Care Program Contractor of the initial comprehensive CANS assessment, IBHA, most recent POC (which includes crisis plan), and the discharging or most recent comprehensive CANS assessment, and any other assessments conducted during the CSoC enrollment.

h. If requested, as per 42 CFR §438.206, the Contractor shall offer a second opinion from a qualified healthcare professional within the network or arrange for a second opinion outside the network at no cost to the member.

c. *Care Management Policies and Procedures*

a. The Contractor shall submit Care Management Program policies and procedures to LDH for approval within thirty (30) days from DOA/OSP approval of signed Contract, and prior to any revisions.

d. *Utilization Management*

a. Utilization Management (UM) is the component of care management that evaluates the medical necessity of healthcare services according to established criteria and practice guidelines to ensure the right amount of services are provided when the member needs them. UM also focuses on individual and system outliers that require review to assess if individual members are meeting their goals and if service utilization across the system is meeting the goals for delivery of community- based services.

b. The Contractor shall implement a UM program that has sufficient LMHPs, including Licensed Addiction Counselors (LACs), as well as a board certified psychiatrist. The other LMHPs shall be available twenty-four (24) hours a day, seven (7) days per week. The Contractor shall provide UM staff experienced and specifically assigned to children and youth.

i. The Contractor will commit to having sufficient staff knowledgeable of and trained in substance use treatment to assist members with addiction treatment needs.

ii. The Contractor will commit to having sufficient staff knowledgeable of and trained in intellectual and developmental disabilities to assist members with I/DD needs.

c. The Contractor shall develop and maintain policies and procedures with defined structures and processes for a UM program that incorporates Utilization Review and Service Authorization. The Contractor shall submit UM policies and procedures within thirty (30) days from the date the Contract is signed and approved by DOA/OSP to LDH for written approval and prior to any revisions.

d. The Contractor shall notify LDH if utilization management activities are conducted outside the organization. Consistent with 42 CFR §438.3 and §§422.208 and 438.210, compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

e. The Contractor's UM program shall comply with Federal utilization control requirements, including the certification of need and recertification of need for continued stay inpatient settings. The Contractor shall require inpatient hospitals to comply with Federal requirements regarding utilization review plans, utilization review committees, plans of care, and medical care evaluation studies as prescribed in 42 CFR Parts 441 and 456. The Contractor shall actively monitor UM activities for compliance with Federal, state, and LDH requirements. The UM Program policies and procedures shall meet the NCQA standards and include medical management criteria and practice guidelines that:

i. Are adopted in consultation with a contracting healthcare professional;

ii. Are objective and based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field;

iii. Consider the needs of the members; and

iv. Are reviewed annually and updated periodically as appropriate.

f. UM Program policies and procedures shall include, but not be limited to:

i. The methodology utilized to grant service authorization based on medical necessity, appropriateness, efficacy, efficiency of healthcare services, and in accordance with waiver and state requirements;

ii. The data sources and clinical review criteria used in decision making;

iii. Required documentation for the clinical review;

iv. Mechanisms to ensure consistent application of review criteria and compatible decisions;

v. Data collection processes and analytical methods used in assessing utilization of healthcare services;

vi. Provisions for ensuring confidentiality of clinical and proprietary information in accordance with 42 CFR §438.224;

vii. A mechanism for monitoring members' utilization of behavioral health services to ensure Title XIX and Title XXI reimbursement is not made beyond the service limitations specified in the *Covered Benefits and Services* section;

viii. Addressing the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the Contractor may deny authorization of the requested service(s);

ix. Providing the WAA and contracted service providers with technical assistance regarding UM policies and procedures and the application of services authorization criteria and practice guidelines;

x. Assisting the WAA with specialized training to develop and manage sustainable Plans of Care, consistent with best practice standards and UM policies and procedures; and

xi. Providing a mechanism in which a member may submit, whether verbally or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures.

g. The Contractor shall develop and disseminate clinical practice guidelines (CPGs) to all providers as appropriate and, upon request, to members and potential members in accordance with 42 CFR §438.236 and this Contract.

i. At a minimum, the Contractor shall develop CPGs for Attention Deficit Hyperactivity Disorder, Trauma Informed Care, Depression and Conduct Disorder. These CPGs must be submitted to LDH for approval within thirty (30) days of Contract execution and upon revision.

ii. The Contractor shall develop additional CPGs based on analysis of prevalent diagnosis of the population, relative benefit on clinical outcomes, or relative benefit on cost-effectiveness. The Contractor shall submit the proposed clinical guidelines and analysis to LDH for approval within twelve (12) months of Contract execution, upon revision, and upon adoption of new clinical practice guidelines.

iii. The Contractor shall require the adoption of the relevant CPGs by providers based on their practice.

h. The Contractor shall have staff with clinical expertise and training to apply service authorization criteria, including but not limited to the application of the CANS algorithm to determine clinical eligibility, based on medical necessity and practice guidelines. Determinations of service authorization must be made by qualified and trained LMHPs in accordance with state and Federal regulations.

i. The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the reviewer's physical, mental, professional or moral character.

ii. The individual making these determinations is

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

i. The Contractor shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for service authorization determinations. The Contractor shall make service authorization determinations that are consistent with the State's definition of medical necessity.

j. The Contractor shall provide a mechanism to reduce inappropriate and duplicative use of behavioral healthcare services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member.

k. The Contractor shall report fraud and abuse information identified through the UM program to LDH's Program Integrity Unit in accordance with 42 CFR §455.1(a)(1), LDH, and the Attorney General's Office when applicable.

l. In accordance with 42 CFR §456.111 and §456.211, the Contractor Utilization Review plan must provide that each member's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:

i. Identification of the member;

ii. The name of the member's provider;

iii. If in a facility, the date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;

iv. The POC required under 42 CFR §456.80 and §456.180;

v. If in a facility, initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133, §456.233 and §456.234; and

vi. Justification of emergency admission, if applicable.

e. *Service Authorization*

a. Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.

b. The Contractor UM Program policies and procedures shall include service authorization policies and procedures consistent with the State Plan, State Plan Amendments SPAs, and 1915(b) and 1915(c) waivers, 42 CFR §438.210, and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

i. Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;

ii. Mechanisms to ensure consistent application of review criteria for authorization decisions and

consultation with the requesting provider as appropriate;

iii. Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a healthcare professional who has appropriate clinical expertise in treating the member's condition and shall be submitted by the Contractor to the provider and member in writing;

iv. Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in the Contractor's member manual and incorporated in the grievance procedures;

v. The Contractor's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and

vi. The Contractor's service authorization system shall electronically store and report all service authorization requests, decisions made by the Contractor regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

c. For all modalities of care, the amount, duration or scope of treatment should be determined by the member's needs and his or her response to treatment. Note: In the absence of medical necessity, Medicaid cannot be the payment source for these services.

d. The Contractor shall collect and report prior authorization required by CMS to LDH each year and include on the Contractor's public-facing website by March 31st of each year.

e. The Contractor shall implement and maintain Application Programing Interfaces (API) for prior authorizations, patient access, providers, and payers which fully meet CMS requirements as specified in the Interoperability and Prior Authorization Rule by the due dates established in the Rule. The Contractor shall provide ongoing training to providers, Wraparound Facilitators and members on use of APIs.

f. Utilization Management (UM) Committee

a. The UM program shall include a UM Committee that integrates with other functional units of the Contractor as appropriate and supports the Quality Assessment and Performance Improvement (QAPI) Program (refer to the Quality Management subsection for details regarding the QAPI Program).

b. The UM Committee shall provide utilization review and monitoring of UM activities of both the Contractor and its providers and is directed by the Contractor CMO. The UM Committee shall convene no less than quarterly and shall submit the meeting agenda, sign-in sheets, handouts and presentations, and minutes to LDH within five (5) business days of each meeting. If minutes are not approved within five (5) business days after meeting, minutes must be submitted within five (5) business days of final approval or draft minutes will be submitted within two (2) weeks of meeting, whichever is sooner. UM Committee responsibilities include:

i. Monitoring providers' requests for PAs;

ii. Monitoring the medical appropriateness and necessity of services provided to its members utilizing provider quality and utilization profiling;

iii. Reviewing the effectiveness of the utilization review process and making changes to the process as needed;

iv. Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;

v. Monitoring consistent application of service authorization criteria to determine medical necessity;

vi. Monitoring of the application of clinical practice guidelines;

vii. Monitoring and addressing over- and under-utilization;

viii. Review of outliers; and

ix. Monitoring of Treatment Record Review (TRR) process and findings.

g. Utilization Management (UM) Reports

a. The Contractor shall submit UM reports as specified by LDH. LDH reserves the right to request additional reports as deemed necessary by LDH.

b. The Contractor shall actively monitor and analyze utilization and cost data for covered behavioral health services, including by provider type. The Contractor shall report complete and accurate utilization data to LDH in a manner and format prior approved by LDH.

h. *Timing of Service Authorization Decisions*

a. There shall be twenty-four (24) hour, seven (7) days per week, three hundred and sixty-five (365) days per year capacity for service authorization by LMHP care managers.

b. Standard Service Authorization

i. The Contractor shall provide notice as expeditiously as the member's health condition requires and within state-established timeframes that may not exceed seven (7) calendar days following receipt of the request for service unless an extension is requested. As per the 1915(b) waiver and 42 CFR §438.206, the Contractor shall ensure its providers meet established standards for timely access to care and services, taking into account the urgency of the need for services.

ii. An extension may be granted for service authorization determination for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the Contractor justifies to LDH, upon request, a need for additional information and the extension for service authorization extension is in the member's best interest. In no instance shall any determination of standard service authorization be made later than fourteen (14) calendar days from receipt of the request.

iii. The Contractor shall make concurrent review determinations within timeframes established by NCQA for each LOC after obtaining the appropriate medical information that may be required.

iv. The Contractor shall create a quarterly report on standard service authorizations and denials in a format to be approved by LDH. Changes in the frequency and format of this report shall be upon the approval and at the discretion of LDH.

c. Expedited Service Authorization

i. In the event a provider indicates, or the Contractor determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

ii. The Contractor shall include in the quarterly report (see the *Reporting* section) expedited service authorizations and denials in a format to be approved by LDH. Changes in the frequency and format of this report shall be upon approval and at the discretion of LDH.

d. Post Authorization

i. The Contractor shall make retrospective review determinations within thirty (30) calendar days of receipt of sufficient medical information necessary to make a determination. Retrospective review determinations shall be completed within one hundred and eighty (180) calendar days from the date of service.

ii. The Contractor shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission, or the provider misrepresented the member's health condition.

e. Timing of Notice

i. Notice of Action

1. The Contractor shall provide draft letters to LDH for approval within thirty (30) calendar days of DOA/OSP approval of the signed Contract. The Contractor shall comply with all state and Federal requirements for notice of action notifications.

ii. Approval

1. For service authorization approval for a routine or non- urgent admission, procedure, or service, the Contractor shall notify the provider verbally as expeditiously as the member's health condition requires but not more than one business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days

of making the initial certification.

2. For service authorization approval for extended stay or additional services, the Contractor shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service, verbally as expeditiously as the member's condition requires, but not more than one (1) business day of making the initial determination and shall provide written confirmation of such notification to the provider within two business days of making the initial certification.

iii. Adverse Benefit Determination

1. The Contractor shall notify the member in writing, using language that is easily understood at a fifth-grade reading level, of decisions and reasons to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, or any other action as defined in the *Grievances and Appeal System* section of this Contract. The notice of adverse benefit determination to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210(b)(c)(d) for member written materials, and any agreements that LDH may have entered into relative to the contents of enrollee notices or denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements. The Contractor must provide at least 10 days' advance notice to a recipient for a termination, suspension, or reduction of previously authorized Medicaid-covered services, within at least 10 days before the date of the termination, suspension of, or reduction of previously authorized Medicaid-covered services. The notice shall contain information regarding the Contractor's grievance and appeals process.

2. The Contractor shall notify the requesting provider of a decision to deny any service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notification shall include an explanation describing the specific reason(s) for the denial or an authorization of a service in an amount, duration, or scope that is less than requested. The Contractor shall notify the provider rendering the service, verbally as expeditiously as the member's health condition requires, but not more than one (1) business day of making the initial determination and shall provide written confirmation of such notification to the provider within two (2) business days of making the initial determination.

iv. Informal Reconsideration

1. As part of the Contractor Service Authorization process, the Contractor shall include an Informal Reconsideration process that allows the provider (on behalf of the member and with the member's written consent) a reasonable opportunity to present clinical information in writing or verbally to discuss a medical necessity denial with a physician or other appropriate reviewer.

2. In a case involving an initial determination or a concurrent review determination, the Contractor shall provide the provider (on behalf of the member and with the member's written consent) an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination.

3. The informal reconsideration shall occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the Contractor's LHMP authorized to make adverse determinations or a clinical peer designated by the Contractor's Medical Director if the LMHP who made the adverse determination cannot be available within one (1) business day.

v. Exceptions to Requirements

1. The Contractor shall not require service authorization for emergency services.

2. The Contractor shall not require service authorization or referral for EPSDT behavioral health screening services.

i. *Documentation for Service Authorization*

a. The Contractor is responsible for eliciting pertinent treatment record information from the treating healthcare provider(s) as needed for purposes of making service authorization determinations based on medical necessity.

b. The Contractor shall take appropriate action when a treating healthcare provider does not cooperate with providing complete medical history and treatment record information within the requested timeframe.

c. The Contractor shall deny payment to providers who do not provide requested treatment record information for purposes of making medical necessity determinations, for a particular item or service, for the provision of such item or service.

d. Should a provider fail or refuse to respond to the Contractor's request for treatment record information, at the Contractor's discretion or directive by LDH, the Contractor shall, at a minimum, impose financial penalties against the provider as appropriate.

j. *Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay*

a. The Contractor shall subject all court-ordered Medicaid behavioral health services to medical necessity review. In order to be eligible for payment, the service shall be

medically necessary and a covered benefit/service, as determined by the Contractor within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.

k. *Provider Utilization and Quality Profiling*

a. The Contractor shall profile all its providers and analyze utilization data to identify provider utilization and quality of care issues. Contractor provider profiling activities shall include, but are not limited to, the following:

i. The Contractor shall maintain a procedure to identify and evaluate member inpatient utilization;

ii. The Contractor shall maintain a procedure to identify and evaluate member's hospital admission utilization; and

iii. The Contractor shall establish individual provider clinical quality performance measures.

b. The Contractor shall investigate and intervene, as appropriate, when utilization or quality of care issues are identified.

l. *Provider Utilization and Quality Profile Reporting Requirements*

a. The Contractor shall provide individual provider profiles or a comprehensive provider profile report upon request from LDH. LDH reserves the right to request additional reports as deemed necessary.

4. Provider Payments

a. *General Provisions*

a. The Contractor shall administer an effective, accurate and efficient claims processing function that adjudicates and settles provider claims for covered services that are filed within the time frames specified by this Section and in compliance with all applicable state and Federal laws, rules and regulations.

b. The Contractor shall train all network providers on provider payment topics, including, but not limited to, claims processing procedures, timelines, grievances and appeals, common claims denial issues, and claims system operations. Training shall occur prior to the first claims submission or within thirty (30) days following execution of the provider agreement, whichever is sooner.

b. *Minimum Reimbursement to Contracted Providers*

a. The Contractor shall provide reimbursement for defined core benefits and services provided by a network provider. The rate of reimbursement shall be no less than the published Medicaid rate in effect on the date of service.

b. The Contractor is responsible for monitoring changes made to State Medicaid rates and shall make changes to ensure rates comply with the minimum Medicaid rate effective on the date of service. System changes shall be completed within thirty (30) days' notice from LDH.

c. Reimbursement to Non-Contracted Providers

a. The Contractor shall make prompt payment for covered emergency and post- stabilization services that are furnished by providers that have no arrangements with the Contractor for the provision of such services. The Contractor

shall reimburse the provider one hundred percent (100%) of the Medicaid rate for emergency services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the Contractor to out-of-network providers for the provision of emergency services shall be no more than what would be paid under Medicaid FFS by LDH and in compliance with 42 CFR §438.114.

b. For services that do not meet the definition of emergency services, the Contractor is not required to reimburse more than ninety percent (90%) of the published Medicaid FFS rate in effect on the date of service to out-of-network providers to whom it has made at least three (3) documented attempts (see Glossary) to include the provider in its network (except as noted in the *Program Integrity* section).

c. When the Contractor is not able to deliver a medically necessary covered behavioral health service, the Contractor shall timely enter an ad hoc network provider agreement with a provider to deliver the service. The Contractor shall expeditiously authorize services and reimburse the out-of-network provider in these circumstances.

d. FQHC Contracting and Reimbursement

a. The Contractor shall attempt to contract with all FQHCs in the State that provide substance use or specialty mental health under state law and to the extent that the FQHCs meet the provider qualifications outlined in the Medicaid State Plan/waivers for those services. However, the Contractor shall contract with and reimburse no less than one FQHC providing these services in each LDH region. The Contractor shall be exempted from this requirement if there is no FQHC providing these specialty behavioral health services in the designated area. The Contractor will collaborate with LDH to address any barriers to this process.

b. Tribal 638 clinics providing basic behavioral healthcare (e.g., physician, APRN, or PA) are reimbursed through the Integrated Medicaid Managed Care Program or any eligible Indian Managed Care Entity (IMCE), using the prospective rate for any Integrated Medicaid Managed Care Program member. If there are any Tribal 638 clinics providing behavioral health, the Contractor will be required to contract with and reimburse that clinic consistent with the SMDL #10-001 and allow any Indian to choose to receive covered services from an eligible and qualified behavioral health Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider, consistent with that guidance and any forthcoming regulations.

c. The Contractor shall reimburse an FQHC the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.

d. The Contractor may stipulate that reimbursement will be contingent upon receiving a clean claim and all the treatment records information required to update the member's treatment records.

e. The Contractor shall inform members of these rights in the Member Handbook.

e. Effective Date of Eligibility for New Members

a. The Contractor is not responsible for payment for core benefits and services prior to the effective date of a member's CSoC eligibility.

f. Claims Processing Requirements (Provider Payments)

a. A clean claim is a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity. Claims with errors that originated in the State's or Contractor's claim system, and through no error on the part of the provider, also qualify as a clean claim.

b. All provider claims that are clean and payable must be paid according to the following schedule:

i. Ninety percent (90%) of all clean claims of each provider type must be paid (date of payment refers to date of check or other form of payment) within fifteen (15) business days of the date of receipt (the date the Contractor receives the claim as indicated by the date stamp on the claim).

ii. Ninety-nine percent (99%) of all clean claims of each provider type must be paid within thirty (30) calendar days of the date of receipt.

c. The Contractor shall run one (1) provider payment cycle per week at a minimum, on the same day each week, as determined by the Contractor. The Contractor and its providers may, by mutual agreement, establish an alternative payment schedule.

d. The Contractor shall support an Automatic Clearinghouse (ACH) mechanism that allows Providers to request and receive electronic funds transfer (EFT) of claims payments.

e. The Contractor shall encourage its providers, as an alternative to the filing of paper-based claims, to submit and receive claims information through EDI, i.e., electronic claims. Electronic claims must be processed in adherence to information exchange and data management requirements specified in the *Claims Management* section of this Contract. As part of this Electronic Claims Management (ECM) function, the Contractor shall also provide online and phone-based capabilities to obtain claims processing status information.

f. The Contractor shall generate EOBs and Remittance Advices (RAs) in accordance with LDH standards for formatting, content and timeliness.

g. The Contractor shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or Maternal and Child Health Integrated Program: MCHIP (MCHIP) and State Children's Health Insurance Program (SCHIP) programs for fraud, waste or abuse, or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The Contractor shall not pay any claim submitted by a provider that is on payment hold under the authority of LDH or its authorized agent(s).

h. The Contractor shall process all appealed claims to a paid or denied status within thirty (30) business days of receipt of the appealed claim.

i. The Contractor shall resolve all disputed claims no later than twenty-four (24) months from the date of service.

j. The Contractor must deny any claim not initially submitted

to the Contractor within three hundred and sixty-five (365) calendar days from the date of service, unless the Contractor or its vendors created the error. If a provider files erroneously with the Contractor, another managed care organization, or with the Medicaid FI, but produces documentation verifying that the initial filing of the claim occurred within the three hundred sixty five (365) calendar day period, the Contractor shall process the provider's claim without denying for failure to timely file.

k. The Contractor shall deny payment for provider preventable conditions as defined by LDH (e.g., Healthcare-Acquired Conditions for any inpatient hospital settings in Medicaid). The Contractor shall be in compliance with requirements mandating provider identification of provider preventable conditions as a condition of payment, as well as the prohibition against payment for provide-preventable conditions as set forth in 42 CFR §438.3(g), §434.6(a)(12) and §447.26 including reporting requirements.

l. The Contractor shall inform all providers about the information required to submit a clean claim at least thirty (30) calendar days prior to the operational start date. The Contractor shall make available to network providers claims coding and processing guidelines for the applicable provider type.

m. The Contractor shall notify providers ninety (90) calendar days before implementing changes to claims coding and processing guidelines.

n. In addition to the specific website requirements outlined within this Contract, the Contractor's website shall be fully capable of interfacing with the website maintained by the Medicaid FI.

o. For the purposes of Contractor reporting on payments to providers, an adjustment to a paid claim shall not be counted as a claim. Electronic claims shall be treated as identical to paper-based claims.

g. Inappropriate Payment Denials

a. If the Contractor has a pattern of inappropriately denying or delaying provider payments for services as identified in provider grievance and appeal information, the Contractor may be subject to remediation, contract cancellation, or refusal to contract in a future time period. This applies not only to situations where LDH has ordered payment after appeal but to situations where no appeal has been made (i.e., LDH is knowledgeable about the documented abuse from other sources).

h. Payment for Emergency Services and Post-Stabilization Services

a. The Contractor shall follow the provisions of 42 CFR §422.113(c) regarding payment for emergency and post-stabilization services.

i. State Directed Payments

a. In accordance with 42 CFR §438.6(c), the Department may utilize a CMS approved State-directed payment arrangement for one or more calendar year periods dependent upon preprint approval or approval of a subsequent renewal by CMS, and enacted by LDH..

i. CMS approval of any directed payment arrangement is for one (1) rating period and it is not renewed automatically. As such, a directed payment

arrangement must be approved by CMS annually, if applicable.

ii. The directed payment arrangement may be made through a separate payment term outside of the monthly Capitation Payment. Separate payment term(s) would be captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to the Contractor.

iii. The Contractor shall make directed payments to support qualified providers as directed by the Department and in accordance with the written approval from CMS for the applicable rating period (s).

b. The Contractor will pay WAAs based on monthly invoices identifying the qualifying employees for whom payments will be triggered. The WAA agency shall be responsible for determining whether the worker that delivered the service qualifies for either a recruitment or a retention payment. The WAA agency will submit an invoice for all qualifying WAAs to the Contractor by the 15th of the month. The Contractor will pay the WAA within the later of 90-days of invoice receipt or the next quarterly payment that would include this payment from LDH, subject to available Contract amounts. If applicable, the Contractor will invoice LDH quarterly beginning on the 15th day of the first quarter of the month following the initial period of eligibility, and quarterly thereafter, for eligible payments covering the applicable performance period. The Contractor will be paid by LDH within 30 days of invoice receipt.

c. In accordance with Federal regulations, directed payments must be based on actual utilization and delivery of services. As such, within twelve (12) months of the end of the applicable calendar year, the Contractor must perform a reconciliation and provide to LDH, a reconciliation report containing any adjustments to be made to each eligible provider.

d. LDH has retained auditing rights to determine if payments have been paid to the correct eligible providers or agencies.

5. Provider Services

a. *Provider Relations*

a. The Contractor shall, at a minimum, provide a provider relations function to provide support and assistance to all providers in the Contractor's network. The Contractor shall:

i. Be available Monday through Friday from 8:00 a.m. to 4:30 p.m. Central Time to address non- emergency provider issues and on a twenty-four (24) hours per day, seven (7) days per week basis for urgent or emergency/crisis requests;

ii. Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements;

iii. Ensure visits as needed to provider sites, as well as ad hoc visits as circumstances dictate, including provider training and technical assistance. Documentation of these visits will be provided to LDH upon request and shall include sign-in sheets, agendas, documented follow-up action items (as

appropriate), and any distributed materials. Materials are subject to LDH approval upon request and

iv. Staff and maintain a provider complaint system as detailed in the *Provider Complaint System* section.

b. The Contractor shall submit all provider informational materials and formal communications to LDH for written approval prior to distribution.

b. *Provider Toll-free Telephone Line*

a. The Contractor must operate a toll-free telephone line to respond to provider questions, comments and inquiries. The toll-free number may be the same number members use to contact the Contractor.

b. The provider access component of the toll-free telephone line must be staffed between the hours of 8:00 a.m. – 4:30 p.m. Central Time Monday through Friday to respond to provider questions in all areas, including provider complaints and grievances, and appeals on member's behalf and regarding provider responsibilities.

c. The Contractor's call center system must have the capability to track provider call management metrics, including:

i. Average speed to answer.

ii. Separate call tracking and record keeping shall be established for tracking and monitoring provider and member phone lines.

iii. Nature of calls.

iv. Call abandonment rates which shall not exceed five percent (5%) daily.

v. The Contractor shall report call center metrics and outcomes to LDH upon request.

vi. The toll-free number shall be submitted to LDH. The Contractor shall agree that LDH shall own the rights to the toll-free call center number. It is anticipated that this number will be transitioned to LDH at the end of the Contract term.

d. After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment in Medicaid for any CSoC member with an emergency or urgent medical condition. This shall not be construed to mean that the provider must obtain verification before providing ED services and care.

e. The Contractor call center shall interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner, and respect the caller's privacy during all communications and calls.

f. As part of its established grievance process, the Contractor call center shall provide information on how to file a provider complaint and member grievance or appeal, log all grievances given through the provider toll-free telephone line, assist as appropriate in the resolution of member grievances, and notify the provider regarding the resolution.

g. The Contractor shall physically locate the call center in Louisiana, with exceptions approved by LDH. Magellan also

utilizes a virtual call center that supports afterhours and provider calls.

h. The provider call center shall have a language line translation system for callers whose primary language is not English (to at least include Spanish) and a TTY/TDD or relay system available. Both services shall be available twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year.

i. The Contractor shall provide periodic live monitoring of provider service calls for QM purposes upon request by LDH.

c. *Provider Website*

a. The Contractor shall have a CSoC-dedicated provider website or web page as approved by LDH. The CSoC provider website shall contain both a public facing and secure provider portal which shall be a comprehensive, integrated, internet- based behavioral health management information system.

b. The Contractor provider website shall include general and up-to-date information about the Contractor as it relates to the CSoC program. Any new materials posted on the website shall be approved by LDH. This shall include, but is not limited to:

i. CSoC Provider manual;

ii. Contractor-relevant LDH bulletins;

iii. Information on upcoming provider trainings;

iv. Information on the provider complaint, member grievance and appeal system;

v. Information on obtaining PA and referrals;

vi. Information on how to contact Contractor Provider Relations;

vii. Information on all programs and services provided through the Contract;

viii. A provider directory;

ix. Emergency preparedness and disaster response contacts and instructions;

x. Limitations on provider marketing; and

xi. Information on requirements and reporting fraud, waste, and abuse.

c. The Contractor provider portal shall provide the ability for the following actions/activities:

i. Claims Payment;

ii. Eligibility verification;

iii. Interface with the Louisiana Medicaid program;

iv. Allow the provider access to member clinical data, with appropriate member consent, including assessments and Plans of Care or relevant data necessary to provide for appropriate coordination of care; and

v. Provide online accessible methodology for providers to review and update staff rosters of credentialed

and network providers of mental health rehabilitation services.

d. The Contractor must keep eligibility data accurate based on the daily feed from the Medicaid FI. Failure to keep systems accurate and up to date shall make the Contractor subject to any sanction which is authorized by the Contract.

e. The provider website shall support claims processing and administration, membership management and services, provider network management (including provider profiling, outcomes, and quality of care information), care management, UM, and grievances and appeals.

f. The Contractor shall use current state and Federal standards and procedures (e.g., HL7, HIPAA, CMS, CPT, ICD-10, DSM-5) for this system and will maintain a uniform service and provider (credentials) taxonomy for billing and information management purposes.

g. The Contractor shall provide online accessible methodology for providers to review and update staff rosters to include educational backgrounds and credentials. The Contractor shall ensure all providers are accurately loaded into its provider registry.

h. The Contractor shall provide technical assistance and consultation to providers on establishing the means for effective, ongoing electronic collection and transfer of required data.

i. The Contractor shall be responsible for maintaining standardized data collection processes and procedures and provide training and support to all provider staff.

j. The Contractor shall perform data quality management, in conjunction with LDH in order to ensure that the data are accurate, appropriate, complete, and timely reported.

k. The Contractor shall maintain disaster recovery and business continuity of this system, as well as the provisions for the State to have continued access to and use of these data in the event of a separation of service with the Contractor.

l. Substantive changes to the website must be approved in writing by LDH.

m. The Contractor must remain compliant with HIPAA privacy and security requirements when providing any member eligibility or member identification information on the website.

n. The Contractor provider website should, at a minimum, be in compliance with Section 508 of the ADA, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.

o. The Contractor shall grant user-defined LDH access to and training on the provider website. User access under this provision shall be determined by LDH.

d. *Provider Handbook*

a. The Contractor shall develop and issue for LDH approval a CSoC specific provider handbook within thirty (30) days of the date the Contractor signs the Contract with LDH. The Contractor may choose not to distribute the provider handbook via surface mail, provided the Contractor submits a written, mailed notification and an email notification to all providers that explains how to access the provider

handbook from the Contractor's website. This notification shall also detail how the provider can request a hard copy from the Contractor at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and Federal laws. The provider handbook shall serve as a source of information regarding CSoC covered services, Contractor policies and procedures, state or Federal statutes, regulations, telephone access and special requirements to ensure all provider requirements are met. At a minimum, the provider handbook shall include the following information:

i. Description of the Contractor and the CSoC program;

ii. Covered benefits and services;

iii. Emergency/Crisis service responsibilities;

iv. Policies and procedures that cover the provider inquiries and provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Contractor to file a provider complaint and which individual(s) has the authority to review a provider complaint;

v. Information about the Contractor's member grievance and appeal system, that the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers (including the Provider Compliance Hotline) and the member's right to request continuation of services while utilizing the grievance system in accordance with 42 CFR §438.414;

vi. Service authorization criteria to make medical necessity determinations as defined by LDH;

vii. Clinical practice guidelines;

viii. Provider rights and responsibilities;

ix. PA and referral procedure;

x. Treatment record and documentation requirements;

xi. Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim submissions and samples of clean and complete claims (troubleshooting tips, common reasons for claim denials, and other helpful information for submitting claims);

xii. Contractor prompt pay requirements (see *Provider Payments* section);

xiii. Notice that provider complaints regarding claims payment shall be sent to the Contractor;

xiv. Quality performance requirements;

xv. Appointment access and availability requirements;

xvi. Information on reporting suspicion of provider or member fraud, waste or abuse; and

xvii. Information on obtaining Medicaid transportation services for members.

b. The Contractor shall disseminate bulletins as needed to incorporate any changes to the provider handbook.

e. *Provider Education and Training*

a. The Contractor shall have a sufficient number of qualified staff and allocate sufficient financial resources to provide training to all providers.

b. The Contractor shall provide training to all providers and their staff regarding the requirements of the Contract. The Contractor shall conduct initial training within thirty (30) days after finalizing enrollment of a new network provider, or provider group. The Contractor shall also conduct ongoing training, as deemed necessary by the Contractor or LDH, in order to ensure compliance with program standards and the Contract. All training will be documented with agendas, written training materials, invited attendees, and sign-in sheets (including documentation of absent attendees). Training to be provided will include but not be limited to:

i. System of Care values and the provider's role in the Coordinated System of Care;

ii. Cultural Competency;

iii. Currently implemented Evidence-Based Practices;

iv. Billing and documentation requirements;

v. Utilizing the CANS assessment and IBHA;

vi. Use of Contractor systems and website;

vii. Home and community-based setting requirements;

viii. Adverse incidents and reporting requirements;

ix. Program Integrity requirements and reporting; and

x. Additional topics as determined through provider/member surveys or as directed by LDH.

c. The Contractor is required to demonstrate deep knowledge of system of care values and Wraparound Process in order to provide technical assistance and ensure training for CSoC providers inclusive of the WAAs, FSO and other network providers is completed.

i. Required training for the WAAs will include OBH approved Introduction to Wraparound Training and OBH approved Wraparound Coaching Training.

ii. Required training for the FSO will include an OBH approved peer training program.

iii. Required training for other providers will include an OBH approved child and family team member training.

d. The Contractor shall ensure that providers are trained on the Contractor's administrative procedures including credentialing, contracting, authorization requests and use of required Contractor systems for submission of claims and the suite of tools available to providers on the Contractor provider website including the provider handbook.

e. Within thirty (30) days of DOA/OSP approval of the signed Contract, the Contractor shall develop, implement, and provide LDH with a copy of an annual training plan that addresses all training requirements, including involvement of members and family members in the development and

delivery of trainings.

f. The Contractor shall submit a copy of any initial provider training materials and a training schedule to LDH for approval within thirty (30) calendar days after the date the signed Contract is approved by DOA/OSP. Any changes to the materials or schedule shall be submitted to LDH for approval prior to the scheduled change and dissemination of such change.

g. The Contractor shall provide thirty (30) days advance notice of all trainings to LDH, and LDH shall be permitted to attend any and all provider training sessions. The Contractor shall maintain and provide upon LDH request all provider training reports identifying training topics provided, dates, sign-in sheets, invited/attendees lists, and organizations trained.

h. The Contractor shall submit all provider informational and training materials and presentations to LDH for written approval prior to distribution.

f. *Provider Complaint System*

a. A provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the Contractor, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the Contractor. Note that member grievance and appeals filed by providers on behalf of a member should be documented and processed with member grievance and appeals policies as outlined in the *Grievance and Appeal System* section.

b. The Contractor shall establish a Provider Complaint System for providers to dispute the Contractor's policies, procedures, or any aspect of the Contractor's administrative functions. As part of the Provider Complaint System, the Contractor shall:

i. Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;

ii. Identify a staff person specifically designated to receive and process provider complaints;

iii. Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual, and network provider agreement provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and

iv. Ensure that Contractor executives with the authority to require corrective action are involved in the provider complaint escalation process as necessary.

c. The Contractor shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The Contractor shall submit its Provider Complaint System policies and procedures to LDH for review and approval within thirty (30) calendar days of the date the Contract with LDH is signed. The policies and procedures shall include, at a minimum:

i. Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaints with the Contractor and the resolution time;

ii. A description of how and under what circumstances providers are advised that they may file a complaint with the Contractor for issues that are Contractor Provider Complaints and under what circumstances a provider may file a complaint directly to LDH for those decisions that are not a unique function of the Contractor or when the provider has exhausted the Contractor's Provider Complaint System;

iii. A description of how Provider Relations staff are trained to distinguish between a provider complaint and a member grievance or appeal in which the provider is acting on the member's behalf;

iv. A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint;

v. A process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation and ensuring that provider complaints are acknowledged within three (3) business days of receipt; resolve or state the result communicated to the provider within thirty (30) business days of receipt (this includes referrals from LDH). If not resolved in thirty (30) business days, the Contractor must document why the issue goes unresolved; however, the issue must be resolved within ninety (90) calendar days;

vi. A description of the methods used to ensure that Contractor executive staff with the authority to require corrective action is involved in the complaint process, as necessary;

vii. A process for giving providers (or their representatives) the opportunity to present their cases in person;

viii. Identification of specific individuals who have authority to administer the provider complaint process;

ix. A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and

x. A provision requiring the Contractor to report the status of all provider complaints and their resolution to at a frequency to be determined by LDH and in the format required by LDH.

d. The Contractor shall distribute the Contractor's Provider Complaint System policies and procedures to network providers at time the network provider agreement is complete. The Contractor may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the Contractor's website. This summary shall also detail how the provider can request a hard copy from the Contractor at no charge to the provider.

e. The Contractor shall maintain all of the above information and forms on its provider website to allow submittal of complaints electronically. In addition, the Contractor shall provide providers with an address to submit complaints in

writing and a phone number to submit complaints by telephone.

6. Enrollment

a. *Enrollment of Children and Youth for CSoC*

a. Upon enrollment in CSoC including a clinical presumptive determination of need, eligible children and youth are assigned to the Contractor for management of specialized behavioral health and waiver services.

i. Screening, clinical eligibility assessment and CSoC enrollment may take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care.

ii. The Contractor will screen and conduct the brief CANS, if appropriate, on non-Medicaid youth to determine clinical eligibility. For youth in which the brief CANS indicates clinical eligibility, the Contractor shall initiate a referral for Medicaid eligibility determination in accordance with standard operation procedures. For youth in which the brief CANS does not indicate clinical eligibility, the Contractor shall provide contact information to the youth/family to applyfor Medicaid and potential receipt of other non-CSoC services, if requested.

iii. Screening, clinical eligibility assessment and CSoC enrollment may also take place while a youth resides in an out-of-home LOC (such as PRTF or TGH) and is preparing for discharge to a home and community-based setting. Screening, clinical eligibility assessment, and CSoC enrollment should be conducted 30 days (not to exceed ninety (90) days) prior to discharge from a residential setting, as it is expected to assist in comprehensive discharge and treatment planning, prevent disruption, and improve stabilization upon reentry to a home and community environment.

iv. A child enrolled in CSoC who enters a residential treatment setting may remain in CSoC if they have an approved Plan of Care (POC), agreed upon by an active and functional Child and Family Team (CFT), that 1) indicates that after exhausting all other community resources, the CFT is in agreement that the child will enter into the residential setting for up to thirty (30) days, not to exceed ninety (90) days, 2) treatment in the residential setting will target increasing stabilization in order for the child to return to his/her home and community for continued work with the CFT, 3) the POC identifies a working plan to expedite return to the community, inclusive of defining resources that need to be pursued, and 4) the POC indicates that while the youth stays in the residential setting, the CFT will meet weekly (by conference call, if needed) to further develop, review and update the POC. The Contractor will ensure that Wraparound Facilitators make all efforts such that the child and family, the residential facility staff who work directly with the child and family, and any current or newly identified community providers be in attendance at these CFTs. These criteria may be further delineated in the Standard Operating Procedures.

v. The Contractor may only permit eligible individuals, who reside in an institution (such as an inpatient

hospital, nursing facility, IMD, ICF/DD, or PRTF) or other non-HCBS setting (such as a group home, any setting on the grounds of or adjacent to a public institution, or any setting located in a building that also provides inpatient institutional treatment), to receive Wraparound Services under the 1915(b)(3) authority for up to ninety (90) days while the participant remains in the institutional/non- HCBS setting for discharge planning purposes to ensure a successful transition to a home and community-based setting and, when clinical eligibility is met, enrollment in the 1915 (c) waiver.

b. The Contractor shall accept referrals of individuals for CSoC consideration in the order in which they are referred, without restriction. The Contractor shall complete the brief CANS in order to determine if the child/youth is presumptively clinically eligible for CSoC. If the child/youth meets presumptive clinical eligibility, the Contractor will build a thirty (30) day authorization and make referral within twenty- four (24) hours to the WAA. The Contractor shall make a referral to the FSO within twenty-four (24) hours of notification of member's choice. The WAA shall ensure that the independent assessment is conducted to determine clinical eligibility. In the event waiver capacity is reached, the Contractor shall establish a wait list based on the order in which members were referred and report to LDH the number of individuals on the wait list and the average amount of time newly enrolled individuals were on the wait list, at the frequency approved by LDH.

c. The Contractor shall not discriminate against Contractor members on the basis of their health history, health status, need for healthcare services or adverse change in health status; or on the basis race, color, national origin, disability, religious belief, sex, sexual orientation, or gender identity, in compliance with 42 CFR §438.3(d).

d. The Contractor shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability, in compliance with 42 CFR §438.3(d).

e. The Contractor shall not request disenrollment of any member who is eligible for CSoC services because of the member's adverse change in health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs and shall comply with applicable disenrollment sections of 42 CFR §438.56.

f. The Contractor may not disenroll CSoC members for any reason other than discharge from CSoC. Eligible recipients may choose to no longer participate in CSoC in which case specialized behavioral health services will be transitioned to the Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge. The state will disenroll effective the 1st day of a month members who lose Medicaid eligibility.

b. *Contractor Enrollment Procedures*

a. Change in Family or Individual Member Status

i. The Contractor will report in writing to LDH's Medicaid Customer Service Unit any changes in contact information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address if outside

Louisiana, e-mail address, telephone number, and insurance coverage.

b. Enrollment Updates

i. LDH Medicaid shall make available to the Contractor weekly via electronic media (with nightly updates), updates on members enrolled in Medicaid in the format established between Medicaid and the Contractor. The Contractor shall have written policies and procedures for receiving these updates, incorporating them into its system, distinguishing which members are eligible for service provision through the Contractor, and ensuring this information is available to their providers. Policies and procedures shall be available for review upon request by LDH. The file shall contain the names addresses, and phone numbers of all new members.

ii. LDH will use its best efforts to ensure that the Contractor receives accurate enrollment and disenrollment information. In the event of discrepancies or irresolvable differences between LDH and the Contractor regarding enrollment, disenrollment or termination, LDH's decision is final.

c. Weekly Reconciliation

i. The Contractor is responsible for weekly reconciliation of the membership list of enrollments and disenrollments received from the Medicaid program Office against its internal records. The Contractor shall provide written notification to the Medicaid program Office and LDH Contract Monitor of any data inconsistencies within ten (10) calendar days of receipt of the data file.

ii. The Contractor is responsible for the daily reconciliation of the allocated CSoC enrollment and census management with the nine (9) WAAs and the Integrated Medicaid Managed Care Program Plans including but not limited to reauthorization, discharges, and referrals.

iii. Using an established protocol, if immediate enrollment in CSoC is not available because the statewide maximum number of participants have been enrolled, the Contractor is responsible for notifying the Integrated Medicaid Managed Care Program Plan that the child/youth should receive Intensive Case Management until such time as he/she is enrolled in CSoC.

7. Grievance and Appeal System

a. *Adverse Benefit Determinations, Grievance and Appeal Procedures*

a. The Contractor shall conduct adverse benefit determinations as provided for in this Contract and in accordance with State and Federal law and regulation. Upon making such determination, the Contractor shall provide all notices required herein as well as all opportunities for grievance and appeals required by this Section or by state or Federal law or regulations. The grievance system must comply with 42 CFR Part 438, Subpart F. The Contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and Federal laws and Medicaid State Plan, 1915(b),

and 1915(c) waiver.

b. The Contractor must have a grievance system in place for members that includes a grievance process, an appeal process, and access to the State Fair Hearing system, once the Contractor's appeal process has been exhausted. The Contractor may have one level of appeal for members in accordance with 42 CFR §438.402(b).

c. The Contractor's grievance and appeals procedures and any changes thereto must be approved in writing by LDH prior to implementation and must include at a minimum the requirements set forth in this Contract.

d. The Contractor shall refer all Members who are dissatisfied with the Contractor, Subcontractors, or its network providers in any respect to the Contractor's staff authorized to review and respond to grievances and appeals and require corrective action.

e. The Member or provider must exhaust the Contractor's internal grievance/appeal procedures as described in the Member Handbook prior to accessing the Louisiana State Fair Hearing process, hereafter referred to as, State Fair Hearing.

f. When the term "member" is used throughout *Grievance and Appeal System* section it includes the member, member's authorized representative, or provider with the member's prior written consent.

g. The Contractor shall not create barriers to timely due process. The Contractor may be subject to remediation, as determined in the *Remediation* section , if it is determined by LDH that the Contractor has created barriers to timely due process, or, if ten percent (10%) or higher of appeal decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of impermissible barriers include but are not limited to:

    i. Labeling grievances as inquiries or complaints and funneled into an informal review;

    ii. Failing to inform members of their due process rights;

    iii. Failing to log and process grievances and appeals;

    iv. Failure to issue a proper notice including vague or illegible notices;

    v. Failure to inform of continuation of benefits; and

    vi. Failure to inform of right to State Fair Hearing following the Contractor's internal appeal process.

h. The Contractor website must allow members to initiate a grievance or appeal through the availability of optional forms to be submitted via the website or via an automated email submission built into the form. However, in addition, a grievance or appeal may be requested orally and in writing.

i. The Contractor's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and how to instruct a member to file a grievance/appeal.

j. Notices of Action to members shall be in compliance with any agreements that LDH may enter into relative to the timing of notice, format of notice, or contents of member

notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out of court settlements.

b. *Applicable Definitions*

a. Adverse benefit determination is the denial, reduction, suspension, delay, or termination of a request for admission, availability of care, continued stay or other health care service upon review by the Contractor of information provided that the requested service does not meet the Contractor's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness. Specific examples include:

i. The denial or limited authorization of a requested service, including the type or level of service; requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

ii. The reduction, suspension, or termination of a previously authorized service.

iii. The denial, in whole or in part, of payment for a service not including claims denied in whole or in part due to not meeting the definition of a clean claim.

iv. The failure to provide services in a timely manner as defined in *Provider Network Requirements* section.

v. The failure of the Contractor to act within the timeframes provided regarding the standard resolution of grievances and appeals.

b. Appeal is defined as a review by the Contractor of an adverse benefit determination.

c. Grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination and includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. Examples of grievances include:

i. Dissatisfaction with quality of care,

ii. Dissatisfaction with quality of services provided,

iii. Aspects of interpersonal relationships such as rudeness of a provider or a network employee or failure to respect a member's rights regardless of whether remedial action is requested, and

iv. Dissatisfaction with network administration practices. Administrative grievances are generally those related to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

c. *Notice of Adverse Benefit Determination*

a. Language and Format Requirements

i. The Notice of Adverse Benefit Determination must be in writing and must meet the language and format requirements of 42 CFR §438.10 and *Member Services* section of this Contract to ensure ease of understanding.

b. Content of Notice of Adverse Benefit Determination must explain the following:

i. The adverse benefit determination the Contractor intends to take;

ii. The reasons for the adverse benefit determination;

iii. The member's right to request an appeal of the Contractor's adverse benefit determination;

iv. The member's right to request a State Fair Hearing, after the Contractor's one level of appeal has been exhausted;

v. The procedures of exercising the rights specified in this Section;

vi. The circumstances under which the expedited appeal process is available and how to request it;

vii. The member's right to have benefits continued pending resolution of the appeal; how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and

viii. Availability of interpretation services for all languages and how to access them.

c. Timing of Notice of Adverse Benefit Determination

i. The Contractor must mail the Notice of Adverse Benefit Determination within the following timeframes:

1. For termination, suspension or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the date of action;

2. In cases of verified member fraud, at least five (5) calendar days before the date of action; or

3. By the date of action for the following:

a. In the death of a member;

b. A signed written member statement requesting service termination or giving information requiring termination or reduction of services (where the member understands that this must be the result of supplying that information);

c. The member's admission to an institution where the member is ineligible for further services;

d. The member's address is unknown and mail directed to the member has no forwarding address;

e. The member has been accepted for Medicaid services by another State or jurisdiction;

f. The member's physician prescribes the change in the level of medical care; or

g. As otherwise permitted under 42 CFR §431.213.

4. For denial of payment, excluding when the denial, in whole or in part, is due to the claim not meeting the definition of a clean claim in accordance with 42 CFR §438.400, at the time of any action affecting the claim according to the terms and conditions outlined in the provider agreement between the network provider and the Contractor.

5. For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within seven (7) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, only if:

    a. The member requests extension; or

    b. For good cause shown and upon express assumption of any liability resulting from such delay; or

    c. The Contractor justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.

6. If the Contractor extends the timeframe in accordance with this contract, it must:

    a. Make reasonable efforts to give the member prompt oral notice of the delay; and

    b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

    c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

7. Untimely authorizations constitute a denial and are thus adverse benefit determinations on the date the timeframe for service authorization expires as specified in this section of the contract.

8. For expedited service authorization decisions where a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or the ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

d. Authority to File

    i. A member, or authorized representative acting on the member's behalf, may file a grievance and

Contractor level appeal, and may request a State Fair Hearing, once the Contractor's appeals process has been exhausted.

ii. A network provider, acting on behalf of the member and with the member's prior written consent, may file a grievance. The provider may also file a Contractor level appeal and may request a State Fair Hearing on behalf of a member with written consent, once the Contractor's appeals process has been exhausted.

e. Time Limits for Filing

i. The Contractor shall permit a member to file a grievance and request a Contractor level appeal subject only to the limitations expressly provided in this Section. A member shall be permitted to request a State Fair Hearing after receiving notice that the adverse benefit determination is upheld or once the Contractor's appeals process has been exhausted.

ii. The member shall be permitted to file a grievance at any time.

iii. The member shall be allowed sixty (60) calendar days from the date on the Contractor's notice of adverse benefit determination to request an appeal.

f. Procedures for Filing

i. The member or a representative acting on the member's behalf, or the provider, acting on behalf of the member and with the member's written consent, may file a grievance either orally or in writing, including online through the Contractor's website, with the Contractor. The Contractor shall confirm an oral appeal in writing.

ii. The member or a representative acting on the member's behalf, or the provider, acting on behalf of the member and with the member's written consent, may request an appeal either orally or in writing, including online.

iii. The Contractor shall ensure that all Contractor members and providers are informed of the Contractor's grievance and appeal procedures and of the State Fair Hearing process. The Contractor shall provide to each member a member handbook that shall include descriptions of the Contractor's grievance and appeal procedures. Forms on which members may file grievances and appeals to the Contractor shall be available through the Contractor, and paper copies shall be provided by the Contractor upon request of the member. The Contractor shall make all forms easily available on the Contractor's website.

iv. If an employee of the Contractor has reason to believe that a member has cause or a desire to file a grievance or appeal but is unaware of the right to do so, the employee shall have an affirmative duty to inform the member of his right to file such grievance or appeal and the procedure for doing so.

d. *Handling of Grievances and Appeals*

a. General Requirements

i. In handling grievances and appeals, the Contractor must meet the following requirements:

1. Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.

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

3. Ensure that the individuals who make decisions on grievances and appeals are individuals:

    a. Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;

    b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by LDH, in treating the member's condition or disease:

        i. An appeal of a denial that is based on lack of medical necessity.

        ii. A grievance regarding denial of expedited resolution of an appeal based on a member’s condition or disease.

        iii. A grievance or appeal that involves clinical issues.

    c. Who take into account all comments, documents, records and other information submitted by the member or member’s representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

ii. Special requirements for grievances involving quality of care (QOC) concerns

1. The Contractor shall address quality of care concerns through the grievance process. This includes investigating, analyzing, tracking, trending, disposing, and reporting, including adherence to all relevant LDH critical incident reporting requirements and the following:

    a. Conducting follow-up with the member, family/caregiver and custodial state agency, if applicable, to determine whether the immediate behavioral healthcare needs are met, including follow up after discharge from inpatient levels of

care within seventy- two (72) hours.

b. Referring grievances with quality of care issues to the Contractor's peer review committee, when appropriate.

c. Referring or reporting the grievance quality of care issue(s) to the appropriate regulatory agency, child or adult protective services and LDH for further research, review, or action, when appropriate.

d. Notifying LDH and the appropriate regulatory or licensing board or agency when the provider agreement with a network provider is suspended or terminated due to quality of care concerns.

b. Special Requirements for Appeals

i. The process for appeals must provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible request date for the appeal). The member may request an expedited appeal either orally or in writing.

ii. The process for appeals must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the member in advance of timeframes for appeals. The Contractor must inform the member of the limited time available in the cases of an expedited appeal.

iii. The process for appeals must provide the member an opportunity to examine member's case file, including treatment records, other documents and records considered during the appeals process and any new or additional evidence considered, relied upon or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the date by which the Contractor must resolve the appeal.

iv. Include, as parties to the appeal:

1. The member and his or her representative; or

2. The legal representative of a deceased member's estate.

c. Training of Contractor Staff

i. The Contractor staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the members and providers. The Contractor shall ensure staff are educated regarding applicable grievance definitions.

d. Identification of Appropriate Party

i. The Contractor grievance and appeal procedures shall identify the appropriate individual or body within the Contractor's staff having decision making authority as part of the grievance and appeal procedures.

e. Failure to Make a Timely Decision

i. Appeals shall be resolved no later than the time frames specified in the *Specific Timeframes* section and all parties shall be informed of the Contractor's decision.

ii. If a determination is not made in accordance with the timeframes specified in the Specific Timeframes section, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

f. Right to State Fair Hearing

i. The Contractor shall inform the member of the member's right to seek a State Fair Hearing if the member is not satisfied with the Contractor's decision in response to an appeal and the process for doing so.

g. Resolution and Notification

i. The Contractor must resolve a grievance or appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.

h. Specific Timeframes

i. Standard Resolution of Grievances

1. For standard resolution of a grievance and notice to the affected parties, the timeframe is established as thirty (30) calendar days or less (depending on applicable waivers) from the day the Contractor receives the grievance.

ii. Standard Resolution of Appeals

1. For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the Contractor receives the appeal. This timeframe may be extended under the *Extension Timeframes* section.

iii. Expedited Resolution of Appeals

1. For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy- two (72) hours after the Contractor receives the appeal. This timeframe may be extended under the *Extension Timeframes* section.

iv. Extension of Timeframes

1. The Contractor may extend the timeframes of this section by up to fourteen (14) calendar days if:

a. The member requests the extension; or

b. The Contractor shows (to the satisfaction of LDH, upon its request) that there is need for additional information and how the

delay is in the member's interest.

2. Requirements Following Timeframe Extension

    a. If the Contractor extends the timeframes, it must, for any extension not requested by the member:

        i. Make reasonable efforts to give the member prompt oral notice of the delay;

        ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

        iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

3. Deemed Exhaustion of Appeals

    a. In the case of the Contractor that fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the Contractor's appeal process and may initiate a State Fair Hearing.

i. Process for Expedited Resolution

    i. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

        1. If the Contractor denies a request for expedited resolution of an appeal, it must:

            a. Transfer the appeal to the timeframe for standard resolution, and shall so notify the Enrollee. Nothing in this section relieves the Contractor of its obligation to resolve the Enrollee's Appeal as expeditiously as the Enrollee's health condition requires, in accordance with Federal and State laws, regulations, rules, policies, procedures, and manuals.

            b. Make reasonable efforts to give the member prompt oral notice of the denial of request for expedited resolution, and follow up within two (2) calendar days with a written notice.

ii. The denial of a request for expedited resolution of appeal does not constitute an adverse benefit determination or require a Notice of Adverse Benefit Determination. The member may file a grievance in response the denial of a request for expedited resolution of an appeal.

iii. Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the Contractor's resolution in writing. If resolution is not made by the above timeframes, the member's request will be deemed to have exhausted the Contractor's process as per the *Specific Timeframes* section above.

j. Authority to File Expedited Appeal

i. The member, the member's representative, or the member's provider acting on behalf of the member and with the member's prior written consent, may file an expedited appeal either orally or in writing.

k. Format of Notice of Resolution

i. All notices must meet the standards described in 42 CFR §438.10.

l. Content of Notice of Grievance Resolution

i. The Contractor will provide written notice to the member of the resolution of a grievance via a letter to the originator of the grievance containing, at a minimum:

1. Sufficient detail to foster an understanding of the quality of care resolution, if grievance was a quality of care issue;

2. A description of how the member's behavioral healthcare needs will or have been met; and

3. A contact name and telephone number to call for assistance or to express any unresolved concerns.

m. Content of Notice of Appeal Resolutions

i. For all appeals, the Contractor must provide written notice to the member of the resolution.

ii. For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice to the member and shall provide the notice in writing.

iii. The written notice of the resolution must include the results of the resolution process and the date it was completed.

iv. For appeals not resolved wholly in favor of the members, the written notice must include:

1. The right to request a State Fair Hearing, and how to do so;

2. The right to request to receive benefits while the hearing is pending, and how to make the request; and

3. That the member may be held liable for the cost of those benefits if the hearing decision

upholds the Contractor's action.

n. State Fair Hearings

i. LDH shall comply with the requirements of 42 CFR §431.200(b), §431.220(4) and 42 CFR §438.414 and §438.10(g)(1). The Contractor shall comply with and all other requirements as outlined in this Contract.

ii. The member may request a State Fair Hearing only after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the Contractor's notice of resolution.

iii. The member may initiate a State Fair Hearing following deemed exhaustion of appeals processes.

iv. At the discretion of LDH, an external medical review may be offered and arranged as described below:

1. The review shall be at the member's option and must not be required before, or used as a deterrent to, proceeding to the State Fair Hearing.

2. The review shall be independent of both the State and the Contractor.

3. The review shall be offered without any cost to the member.

4. The review shall not extend any timeframes specified in 42 CFR §438.408 and must not disrupt continuation of benefits as per 42 CFR §438.420.

v. The parties to the State Fair Hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate.

e. *Prohibition Against Punitive Action*

a. The Contractor shall not take punitive action against a provider acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.

f. *Continuation of Benefits*

a. As used in this section, timely filing means filing on or before the later of the following:

i. Within ten (10) calendar days of the Contractor mailing the notice of action adverse benefit determination; or

ii. The intended effective date of the Contractor's proposed adverse benefit determination.

b. The Contractor must continue the member's benefits if:

i. The member files the appeal timely in accordance with 42 CFR §438.420(c)(1)(ii) and (c)(2)(ii) ;

ii. The appeal involves the termination, suspension, or reduction of previously authorized services;

iii. The services were ordered by an authorized

provider;

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

v. The member timely files for continuation of benefits.

c. Duration of Continued or Reinstated Benefits

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

1. The member withdraws the appeal or request for State Fair Hearing;

2. The member fails to request a State Fair Hearing or continuation of benefits within ten (10) calendar days after the Contractor mails the notice of adverse resolution to the member's appeal; and

3. A State Fair Hearing Officer issues a hearing decision adverse to the member.

ii. A provider may not request continuation of benefits for the member.

d. Member Responsibility for Services Furnished While the Appeal is Pending

i. If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR §431.230(b).

e. Effectuation of Reversed Appeal Resolutions

i. If the Contractor or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

ii. If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services, in accordance with this Contract.

f. Information to Subcontractors and Network Providers

i. The Contractor must provide the information specified in 42 CFR §438.414 about the grievance and appeal system to all Subcontractors and network providers at the time they enter a provider agreement or subcontract.

g. Grievance/Appeal/State Fair Hearing Records and Reports

a. The Contractor must maintain records of all grievances and appeals. A copy of grievances logs and records of resolution of appeals shall be retained for ten (10) years from the date

of the grievance or appeal resolution. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later.

b. The Contractor shall electronically provide LDH with grievance and appeal reports in a format prior approved by LDH in accordance with the requirements outlined in this Contract, and at the frequency established by LDH to include, but not be limited to:

   i. General description of the reason for the appeal or grievance;

   ii. Date the request was received;

   iii. Date of each review, and if applicable, date of each review meeting;

   iv. Resolution of each appeal or grievance, if applicable;

   v. Date of resolution at each level, if applicable;

   vi. Member name and Medicaid number;

   vii. Summary of grievances and appeals;

   viii. Current status;

   ix. Resolution with date of resolution and resulting corrective action;

   x. The total number of grievances, appeals and State Fair Hearings held for the reporting period broken out by members and providers filing on behalf of members;

   xi. The status and resolution of all claims disputes;

   xii. Trends and types of grievances and appeals;

   xiii. The number of grievances and appeals in which the Contractor did not meet timely disposition or resolution; and

   xiv. The number of State Fair Hearings and resolution during the reporting period.

c. Reports with redacted personally identifying information will be made available for public inspection upon request.

d. The record must be maintained in a manner accessible to LDH and upon request by CMS.

8. Quality Management

a. *Quality Assessment and Performance Improvement Program*

a. The Contractor shall implement and maintain an internal QAPI program that complies with state and Federal standards specified in 42 CFR §438.200, the Medicaid State Plan and waiver applications relative to the CSoC, and any other requirements as issued by LDH. The Contractor shall:

   i. Establish a QAPI program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria.

   ii. Recognize that the QAPI process shall be data

driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements and requiring re-measurement of effectiveness and continuing development and implementation of improvements as appropriate.

iii. Have sufficient mechanisms in place to assess the quality and appropriateness of care furnished to members with special healthcare needs.

iv. Collect and utilize data on race, ethnicity, primary language, gender, age, and geography (e.g., urban/rural) to identify and address health disparities between population groups.

b. Detect and address under- and over-utilization of services.

i. Verify Members' receipt of services.

ii. Monitor network provider activities to ensure compliance with Federal and state laws, regulations, waiver and Medicaid State Plan requirements, the Contract, and all other quality management requirements, including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule determined by the Contractor and approved by LDH.

iii. Conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.

iv. Increase the alignment of assessment and treatment with best practice standards through policies such as increasing the use of evidence- based behavioral therapies as the first-line treatment for Attention Deficit Hyperactivity Disorder (ADHD) for children younger than six years of age, or other methods to increase alignment with best practices for ADHD care for all children and particularly for children under age six (6).

v. Develop a performance scorecard (wraparound scorecard) for each wraparound agency to include comprehensive data on a variety of measures.

vi. Take appropriate action to address service delivery, provider, or other QAPI issues as they are identified.

vii. Have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, subcontracts, members and their families/caregivers, and providers and use the feedback and recommendations to improve performance.

viii. Disseminate information about findings and improvement actions taken and their effectiveness to LDH, the CSoC Governance Board, and other participating agencies, members and their families/caregivers, providers, committees, and other key stakeholders and post the information on the Contractor's website in a timely manner.

ix. Ensure that the ultimate responsibility for the QAPI is with the Contractor and shall not be delegated to Subcontractors or network providers.

x. Participate in the LDH quality committee meetings and other meetings as directed by LDH.

xi. Participate in the review of quality findings and take action as directed by LDH. The Contractor shall submit requested materials to LDH at least three (3) business days prior to the scheduled meeting date.

b. *Quality Assessment and Performance Improvement Program (QAPI) Committee*

a. The Contractor shall form a QAPI committee that shall, at a minimum include:

i. The Contractor's Medical Director, who must serve as the chair or co- chair and

ii. Appropriate Contractor staff representing the various departments of the Contractor organization including but not limited to grievance and appeal staff and corporate compliance administrator responsible for fraud, waste and abuse activities.

b. QAPI committee responsibilities shall include:

i. Directing and reviewing QI activities;

ii. Ensuring that QAPI activities take place throughout the organization;

iii. Suggesting new or improved QI activities;

iv. Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;

v. Conducting provider quality performance measure profiling;

vi. Reporting findings to appropriate executive authority, staff, and departments within the Contractor;

vii. Directing and analyzing periodic reviews of members' service utilization patterns; and

viii. Maintaining minutes of all committee and sub-committee meetings and submitting meeting minutes, agendas, and referenced materials to LDH within five (5) business days following the meeting. The Contractor shall submit draft meeting minutes within five (5) business days following the meeting, if the final meeting minutes are not approved by the QAPI committee within five (5) business days following the meeting.

c. QAPI Program Description, Work Plan and Evaluation

i. The QAPI committee shall develop and implement a written QAPI program description and work plan, which must be submitted to LDH within thirty (30) days of DOA/OSP approval of the signed Contract and annually thereafter. The combined QAPI program description and work plan shall not exceed 30 pages unless otherwise approved by OBH.

ii. The QAPI program description at a minimum, shall:

1. Include a description of the Contractor staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.

2. Include the methodology utilized for collecting data and describe the methods for

ensuring data collected and reported to LDH is valid and accurate.

3. Specify the remediation actions that will be implemented when system performance is less than the required threshold.

4. Demonstrate that active processes are in place that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention's effectiveness.

5. Describe how the Contractor will obtain feedback from providers and members.

6. Describe how the Contractor will collect and utilize data on race, ethnicity, gender, age, primary language, and geography to identify potential health disparities.

7. Be exclusive to the CSoC Program and shall not contain documentation from other state Medicaid programs or product lines operated by the Contractor.

iii. The QAPI work plan at a minimum shall:

1. Include objectives for the Contract year, inclusive of associated action steps and timelines.

2. Include metrics and associated benchmarks for the wraparound agency scorecard.

3. Include a fidelity monitoring plan that includes utilization of a standardized fidelity monitoring tool to ensure the core elements of the wraparound facilitation are maintained, in accordance to the standards of practice established by the National Wraparound Initiative (NWI). The Contractor must conduct fidelity monitoring on an annual basis to ensure that the WAAs adhere to evidence-informed practices. The fidelity plan at a minimum shall include the fidelity criteria for the sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.

4. Include a plan to evaluate ongoing implementation of high- fidelity Wraparound in accordance with NWI standards inclusive of best practice indicators approved by OBH. The plan shall include a formalized monitoring review process of WF's demonstration of established wraparound competencies on a quarterly basis.

iv. The QAPI committee shall submit an annual QAPI evaluation to LDH, not to exceed 30 pages unless otherwise approved by OBH, which includes:

1. Result of QAPI activities and

2. Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of care.

c. *Managed Care Incentive Program*

a. To the extent that Contractor has met the Measureable Indicators set forth in the Approved Incentive Arrangements (AIAs), Contractor shall be eligible to receive incentive payments in accordance with the payment schedule detailed within the AIA.

b. At the beginning of each program year, LDH and Contractor will partner, develop, and prioritize new or expanded initiatives that will best benefit members.

c. LDH may make incentive payments in accordance with the AIA payment schedule.

d. LDH will, for each AIA to be implemented, specify the activities, targets, performance measures, or quality-based outcomes to be achieved and how each will be evaluated. LDH will only implement AIAs that are consistent with 42 CFR §438.6(b)(2).

e. AIAs will be for a fixed period of time and performance will be measured during the rating period under the Contract in which the AIA is applied.

f. AIAs will not be renewed automatically.

g. Each AIA shall define the quality strategy objectives.

h. For each Measurement Year, LDH will evaluate performance relative to the specified activities, targets, performance measures, or quality-based outcomes to be achieved for the AIA. LDH's evaluation will be based on documentation, submitted by Contractor, reflecting performance.

i. LDH shall timely notify the Contractor regarding achievement for the specified activities, targets, performance measures, or quality-based outcomes for the AIA for that Measurement Year. In the event LDH finds a deficiency, LDH will notify Contractor of its findings, including the portion of the incentive payments made attributable to such deficiency. Upon request of Contractor, LDH may defer recoupment, and Contractor may confer regarding LDH's findings, proposed action, and opportunity for cure. Upon final determination by LDH, which shall not be subject to appeal, LDH may recoup from Contractor the portion of the incentive payments made attributable to any uncured deficiency. All LDH recoupments made from Contractor pursuant to this section shall be made in accordance with the recoupment terms established by LDH, which terms shall be provided to Contractor in writing at least thirty (30) calendar days in advance of LDH recoupment from Contractor.

j. Contractor's participation in the AIAs shall have no impact on Contractor's rights or obligations under this Contract, except as it relates specifically to the AIAs. Contractor's participation in an AIA does not represent a binding obligation on Contractor to achieve the approved targeted health outcomes, and failure to achieve such outcomes shall not be considered a breach of this Contract. Further, except for recoupment of AIA payments, either directly or via offset, no penalty shall be applied for failure to achieve targeted outcomes. The aforementioned penalty limitation shall not apply to instances of the Contractor's fraudulent conduct. In the event of a conflict with other terms of this Contract, the provisions of this Section shall prevail.

d. *CSoC Outcome Evaluation*

a. The Contractor shall develop and implement a comprehensive strategy to determine the effectiveness of the CSoC program for different member population groups, such as but not limited to gender, race, age, diagnosis and system involvement, and for members receiving different support and services, such as but not limited to CSoC waiver peer support services and other behavioral health interventions. The strategy must be submitted to LDH for approval within ninety (90) days of the Contract go-live date and upon revision.

b. The Contractor shall submit the program evaluation results to LDH on an annual basis.

e. *Medicaid Home and Community-Based Waivers*

a. Home and Community-Based Setting Rule

i. The Contractor shall ensure 1915(c) and 1915(b)(3) members reside and receive services in settings that are home and community-based, as defined at 42 CFR §441.301(c)(4), and any subsequent guidance issued by LDH or CMS.

ii. The Contractor shall ensure provider and member enrollment staff receive training initially upon hire and annually thereafter and are knowledgeable about the home and community-based setting rule, including the settings that are prohibited. Upon certification/recertification or credentialing/re-credentialing, the Contractor must assess whether the provider applicant/provider's proposed/current service location comports with the home and community-based setting rule. Providers whose service setting does not comport with the rule shall not be permitted to provide CSoC services.

iii. The Contractor shall train waiver providers and Wraparound Facilitators initially upon contracting and at least annually thereafter about the home and community-based setting rule requirements, including the settings that are prohibited.

iv. Prior to enrolling members into the CSoC program, the Contractor shall assess whether the member resides in a prohibited setting. Members who reside in prohibited settings shall not be enrolled into the1915(c) waiver. The Contractor may only permit eligible individuals, who reside in an institution (such as an inpatient hospital, nursing facility, IMD, ICF/DD, or PRTF) or other non-HCBS setting (such as a group home, any setting on the grounds of or adjacent to a public institution, or any setting located in a building that also provides inpatient institutional treatment), to receive Wraparound Services under the 1915(b)(3) authority for up to ninety (90) days while the participant remains in the institutional/non- HCBS setting for discharge planning purposes to ensure a successful transition to a home and community-based setting and, when clinical eligibility is met, enrollment in the 1915(c) waiver.

v. The Contractor shall monitor members on no less than a quarterly basis to ensure they continue to reside in settings that are home and community-based and notify LDH of any members found to be residing or receiving services in a prohibited setting, and proposed action steps to transition the member to an appropriate setting.

vi. The Contractor shall monitor each waiver provider at least one (1) time per year, using an LDH approved quarterly sampling methodology, to ensure they provide services in settings that are home and community- based. The Contractor shall notify LDH of any waiver providers found to be non-compliant with the setting rule and proposed action steps to address non-compliance.

b. Waiver Performance Measures and Assurances

i. The Contractor shall have systems in place to meet the waiver assurances set forth at 42 CFR 441.301 and 302, measure performance on CMS-established Home and Community-Based Measures and 1915(c) waiver measures using the technical specifications issued by the Centers for Medicare and Medicaid Services (CMS) or approved by LDH, and meet the performance targets established by LDH. The Contractor shall collect data, perform data analysis, and report data for the performance measures identified in the current, approved 1915(c) application. In addition, the Contractor shall report data for the 1915(b)(3) population utilizing the specified 1915(c) measures. Data shall be available in both individual-level and aggregate form for all performance measures, as requested by LDH.

ii. The Contractor shall ensure staff, network providers, and Wraparound Agency staff utilize an LDH-approved or developed critical incident management system that enables data collection, tracking of status and resolution and trending.

1. The Contractor shall report individual-level remediation actions taken for critical incidents involving substantiated abuse, neglect, exploitation, medication error, and death to LDH. In the event of the death of a member, the Contractor must notify LDH in writing within one (1) calendar day of the Contractor's knowledge of the incident.

2. The Contractor shall develop and implement a training curriculum specific to Contractor staff (including but not limited to Case Managers, Call Center/Members Services, Grievance/Appeals, Quality staff, and other staff who interact with members), providers, and Wraparound Facilitators on the types of critical incidents, reporting requirements, roles/responsibilities (including that of providers, Wraparound Facilitators, protective services, and Health Standards), processes for responding to/resolving incidents and identified systemic issues. Training shall be provided on an initial and annual basis.

3. The Contractor shall provide education to members on their rights, types of critical incidents, and how to report incidents.

iii. When performance falls below the LDH established threshold for any measure, the Contractor shall conduct further analysis to determine the cause and complete a quality improvement project (QIP), subject to the review and approval of LDH. The QIP will be due to LDH no later than thirty (30) calendar

days following the reporting period. In addition, the QIP must measure the impact to determine whether the project was effective. If the project is deemed not effective by LDH, the Contractor shall submit a revised QI plan no later than fifteen (15) calendar days following notification from LDH, which specifies the interventions the Contractor will employ to improve performance.

c. Quality Performance Measures

i. The Contractor shall collect data, perform data analysis, and report data for the quality performance measures identified in the Medicaid Managed Care Quality Strategy prepared by LDH and in accordance with the frequency and the methodology approved by LDH.

ii. The Contractor shall submit a CAP within thirty (30) calendar days of notification by LDH, incorporating a timetable within which it will correct deficiencies identified when it fails to meet performance measure benchmarks set by LDH. LDH must prior approve the CAP and will monitor the Contractor's progress in correcting deficiencies.

iii. The Contractor shall provide weekly reports of wraparound referrals and enrollment from the WAAs to LDH.

iv. The Contractor shall submit quarterly a summary document ("one pager") that includes an overview of the CSoC program, its goals, current enrollment, and outcomes data to LDH.

v. The Contractor shall collect data from the WAAs to be utilized in various reports including but not limited to the WAA data spreadsheet which includes information on client progress and outcomes in identified domains such as schools and communities (use of natural supports, Out-of-Home placements, status at discharge, hospitalizations, etc.).

vi. The Contractor shall submit Quantitative reports that shall include a summary table that presents data over time including monthly, quarterly, or year-to- date summaries as directed by LDH.

1. Each report must include the analytical methodology (e.g. numerator, denominator, sampling methodology, data source, data validation methods, results summary, and source code in a statistical language matching one used by LDH), as requested by LDH. LDH reserves the right to validate all reporting.

vii. The Contractor shall adhere to the current technical specifications developed by the measure steward (i.e., the entity that developed the measure) and approved by LDH for all quality reports and performance measures.

viii. The Contractor shall stratify data reports as directed and requested by LDH.

ix. The Contractor shall utilize systems, operations, and performance monitoring tools or automated systems for monitoring; the tools and reports shall be flexible and adaptable to changes in quality measurements

required by LDH.

f. *Performance Improvement Projects*

a. The Contractor shall establish and implement an ongoing program of PIP that focus on clinical and non-clinical performance measures as specified in 42 CFR §438.240.

b. The Contractor shall perform a minimum of one LDH approved PIP. LDH may require up to two (2) additional projects for a maximum of three projects.

c. The Contractor shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for PIPs are documented.

d. The Contractor shall provide a general and detailed description of each PIP to LDH within three (3) months of the signed Contract date and within three (3) months of the beginning of each Contract year thereafter, unless otherwise directed by LDH.

i. Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.

ii. If CMS specifies Performance Improvement Projects, the Contractor will participate and this will count toward the State-approved PIPs. In addition, if CMS identifies more than the Contract required number of PIPs, the Contractor shall comply.

iii. The Contractor shall submit PIP data analysis to LDH, using a format approved by LDH and at the frequency determined by LDH.

iv. The Contractor shall submit PIP outcomes annually to LDH, using a format approved by LDH, , including but not limited to:

1. Results with quantifiable measures;

2. Analysis with time period and the measures covered;

3. Analysis and identification of opportunities for improvement; and

4. An explanation of all interventions to be taken with associated anticipated timelines.

g. *Provider Monitoring*

a. The Contractor shall develop and implement a plan for monitoring providers, including direct care staff, Wraparound Agencies, and facilities to ensure quality of care and compliance with state and federal requirements. The Contractor shall submit the plan to LDH for approval within thirty (30) days of Contract execution and upon revision. The plan must include:

i. Review criteria for each applicable provider type;

ii. Tools to be used;

iii. Sampling approach;

iv. Frequency of review;

v. Corrective actions to be imposed based on the

degree of provider non- compliance with review criteria elements on both an individual and systemic basis;

vi. Plan for ensuring corrective actions are implemented appropriately and timely by providers; and

vii. Inter-rater reliability methods.

b. The Contractor must adhere to the minimum sampling approach described in the approved waiver authority document or as required by LDH.

c. The Contractor must use LMHPs to conduct the quality monitoring reviews.

d. The Contractor's review criteria shall address the following areas at a minimum:

i. Quality of care consistent with professionally recognized standards of practice;

ii. Adherence to clinical practice guidelines;

iii. Member rights and confidentiality, including advance directives and informed consent;

iv. Cultural competency;

v. Patient safety;

vi. Compliance with waiver requirements;

vii. Compliance with critical incident reporting requirements;

viii. Appropriate use of restraints and seclusion, if applicable;

ix. Treatment planning components, including criteria to determine if the treatment plan includes evidence of implementation as reflected in progress notes and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member;

x. Continuity and coordination of care, including adequate discharge planning;

xi. Adherence to SAMHSA Peer Worker Core Competencies for FSO peer staff; and

xii. Delivery of services in accordance with the treatment plan.

e. The Contractor shall ensure that an appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with Federal and state regulations. The Contractor shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.

f. The Contractor shall submit quarterly reports which summarize monitoring activities, findings, corrective actions, quality of care investigations and findings, and improvements for specialized behavioral health services.

h. *Member Satisfaction Surveys*

a. The Contractor shall survey members on an annual basis to assess member satisfaction with the quality, availability, and accessibility of care and experience with his/her providers and the Contractor unless otherwise directed by LDH.

b. The survey shall provide a statistically valid sample of members who have at least three (3) months of continuous enrollment.

i. The survey tool and methodology must be approved by LDH prior to administration. LDH reserves the right to require the use of a LDH- issued survey tool.

ii. The survey results shall be provided to LDH annually.

i. *Quality Reviews*

a. The Contractor and its network providers shall fully cooperate in quality reviews conducted by LDH or its designee.

i. The Contractor shall comply with external independent reviews of quality outcomes, timeliness of, and access to the services covered under the Contract. The external review may include, but not be limited to, all or any of the following: treatment record review, performance improvement projects and studies, surveys, calculation and audit of quality and utilization indicators, data analyses and review of individual cases.

ii. The Contractor shall make available records and other documentation and be fully responsible for obtaining records from providers, as directed by LDH.

iii. The Contractor and its providers shall cooperate with and participate, as required, in SAMHSA core reviews of services and programs funded through Federal grants.

b. The Contractor shall use quality review findings to improve the QAPI program and shall take action to address identified issues in a timely manner, as directed by LDH.

c. The standards by which the Contractor will be surveyed and evaluated will be at the sole discretion and approval of LDH. If deficiencies are identified, the Contractor must formulate a CAP, within thirty (30) calendar days of notification by LDH, incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. LDH must prior approve the CAP and will monitor the Contractor's progress in correcting deficiencies.

9. Program Integrity

a. *Fraud, Waste and Abuse Prevention*

a. General Requirements

i. The Contractor shall comply with all state and Federal laws and regulations and LDH established policies and procedures relating to fraud, waste and abuse in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.608, 42 CFR §438.611-438.812; La. R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. Compliance with 42 CFR §438.610 is also required until the State notifies the Contractor

that it has implemented its own screening of Contractor-only providers and has notified the Contractor that it has assumed this function.

ii. The Contractor shall develop and maintain internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste and abuse activities.

iii. Such policies and procedures must be in accordance with state and Federal regulations. Contractor shall have adequate staffing and resources to investigate potential incidents of fraud, waste, and abuse and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities. Minimum staffing shall include one (1) full- time investigator for every fifty thousand (50,000) enrollees or fraction thereof. LDH may approve written requests with detailed justification to substitute another Special Investigation Unit (SIU) position in place of an investigator position.

iv. The Contractor shall require that all providers and all Subcontractors take such actions as are necessary to permit the Contractor to comply with Program Integrity, Fraud, Waste, and Abuse Prevention requirements listed in the Contract. To the extent that the Contractor delegates oversight responsibilities to a third party, the Contractor shall require that such third party complies with provisions of the contract relating to Fraud, Waste, and Abuse Prevention. Although all network providers with whom the Contractor contracts are enrolled in the program and subject to regulations, the Contractor agrees to require, via contract, that such providers comply with regulations and any enforcement actions directly initiated by LDH under its regulations, including but not limited to termination and restitution. The Contractor shall require program integrity disclosure on provider enrollment forms as mandated by LDH. LDH reserves the right to update enrollment forms periodically and require immediate use of the updated form.

v. The Contractor, including the Contract Compliance Coordinator and Program Integrity Compliance Officer, shall meet with LDH and the Medicaid Fraud Control Unit (MFCU) upon LDH request, to discuss program integrity issues, fraud, waste, abuse, and overpayment issues.

vi. In accordance with 42 CFR §438.608(a)(1), the Contractor shall establish a compliance program, and designate a compliance officer and a regulatory compliance committee on the Board of Directors that have the responsibility and authority for carrying out the provisions of the compliance program. The Compliance Officer shall answer directly to the Chief Executive Officer and Board of Directors.

vii. The Contractor shall maintain a self-balancing set of records in accordance with Generally Accepted Accounting Procedures. The Contractor agrees to maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable Federal and state requirements, and are sufficient to ensure the accuracy and validity of Contractor

invoices. Such documents, including all original claim forms, shall be maintained and retained by the Contractor for a period of ten (10) years after the Contract expiration date or until the resolution of all litigation, claims, financial management reviews or audits pertaining to the Contract, whichever is longer.

viii. The Contractor shall not have restrictions on the right of the State and Federal governments to conduct inspections and audits as deemed necessary to ensure quality, accuracy, appropriateness or timeliness of services and the reasonableness of their costs. LDH, state government, Federal government, or their designees including but not limited to the Attorney General, Office of the Inspector General, Louisiana Legislative Auditor, and Comptroller General, may inspect and audit any financial or other records of the entity, network providers, or Subcontractors. Upon reasonable notice (as defined by LDH based upon the request), the Contractor shall provide the officials and entities identified in this section on Program Integrity with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the scope of work. The Contractor agrees to provide the access described within the state regardless of where the Contractor maintains such books, records, and supporting documentation. The Contractor further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this section. The Contractor shall require its Contractors to provide comparable access and accommodations.

ix. The Contractor and its employees shall cooperate fully and assist the State and any state or Federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, waste or abuse. Such cooperation may include participating in periodic fraud and abuse training sessions, meetings, and joint reviews of network providers or members. The Contractor will cooperate with any independent verification and validation Contractor or quality assurance Contractor acting on behalf of LDH. LDH or any authorized Federal or state agency for a period of ten
(10) years from the expiration date of the contract (including any extensions to the contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the contract and any other applicable rules. The Contractor and its network providers and Subcontractors shall make all program and financial records and service delivery sites open to the representative or designees of the State or Federal agencies authorized to review matters related to service delivery as specified by the Contract.

x. The Contractor and its providers and Subcontractors shall provide originals or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested. If a provider fails to respond to a request from the Contractor or fails to supply the

requested record or information to the Contractor, the Contractor shall place the provider on a payment suspension or payment withhold until the record or information is produced or the provider notifies the Contractor in writing that the record or information cannot be produced.

xi. The Contractor and any Subcontractors or Material Subcontractors, shall cooperate fully with the agencies that conduct investigations; full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing fraud and abuse, allowing prompt access to information, providing copies of documents at no charge, granting access to all available information related to program violations, and making knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding. The Contractor and all Subcontractors or Material Subcontractors shall maintain the confidentiality of any investigation.

xii. The Contractor shall ensure compliance with or outline CAP for any finding of noncompliance based on law, regulation, audit requirement, or generally accepted accounting principles or any other deficiency contained in any audit, review, or inspection conducted. This action shall include the Contractor's delivery to LDH, for approval, a CAP that addresses deficiencies identified in any audit(s), review(s), or inspection(s) shall be submitted within thirty (30) calendar days of the close and final report of the audit(s), review(s), or inspection(s). Upon receipt and review of the submitted CAP, LDH will notify the Contractor that its CAPs are accepted, rejected, or require modification of any portion found to be unacceptable. The Contractor shall bear the expense of compliance with any finding of non- compliance under the contract.

xiii. Upon LDH request, the Contractor shall provide a copy of those portions of the Contractor's, Subcontractors and its providers internal audit reports relating to the services and deliverables provided to LDH under the Contract.

xiv. The Contractor shall provide access to LDH or its designee to all information related to grievances and appeals filed by its members. The Contractor shall ensure proper implementation of grievance procedures, in compliance with 42 CFR §438.228.

xv. The Contractor shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The Contractor shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to Federal and state law, applicable regulations, the contract, and LDH policy.

xvi. The Contractor shall require all employees to complete and attest to training modules within thirty (30) days of hire and annually related to the following in accordance with Federal and state laws:

1. Contractor Code of Conduct Training;
2. Privacy and Security – Health Insurance Portability and Accountability Act;

3. Fraud, waste, and abuse identification and reporting procedures;

4. Federal False Claims Act and employee whistleblower protections;

5. Procedures for timely consistent exchange of information and collaboration with LDH;

6. Organizational chart including the Program Integrity Compliance Officer and program integrity staff and investigator(s); and

7. Provisions that comply with 42 CFR §438.608 and §438.610 and all relevant state and Federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by the Department, the Department of Health and Human Services (HHS), CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its Departments.

xvii. The Contractor shall promptly perform a preliminary investigation of all incidents of suspected or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud or suspected abuse or confirmed abuse, the Contractor shall not take any of the following actions as they specifically relate to Medicaid claims:

1. Contact the subject of the investigation about any matters related to the investigation;

2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

b. Fraud, Waste and Abuse Compliance Plan

i. In accordance with 42 CFR §438.608(a), the Contractor and any subcontractors, to the extent the subcontractor is delegated responsibility for coverage of services and payment of claims under the contract, shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud, Waste and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, waste, and abuse in the administration and delivery of services.

ii. The Contractor shall establish and implement procedures and a system with dedicated staff responsible for routine internal monitoring and auditing of compliance risks, promptly responding to compliance issues, investigating compliance

problems identified, and correcting compliance issues to reduce the potential for recurrence, including coordinating with law enforcement agencies if issues are suspected to be criminal in nature, and ongoing compliance with the requirements of the contract.

iii. The Contractor shall submit the written Fraud, Waste and Abuse Compliance Plan within thirty (30) days from the date the contract is signed and approved by DOA/OSP and annually thereafter by contract year. The Contractor shall submit requests for revision(s) to the Plan in writing to LDH-OBH for approval at least thirty (30) days prior to Plan implementation of such revision(s). LDH-OBH, at its sole discretion, may require that the Contractor modify its compliance plan. The Fraud, Waste and Abuse Compliance Plan shall include the following:

1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and state standards;

2. Effective lines of communication between the Program Integrity Compliance Officer and Contractor's employees, providers and subcontractors;

3. Procedures for ongoing monitoring and auditing of the Contractor's systems, including, but not limited to, claims processing, encounters, billing and financial operations, member services, continuous quality improvement activities, and provider activities;

4. Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;

5. A description of the methodology and standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;

6. Enforcement of standards through well-publicized disciplinary guidelines (e.g., member/provider manuals, trainings, newsletters, bulletins);

7. Provisions for internal monitoring and auditing of the Contractor's providers, subcontractors, employees, and others;

8. Provisions for prompt response to detected offenses and for development of corrective action initiatives relating to the contract;

9. Procedures for timely and consistent exchange of information and collaboration with LDH Program Integrity, LDH-OBH, the Louisiana Attorney General, Medicaid Fraud

Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud;

10. Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly; and

11. Protections to ensure that no individual who reports program integrity related violations or suspected fraud or abuse is retaliated against by anyone who is employed by or contracts with the Contractor. The Contractor shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH or the U.S. Office of Inspector General.

iv. The Contractor shall establish policies and procedures for referral of suspected Fraud, Waste and Abuse to the LDH Program Integrity Office and Law Enforcement. A standardized referral process will be developed to expedite information for appropriate disposition.

v. The Contractor's Fraud, Waste and Abuse policies and procedures shall provide and certify that the Contractor's Fraud, Waste and Abuse unit has access to records of providers. These policies along with the designation of the Compliance Officer and committee shall be submitted to LDH-OBH for approval thirty (30) days prior to contract go-live and then thirty (30) days prior to whenever changes occur. The Contractor's submission of new or revised policies and procedures for review and approval by LDH-OBH shall not act to void any existing policies and procedures which have been prior approved by LDH-OBH for operation. Unless otherwise required by law, the Contractor may continue to operate under such existing policies and procedures until such time as LDH-OBH approves the new or revised version thereof. The Contractor shall develop an approval process that demonstrates the policies and procedures were reviewed and approved by the Contractor's senior management. The Contractor shall, in order to remain in compliance with the Agreement, comply with its Fraud, Waste and Abuse policies and procedures;

vi. Comply with LAC 50:I.Chapter 41 relative to the SURS;

vii. The Contractor shall create and disseminate written materials for the purpose of educating employees, managers, providers, subcontractors and subcontractors' employees about healthcare fraud laws, the Contractor's policies and procedures for preventing and detecting Fraud, Waste and Abuse and the rights of employees to act and be protected as whistleblowers. The Contractor's education materials shall comply with all requirements of

§1902(a)(68) of the Social Security Act regarding Employee Education About False Claims Recovery. This information shall also be contained in any employee handbook;

viii. The Contractor shall establish written policies for all employees (including management), providers and of any subcontractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section §1902(a)(68)(A) of the Social Security Act and the Louisiana Medical Assistance Program Integrity Law (MAPIL). Adherence to the False Claims Act ("FCA") which, in pertinent part, imposes liability on any person who submits a claim to the Federal government that he or she knows (or should know) is false in order to obtain payment from the government, or fraudulently retains government funds (31 U.S.C. §3729 through §3733); and

ix. Provisions that comply with 42 CFR §438.610 and all relevant state and Federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its Departments;

x. A procedure for conducting explanation of benefits as outlined in the *Care and Utilization Management* section of this contract;

xi. Description of effective training and education for the Compliance Officer, the organization's employees, Contractor providers and members to ensure that they know and understand the provisions of the Fraud, Waste and Abuse Compliance Plan and know about fraud and abuse and how to report it;

xii. A toll-free Provider Compliance Hotline phone number for members and providers to report suspected fraud or abuse. This hotline shall be separate from the Contractor's toll-free member and provider toll-free phone number(s). The Provider Compliance Hotline may utilize an interactive voice response (IVR) system with options that are user-friendly to callers and include a decision tree illustrating IVR system and expected duration times of navigating the IVR system to reach a live person. The issues reported through the Provider Compliance Hotline, corrective actions taken, and final results must be reported annually to LDH-OBH in the Fraud, Waste and Abuse Compliance Plan, or more frequently upon request of LDH-OBH. The Contractor's toll-free Provider Compliance Hotline number and accompanying explanatory statement shall be distributed to its members and providers through its Member and Provider Handbooks; and

xiii. The Contractor shall require and has procedures for a network provider to report to the Contractor when it has received an overpayment, and to return the overpayment to the Contractor within sixty (60) calendar days of the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.

b. *Contractor Prohibited Relationships*

a. As required in 42 CFR §455.104(a), the Contractor shall provide LDH with full and complete information on the identity of each person or corporation with an ownership interest of five percent (5%) or greater in the Contractor, or any subcontractor in which the Contractor has five percent (5%) or more ownership interest. The Contractor shall also provide such required information including, but not limited to financial statements, for each person or entity with ownership or controlling interest of five percent (5%) or greater in the Contractor and any of its subcontractors, including all entities owned or controlled by a parent organization. This information shall be provided to LDH on the LDH approved Contractor Disclosure Form within thirty (30) days of DOA/OSP approval of the signed contract and whenever changes in ownership occur.

b. In accordance with 42 CFR §438.610, the Contractor is prohibited from knowingly having an employment or contractual relationship with:

i. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal regulations or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The Contractor and its subcontractors shall comply with all applicable provisions of 42 CFR §438.608 and §438.610 pertaining to debarment or suspension including written disclosure to LDH of any prohibited affiliation. Unless a provider has previously been screened by LDH pursuant to 42 CFR §455.436,the Contractor and its subcontractors shall screen all employees, contractors, and providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, or any Federal healthcare programs. To help make this determination, the Contractor shall conduct monthly screenings to comply with the requirements set forth at 42 CFR §455.436, except when the Contractor has verified and confirmed that a provider is enrolled with the State and search at minimum the following sites:

1. Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://exclusions.oig.hhs.gov/;
2. Louisiana Adverse Actions List Search (LAALS) https://adverseactions.dhh.la.gov/;
3. The System for Award Management (SAM) https://www.sam.gov/index.html;
4. National Practitioner Data Bank http://www.npdb-hipdb.hrsa.gov/index.jsp; and
5. Other applicable sites as may be determined by LDH.

The Contractor shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should

be immediately reported to LDH. An attestation certifying checks are completed on a monthly basis by the 15th of each month is required. See Section 1128A(a)(6) of the Social Security Act and 42 CFR §1003.102(a)(2). Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries.

ii. An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in this section.

c. In addition to the Contractor, the following shall also be subject to the prohibitions in the *Contractor Prohibited Relationships* section:

i. A director, officer, or partner of the Contractor;

ii. A subcontractor of the Contractor;

iii. A provider;

iv. A person with beneficial ownership of five percent (5%) or more of the Contractor's equity; or

v. A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services which are significant and material to the Contractor's obligations.

d. The Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) which could result in exclusion, debarment, or suspension of the Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

c. *Criminal Background Checks and Information on Persons Convicted of Crimes*

a. The Contractor shall comply with LDH Policy No. 47.1 , "Criminal History Records Check of Applicants and Employees", which requires criminal background checks to be performed on all employees of LDH Contractors who have access to electronic protected health information on Medicaid applicants and recipients. The Contractor shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of the contract.

b. The Contractor must screen all employees and subcontractors to determine whether any of them have been excluded from participation in Federal healthcare programs. The HHS-OIG website, which can be searched by the names of any individual, can be accessed at the following URL: http://www.oig.hhs.gov/fraud/exclusions.asp.

c. The Contractor shall furnish LDH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of the contract.

d. Excluded Providers

a. FFP is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services as specified in 42 CFR §1001.1901.

b. LDH may recover from the Contractor, via a deduction from the Contractor's capitation payment, any payments made for services rendered by an excluded provider.

c. The Contractor shall not contract with or shall terminate contracts with providers of services or persons who have been excluded from participation in the Medicare or Medicaid program pursuant to §1128 (42 U.S.C. §1320a-7) or §1156 (42 U.S.C. §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings:

i. Revocation of the provider's facility license or certification, or individual practitioner license;

d. Exclusion from the Medicaid program;

i. Termination from the Medicaid program;

ii. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review (SURS) Rule (LAC 50:I.Chapter 41);

iii. Provider fails to timely renew its Louisiana issued facility license or Federal certification; or

iv. The Louisiana Attorney General's Office has seized the assets of the network provider.

e. Program Integrity Reporting and Investigating Suspected Fraud and Abuse

a. In accordance with 42 CFR §455.1(a)(1) and §455.17, the Contractor shall be responsible for promptly reporting suspected fraud, waste, and abuse information to the Louisiana Office of Attorney General, MFCU, and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).

b. The Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor, an Contractor employee, or network providers or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any Contractor which could result in exclusion, debarment, or suspension of the Contractor or a Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

c. The Contractor shall notify LDH within three (3) business days of contact by any investigative authorities conducting Medicaid fraud and abuse investigations, except in situations where the investigative authorities request non- disclosure of the investigation or disclosure of the on-going investigation is prohibited by law.

d. The Contractor shall notify LDH in writing within three (3) business days of receipt of any voluntary provider disclosures resulting in the receipt of overpayments in excess of twenty-five thousand ($25,000) dollars, regardless of whether fraud is suspected.

e. The Contractor shall report to LDH-OBH and the LDH Program Integrity Unit any program integrity-related (fraud, integrity, or quality) adverse action taken on a provider participating in its network. These reportable actions will include denial of credentials, enrollment, or contracts. Additionally, when the State executes permissive exclusions to terminate a provider for program integrity issues, the public will be notified as required by the regulation at 42 CFR §1002.212.

f. The Contractor, through its Compliance Officer, has an affirmative duty to report all activities on a quarterly basis to LDH. If fraud, waste, abuse, and overpayment issues are suspected, the Contractor compliance officer shall report it to LDH immediately upon discovery. Reporting shall include, but are not limited to:

    i. Number of complaints of fraud, waste, abuse, adverse contract terminations (any contractual termination initiated by someone other than a participating provider), and overpayments made to the Contractor that warrant preliminary investigation;

    ii. Number of complaints reported to the Compliance Officer; and

    iii. For each complaint that warrants investigation, the Contractor shall provide LDH, at a minimum, the following:

        1. Name and ID number;

        2. Source of complaint;

        3. Type of provider;

        4. Nature of complaint;

        5. Approximate dollars involved if applicable; and

        6. Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

g. Within three (3) business days of when it is discovered, the Contractor shall report to LDH and the LDH Program Integrity Unit (PIU) any Contractor employee or provider that has been excluded, suspended, or debarred from any state or Federal healthcare benefit program, including any payment history for the individual that occurred subsequent to the effective date of the exclusion as per 42 CFR §455.17.

h. The Contractor shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its providers and subcontractors. Reporting must specify which

overpayments are attributed to potential fraud.

i. The Contractor shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the Contractor or its subcontractors by providers for overpayments identified through self- audit or self-disclosure.

j. The Contractor shall confer with LDH Program Integrity before initiating any recoupment or withhold of any program integrity-related funds to ensure that the recovery, recoupment or withhold is permissible.

k. The Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

   i. The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or Federal investigation or lawsuit, including but not limited to false claims act cases;

   ii. The improperly paid funds have already been recovered by the State's Recovery Audit Contractor (RAC) contractor; or

   iii. When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.

l. This prohibition described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the Contractor obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the Contractor will return the funds to LDH.

m. The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its providers and subcontractors.

n. The Contractor shall notify MFCU and LDH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the Contractor shall take steps to triage or substantiate these tips and provide simultaneous and timely updates to MFCU and LDH when the concerns or allegations of any tips are authenticated.

o. Suspected fraud and abuse in the administration of the program shall be reported to LDH and MFCU.

p. All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH and MFCU.

q. All confirmed or suspected member fraud and abuse shall be reported immediately to LDH and local law enforcement.

r. The Contractor shall utilize a Fraud Reporting Form deemed satisfactory by the agency to whom the report is to be made

under the terms of the contract.

s. The Contractor shall be subject to a civil penalty, to be imposed by LDH, for willful failure to report fraud and abuse by employees, subcontractors, recipients, enrollees, applicants, or providers to LDH or to MFCU, as appropriate.

t. The Contractor shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

u. The Contractor and its subcontractors shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program or in medical or pharmaceutical questions or in any matter related to an investigation.

v. The Contractor or its subcontractors shall suspend payment to a provider when the State determines there is a credible allegation of fraud, unless the State determines there is good cause for not suspending payments to the network provider pending the investigation. The Contractor is responsible for sending the network provider the required notice and appeal rights as required by the code of Federal regulation.

w. The State shall not transfer its law enforcement functions to the Contractor.

x. The Contractor shall provide an annual report to LDH on the PIHP's recoveries of overpayments in accordance with 42 C.F.R. § 438.608. The annual report shall be made through the fourth quarter 145 report and will be due on January 31 of each year.

f. *Right to Review and Recovery by Contractor and LDH*

a. The Contractor and its subcontractors are responsible for investigating and reporting possible acts of provider fraud, waste, and abuse for all services under the contract.

b. The Contractor and its subcontractors shall have the right to audit and investigate providers and enrollees within the Contractor's network for a five (5) year period from the date of service of a claim. The collected funds from those reviews are to remain with the Contractor. The Contractor shall report to LDH on a quarterly basis the results of all reviews, and include instances of suspected fraud, identified overpayments, and collection status.

c. All reviews must be completed within two hundred and forty (240) days of the date the case was opened unless an extension is approved prior by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.

d. The Contractor shall confer with LDH before initiating a review to ensure that review and recovery is permissible. Notification of intent to review or recover must include, at a minimum, provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or national drug codes (NDCs) under review, date range for dates of service under review, and amount paid. LDH shall respond within ten (10) business days to each review

notification. In the event LDH does not respond, the Contractor may proceed with the review. Provision pending LDH guidance.

e. Contact with a provider shall be prohibited in instances resulting from suspected fraud, which the Contractor has identified and submitted a referral of fraud to the Department, MFCU or other appropriate law enforcement agency, unless approved by LDH.

f. If the Contractor fails to collect at least a portion of an identified recovery after three hundred and sixty-five (365) days from the date of notice to the Department, unless an extension or exception is authorized by the Department, the Department or its agent may recover the overpayment from the provider and said recovered funds will be retained by the State.

g. LDH or its agent shall have the right to audit and investigate providers and enrollees within the Contractor's network via "complex" or "automated" review for a five (5) year period from the date of service of a claim. LDH may recover from the Contractor, via a deduction from the Contractor's capitation payment, all of the following amounts assessed to a provider as a result of LDH's audit, whether the provider is excluded from the Medicaid program or not:

- Monetary Penalties assessed in accordance with the SURS Rule (LAC 50:I.4161.A.18);
- State-identified improper payments and overpayments;
- Overpayments determined through statistical sampling (extrapolation); and
- Investigation costs.

i. Any Contractor overpayments identified by LDH or its agent, and said recovered funds will be retained by the State. The Contractor may pursue recovery from the provider as a result of the State-identified overpayment. However, the Contractor is prohibited from recouping a State-identified overpayment from a provider when the Contractor is responsible for the overpayment, unless approved in writing by LDH. The Contractor shall submit corrected Encounter Data within thirty (30) Calendar Days of notice of the overpayment from LDH, regardless of whether the MCO recovers the overpayment from the provider.

h. LDH shall not initiate its own review on the same claims for a network provider which has been identified by the Contractor as under a review approved by LDH. LDH shall track open LDH and Contractor reviews to ensure audit coordination. LDH shall not approve Contractor requests to initiate reviews when the audit lead and timeframe is already under investigation by LDH or its agents.

i. In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the Contractor's Program Integrity Compliance Officer or designee. The LDH notification of intent to review must include provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The Contractor shall have ten (10) business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from LDH. If the State does not receive a response from the Contractor within ten (10) days, the State may proceed with its review.

j. In the event the State or its agent investigates or audits a provider or enrollee within the Contractor's network, the Contractor shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the Contractor and State. Document requests do not include treatment records that must be obtained from the provider.

k. LDH shall notify the Contractor and the network provider concurrently of overpayments identified by the State or its agents.

l. The Contractor shall not correct the claims nor initiate an audit on the claims upon notification of the identified overpayment by LDH or its agent unless directed to do so by LDH.

m. In the event LDH or its agent recovers any amounts assessed to a provider as a result of an LDH audit as provided for within this Section from the Contractor's capitation payment or any other method, the Contractor may pursue recovery from the provider. If the Contractor recovers State-identified improper payments, the Contractor shall submit corrected encounter data within thirty (30) days upon notification by LDH.

n. The Contractor and its subcontractors must enforce LDH directives regarding sanctions on Contractor network providers and enrollees, up to termination or exclusion from the network.

o. There will be no LDH provider improper payment recovery request of the Contractor applicable for the dates of service occurring before the start of the contract period or for providers for which no Contractor relationship existed.

p. The Contractor is subject to all regulations and requirements of the False Claims Act (FCA).

19. Claim Management

a. The Contractor shall implement and maintain a comprehensive claims processing system capable of paying claims in accordance with state and Federal requirements and in terms of the contract.

b. *Functionality*

a. To the extent that the Contractor compensates providers on a FFS basis requiring the submission of claims as a condition of payment, the Contractor shall process the provider's claims for covered services provided to members, consistent with applicable state policies and procedures and the terms of the contract and the *PIHP CSoC Systems Companion Guide*, including, but not limited to, timely filing, and compliance with all applicable state and Federal laws, rules and regulations.

b. The Contractor shall maintain an electronic claims management system that will:

i. Provide a payment system for Medicaid and all other funding sources providing services within the CSoC;

ii. Have the capability to perform eligibility, billing, accounts receivable, accounts payable, remittance advices, PA , fiscal management, provider enrollment, and other requirements as determined by LDH;

iii. Uniquely identify the attending and billing provider of each service;

iv. Identify the date of receipt of the claim (the date the Contractor receives the claim as indicated by the date stamp on the claim);

v. Store claims and encounters to the claims line level;

vi. Identify real-time complete and accurate claims and encounters history with dates of adjudication status of each claim such as paid (including multiple paid amounts such as TPL, Medicare, what the Contractor paid, and billed amount), denied, rejected, pended, appealed, etc., and follow up information on appeals;

vii. Provide a means of electronically submitting, tracking, and reconciling claims and encounters (including those where a third party is the primary payer);

viii. Identify the date of payment, the date and number of the check or other form of payment such as electronic funds transfer (EFT);

ix. Identify all data elements as required by LDH for complete and accurate encounter data submission as stipulated in this section of the contract and the *PIHP CSoC Systems Companion Guide*;

x. Accept submission of paper-based claims and electronic claims by contracted providers, and non-participating providers according to the Contractor policies as approved by LDH;

xi. Accept submission of electronic adjustment and void transactions;

xii. Accept submission of paper adjustment and void transactions; and

xiii. Have capability to pay claims at zero dollars ($0.00).

c. The Contractor shall ensure that as part of the ECM function it can provide on-line and phone-based capabilities to obtain processing status information.

d. The Contractor shall support an Automatic Clearing House (ACH) mechanism that allows providers to request and receive EFT of claims payments.

e. The Contractor shall not derive financial gain from a provider's use of electronic claims filing functionality or services offered by the Contractor or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees or charges.

f. The Contractor shall require that its providers comply at all times with standardized billing forms and formats, and all future updates for Professional claims (CMS 1500) and Institutional claims (UB 04).

g. The Contractor must comply with requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010, regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

h. The Contractor agrees that at such time that LDH presents recommendations concerning Contractor system changes, the Contractor shall comply with said recommendations

within ninety (90) calendar days from notice by LDH, or within a timeframe specified by LDH.

i. The Contractor shall have procedures thirty (30) days prior to contract go-live available to providers, in written and web format, for the acceptance of claim submissions. The Contractor shall revisit and update these procedures at least annually. These procedures must be approved by LDH and include the following:

    i. The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims;

    ii. The process for reviewing claims for accuracy and acceptability;

    iii. The process for prevention of loss of such claims; and

    iv. The process for reviewing claims for determination as to whether claims are accepted as clean claims.

j. The Contractor shall have a procedure approved by LDH available to providers in written and web form for notifying providers of batch rejections to the individual claim line level thirty (30) days prior to contract go-live. The report, at a minimum, should contain the following information:

    i. Date batch was received by the Contractor;

    ii. Date of rejection report;

    iii. Claim line level rejection detail;

    iv. Name or identification number of the Contractor issuing batch rejection report;

    v. Batch submitter's name or identification number; and

    vi. Reason batch is rejected.

k. Acceptance of claims submission or batch denial notification procedures must be revised annually. The Contractor shall submit the revised procedures to LDH for approval. Upon approval, the procedures must be made available to providers in written and web format within ten business days of LDH approval.

l. The Contractor shall assume all costs associated with claims processing, including costs for reprocessing encounters due to errors caused by the Contractor, or due to systems within the Contractor's span of control.

m. The Contractor shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from LDH.

n. For purposes of network management, the Contractor shall notify all contracted providers to file claims associated with covered services directly with the Contractor, or its Contractors, on behalf of CSoC members.

o. At a minimum, the Contractor shall run one (1) provider payment cycle per week, on the same day each week, as determined by the Contractor and approved by LDH.

p. The Contractor must process as either a claim or encounter, claims for all patients who receive state-funded specialized behavioral health services.

c. *Claims Processing*

a. The Contractor shall perform system edits, including, but not limited to:

i. Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by LDH or any other state entity that applies to the period during which the charges were incurred;

ii. A review of the entire claim within five (5) business days of receipt of an electronic claim, to determine that the claim is not a clean claim and issue an exception report to the provider indicating all defects or reasons known at that time that the claim is not a clean claim. The exception report shall contain at a minimum the following information:

1. Member name;

2. Provider claim number, patient account number, or unique member identification number;

3. Procedure, revenue, and diagnostic codes;

4. Date of service;

5. Total billed charges;

6. Provider name/identification number; and

7. The date the report was generated.

iii. The system shall validate that medical necessity was determined;

iv. The system shall determine whether a covered service required prior approval and if so, whether the Contractor granted such approval;

v. The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed (duplicate logic shall follow LDH policy). The Contractor's system shall have sufficient mechanisms in place to capture service begin and end time, service type, billing provider, servicing provider, and recipient details in order to detect duplicate claims;

vi. Ensure that the system verifies that a service is a covered service and is eligible for payment according to the provider type and modifier (as applicable);

vii. Ensure the system can edit claims up front for other insurance;

viii. Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments;

ix. Ensure that the system shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied;

x. Perform system edits for valid dates of service, and ensure that dates of services are valid dates such as

not in the future or outside of a member's Medicaid eligibility span; and

xi. Have claims processing staff qualified in accordance with the *Personnel Qualifications* section of this contract.

b. The Contractor shall provide its claims processing systems guide to LDH at least thirty (30) days prior to the contract go-live date, inclusive of all edits used to manage utilization, eligibility, appropriate payment, and appropriateness of provider billing.

d. *Sampling of Paid Claims*

a. On a monthly basis, the Contractor shall provide individual EOB notices to a sample group of the members who received services, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). The required notice must specify:

i. The service furnished;

ii. The name of the provider furnishing the service;

iii. The date on which the service was furnished; and

iv. The amount of the payment made for the service.

b. The Contractor shall stratify the sample to ensure that all provider types are represented in the same pool. The sample should be a minimum random sample of at least sixty-five (65) members per month who received a paid service to be reported on a quarterly basis. The Contractor shall submit the methodology to LDH for prior approval.

c. Surveys shall be performed within forty-five (45) days after a claim has been paid. This sampling may be performed by mail, telephonically, or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.

d. The Contractor shall over sample particular provider groups upon request by LDH.

e. The Contractor shall track any feedback received from members. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

f. Within five (5) business days, results indicating that paid services may not have been received shall be referred to the Contractor's fraud and abuse department for review and to LDH's designated Program Integrity contact.

g. The Contractor shall provide a quarterly report to LDH regarding the EOB results from sample group notices in a format to be approved by LDH. This report shall include attestations certifying EOBs were developed and sent to beneficiaries, and that the beneficiaries were provided sixty (60) days for comment and suggestion. The attestation form will be provided by LDH. LDH reserves the right to conduct monitoring reviews of all EOBs.

e. *Remittance Advices*

a. In conjunction with its payment cycles, the Contractor shall provide remittance advices.

i. Each remittance advice generated by the Contractor to a provider shall clearly comply with the provisions of La. R.S 46:460.71

ii. Adjustments and Voids shall appear on the RA under "Adjusted or Voided claims" either as approved or denied.

iii. In accordance with 42 CFR §455.18 and §455.19, the following statement shall be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from Federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable Federal or state laws."

f. *Encounter Data*

a. The Contractor's System shall be able to transmit to and receive encounter data from the LDH FI's system as required for the appropriate submission of encounter data.

b. For encounter data submissions, the Contractor shall:

i. Submit complete and accurate encounter data at least weekly;

ii. Submit data timely in accordance with the encounter reconciliation schedule published by LDH or its contracted review organization, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the Contractor or its subcontractor has a capitation arrangement with a provider. If the Contractor fails to submit complete encounter data, including encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) as measured by a comparison of encounters to cash disbursements within a five percent (5%) error threshold (at least ninety-five percent (95%) complete), the Contractor may be penalized as outlined in the *Remediation* section of the contract;

iii. Submit encounter data to the FI as specified in the *PIHP CSoC Systems Companion Guide* upon contract start. Inpatient Hospital services (Institutional encounters indicating Facility Type Code of 11, 12, 18, 21 or 86) are adjudicated at the document level. All other encounters are adjudicated at the line level;

iv. The Contractor's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-provider COB format upon contract start. The Contractor must incur all costs associated with certifying HIPAA transactions readiness through a product specified by LDH, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the *PIHP CSoC Systems Companion Guide*. Pharmacy encounter requirements are in the *Batch Pharmacy Encounter System Companion Guide* available at https://ldh.la.gov/page/system-companion-guides;

v. Within sixty (60) days of contract go-live, the Contractor shall submit all encounters electronically in the standard HIPAA 5010 transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-provider COB Transaction formats (P – Professional and I – Institutional). Compliance with all applicable HIPAA, Federal and state mandates, both current and future is required; and

vi. The Contractor shall provide LDH's FI with a weekly prior authorization file. The data shall be reported electronically as specified in the *PIHP CSoC Systems Companion Guide*. The Contractor shall report prior authorization requests on all services which require prior authorization.

c. The Contractor shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided, including all claims adjudicated, including but not limited to paid, denied, adjusted, and voided, directly by the Contractor or indirectly through a subcontractor.

d. The Contractor shall have the capability to convert, all information that enters its claims system via hard copy paper claims, to electronic encounter data, for submission in the appropriate HIPAA compliant formats to LDH's FI.

e. The Contractor shall ensure that all encounter data from a subcontractor is incorporated into files submitted by the Contractor to the FI. The Contractor shall not submit separate encounter files from subcontractors.

f. The Contractor shall ensure the level of detail associated with encounters from providers with whom the Contractor has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the Contractor received and settled a fee-for-service claim.

g. The Contractor shall utilize LDH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The Contractor shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with LDH and its FI's billing requirements.

h. The Contractor shall adhere to Federal or LDH payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the encounter data submissions and will be treated similarly by LDH across all Contractors.

i. The Contractor shall ensure that encounter files contain settled claims, adjustments, denials or voids, including but not limited to adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the Contractor has a capitation arrangement.

j. The FI encounter process shall utilize a LDH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from a batch submission by the Contractor. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the Contractor for correction and resubmission to the FI in the next payment cycle.

k. LDH has authorized its FI to edit Contractor encounters using a common set of edit criteria that might cause denials, and Contractors shall resolve denied encounters when appropriate. The Contractor is required to be familiar with the FI edit codes for the purpose of repairing encounters denied by the FI. A list of encounter edit codes is located in the *PIHP CSoC Systems Companion Guide*.

l. The Contractor CEO, CFO or its designee shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

m. Contractor must make an adjustment to encounter claims when Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If LDH or its subcontractors discover errors or a conflict with a previously adjudicated encounter claim, Contractor shall be required to adjust or void the encounter claim within thirty (30) calendar days of notification by LDH or if circumstances exist that prevent Contractor from meeting this time frame a specified date shall be approved by LDH.

g. *Adherence to Key Claims Management Standards*

a. Prompt Payment to Providers

i. The Contractor shall ensure that all provider claims are processed according to the following timeframes:

1. Within five (5) business days of receipt of a claim, the Contractor shall perform an initial screening and either, reject the claim, or assign a unique control number.

2. The Contractor shall process and pay or deny, as appropriate, at least ninety percent (90%) of all clean claims for each claim type, within fifteen (15) calendar days of the date of receipt.

3. The Contractor shall process and pay or deny, as appropriate, at least ninety-nine percent (99%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.

4. The Contractor shall fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

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

ii. To the extent that the provider contract requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than:

1. The time period specified in the provider contract between the provider and the Contractor, or if a time period is not specified in the contract:

a. The tenth (10th) day of the calendar month after the month of capitation coverage if the payment is to be made by the Contractor; or

b. Within five (5) calendar days after receipt of the capitated payment and supporting member roster information from LDH when the Contractor is required to compensate the provider directly.

b. The provider should bill the third party insurance first. The

Contractor must deny any claim not initially submitted to the Contractor by the three hundred and sixty-fifth (365) calendar day from the date of service, unless the Contractor or its subcontractors created the error. If a provider files erroneously with the Medicaid FI, but produces documentation verifying that the initial filing of the claim occurred timely within the three hundred and sixty-five (365) calendar day period, the Contractor shall process the provider's claim and not deny for failure to meet timely filing guidelines.

c. The Contractor shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. Claims involving third party liability shall be submitted within three hundred and sixty-five (365) days from the date of service.

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

h. *National Provider Identifier (NPI)*

a. The HIPAA Standard Unique Health Identifier regulations (45 CFR Part 162, Subparts A and D) require that all covered entities (healthcare clearinghouses and those healthcare providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

i. *Claims Dispute Management*

a. The Contractor shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.

b. The Claims Dispute process shall allow providers the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled. Arbitration conducted pursuant to this section shall be binding on all parties. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

j. *Claims Payment Accuracy Report*

a. On a monthly basis, the Contractor shall submit a claims payment accuracy percentage report to LDH. The report shall be based on an audit conducted by the Contractor. The audit shall be conducted by an entity or staff independent of claims management as specified in this section of the contract, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two percent (2%) of daily claims per month, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

b. The minimum attributes to be tested for each claim selected shall include:

i. Claim data correctly entered into the claims processing system with assigned transaction number;

ii. Claim is associated with the correct provider;

iii. Proper authorization was obtained for the service;

iv. Authorization limits have not been exceeded;

v. Member eligibility at processing date correctly applied;

vi. Allowed payment amount agrees with contracted rate;

vii. Duplicate payment of the same claim has not occurred;

viii. Denial reason applied appropriately;

ix. Co-payment application considered and applied, if applicable; 15.10.2.10. Effect of modifier codes correctly applied;

x. Proper coding consistent with provider credentials;

xi. Adjustments to claims are properly made with supporting documentation; and

xii. Payment is coordinated properly when other insurance is applicable.

c. The results of testing at a minimum should be documented to include:

i. Results for each attribute tested for each claim selected;

ii. Amount of overpayment or underpayment for each claim processed, adjusted, or paid in error;

iii. Explanation of the erroneous processing for each claim processed, adjusted, or paid in error;

iv. Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and

v. Claims processed, adjusted, or paid in error have been corrected.

d. If the Contractor subcontracted for the provision of any covered services, and the Contractor's subcontractor is responsible for processing claims, then the Contractor shall submit a claims payment accuracy percentage report forthe claims processed by the subcontractor.

20. Audits and Records

a. *Audit Requirements*

a. The Contractor shall ensure that its Systems facilitate the auditing of individual claims. Audit trails shall be provided throughout the Systems. LDH may require the Contractor or subcontractors, if performing a key internal control, to submit to financial and performance audits from outside companies to ensure both the financial viability of the program and the operational viability, including the policies and procedures placed into operation.

b. The Contractor shall allow the State, CMS, the Office of the Inspector General, the Comptroller General, and their designees to, at any time, inspect and audit any records or documents of the Contractor, and may, at any time inspect the premises, physical facilities, and equipment where Medicaid related activities or work is conducted. The right to audit exists for 10 years from the final date of the contract period or date of completion of any audit, whichever is later in accordance with 42 CFR §438.3(h).

c. Non-Federal entities that expend seven hundred and fifty thousand dollars ($750,000) or more in a year in Federal awards shall have a single or program- specific audit conducted for that year in accordance with the provisions of this part.

b. *State Audits*

a. The Contractor shall provide, through LDH, to State auditors (including the Louisiana Legislative Auditor), upon written request, files for any specified accounting period that a valid contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with LDH or state auditor's facilities. The Contractor shall provide information necessary to assist the State auditor in processing or utilizing the files.

b. If the auditor's findings point to discrepancies or errors, the Contractor shall provide a written CAP to LDH within ten (10) business days of receipt of the final audit report.

c. Independent Audit of Systems

a. The MCO shall submit an independent SOC 2 Type II system audit of its internal controls from its company to ensure the operational viability, including the policies and procedures placed into operation. The audit firm shall conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. These audits shall require the MCO to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the independent audit which shall contain a final report on controls placed in operation and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The audit period shall be twelve (12) consecutive months with no breaks between subsequent audit periods.

b. The Contractor shall supply the Department with an exact copy of the independent audit by March 31st of each year.

c. The Contractor shall deliver to LDH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report.

d. These audit requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the Contractor. The Contractor's or subcontractor's own cost of the audit shall be borne by the Contractor or subcontractor.

d. Audit Coordination and Claims Reviews

a. The Contractor shall coordinate audits with the Department or designee and respond within thirty (30) calendar days of a request by the Department regarding the Contractor's review of a specific provider or claim(s), and the issue reviewed.

b. In the event the Department or its designee identifies an overpayment, the Contractor shall have ten (10) business days from the date of notification of overpayments to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or designee. The Contractor shall not correct the claims upon notification by the Department or designee, unless directed to do so by the Department.

c. LDH reserves the right to review any claim paid by the

Contractor or designee. The Contractor has the right to collect or recoup any overpayments identified by the Contractor from providers of service in accordance with existing laws or regulations. If an overpayment is identified by the State or its designee, and the provider fails to remit payment to the State, LDH may require the Contractor to collect and remit the overpayment to LDH. The Contractor shall refund the overpayment to the Department within thirty (30) calendar days. Failure by the Contractor to collect from the provider does not relieve the Contractor from remitting the identified overpayment to LDH.

e. Behavioral Health Records

a. The Contractor shall have a method to verify that services for which reimbursement was made, were provided to members.

b. The Contractor shall have policies and procedures requiring network providers and the Contractor to maintain an individual behavioral health record for each member for this purpose.

c. The Contractor shall ensure the behavioral health record is: 16.15.3.1.Accurate and legible;

i. Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and

ii. Readily available for review and provides clinical data required for Quality and UM review.

d. The Contractor shall be responsible for any costs associated with the electronic submission and data layout of requested information.

e. The Contractor shall ensure the behavioral health record includes, minimally, the following:

i. Member identifying information, including name, identification number, date of birth, gender, and legal guardianship (if applicable);

ii. Primary language spoken by the member and any translation needs of the member;

iii. Services provided through the Contractor, date of service, service site, and name of service provider;

iv. Behavioral health history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by a provider;

v. Treatment Plan and POC (if required);

vi. Documentation of freedom of choice (e.g., Freedom of Choice form), particularly with regard to choice between institutional and waiver services;

vii. The IBHA;

viii. Referrals including follow-up and outcome of referrals;

ix. CANS documentation (at the request of LDH);

x. Documentation of emergency or after-hours encounters and follow-up;

xi. Other member assessments as required by LDH;

xii. Signed and dated consent forms (as applicable);

xiii. Documentation of advance directives, as appropriate;

xiv. Documentation of each visit, which must include:

1. Date and begin and end times of service;
2. Chief complaint or purpose of the visit;
3. Diagnoses or medical impression;
4. Objective findings;
5. Patient assessment findings;
6. Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG);
7. Medications prescribed;
8. Health education provided;
9. Name and credentials of the provider rendering services and their signature or initials; and
10. Initials of providers must be identified with correlating signatures.

f. The Contractor is required to provide one (1) free copy of any part of the enrollee's record to the enrollee upon request.

g. All documentation or records maintained by the Contractor, its subcontractors and any and all of its network providers related to all services, charges, operations and agreements under the contract shall be maintained for at least ten (10) years after the last good, service or supply has been provided to an enrollee or by an authorized agent of the State or Federal government or any of its authorized agents, unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the State or Federal government.

21. Transition Requirements

a. *Introduction*

a. Transition is defined as those activities that the Contractor is required to perform upon initiation of, expiration of, or termination of the contract. The transition requirements in this section shall become applicable upon any termination/change in the scope of the contract that 1) is initiated by LDH; 2) is initiated by the Contractor; or 3) occurs at the expiration of the contract term. This section addresses the Contractor's fulfillment of the following responsibilities:

i. Developing an implementation plan;

ii. Transition and development of a transition plan;

iii. Providing transition services and related information;

iv. Providing member and network transition information including member correspondence and provider lists and contacts;

v. Providing transfer of data; and

vi. Providing post-transition services.

b. General Requirements

a. The Contractor shall have a transition of care policy prior to go-live to ensure continued access to services during a transition.

b. The Contractor may be required to update information submitted in its implementation or transition plan at the request of LDH.

c. Failure to timely or correctly perform implementation or transition requirements shall subject the Contractor to monetary penalties or sanctions as outlined in the *Remediation* section of this contract.

c. Implementation Plan

a. The Contractor is required to create a written implementation plan due to be submitted to LDH at a date to be determined by LDH based on the contract award date but no later than thirty (30) days after contract award. The implementation plan shall present the scope of work for the activities that must occur between the contract award and the go-live date when services must be provided.

b. The Contractor shall designate a full time project manager for implementation within ten (10) days of contract award announcement.

c. The Contractor agrees to provide all materials required to complete the implementation plan by the dates established by LDH, as agreed to in the implementation plan, or as required by a Readiness Review Contractor, if applicable.

d. If LDH determines the Contractor does not fully meet any area of readiness prior to the go-live date, LDH may impose monetary penalty for each day beyond the go-live date.

e. The implementation plan shall include, at a minimum, all requirements in this section and specifically address the following elements: administration and personnel, financial readiness, system readiness and contingency plan, member transition, operational readiness and network adequacy by go-live date.

f. Implementation deadlines may be amended upon agreement of LDH.

d. General Transition Requirements

a. In the event the contract or any portion thereof expires or is terminated for any reason, the Contractor shall:

i. Comply with all terms and conditions stipulated in the contract, including continuation of core benefits and services under the contract, until the termination effective date;

ii. Promptly supply all information necessary for the reimbursement of any outstanding claims;

iii. Comply with direction provided by LDH in consultation with LDH to assist in the orderly transition of data, equipment, services, software, leases, etc. to LDH;

iv. Participate in a transition planning team as established by LDH. The Contractor's transition

planning team shall include care management staff, program evaluation staff, provider network staff, claims administration staff, and program monitoring staff, as well as staff that supports all automated and computerized systems and databases; and

v. Assist LDH in the notification to and transition of its members and providers at the Contractor's own expense.

b. The Contractor shall cooperate with LDH to ensure timely transition to any successor Contractor. The Contractor shall designate a full time transition liaison to work with LDH during transition. This transition liaison shall work with LDH, the successor Contractor, or the Integrated Medicaid Managed Care Program Plans on projects including, but not limited to, transition work groups.

e. Transition Plan

a. In the event of written notification of termination of the contract by LDH, the Contractor shall submit a Transition Plan within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the Contractor and LDH. In the event the Contractor terminates the contract, a transition plan shall be submitted for approval with notification of contract termination. Six (6) months prior to expiration of the contract term, a transition plan shall be submitted to LDH. The Plan shall address the transition of records and information maintained by the Contractor relative to core benefits and services and supports provided to CSoC members. The Transition Plan must be mutually agreed upon and approved by LDH.

b. The transition plan must comprehensively detail:

i. Proposed approach to transition, addressing both members' and providers' needs as well as LDH's perspective and needs;

ii. Proposed schedule for transition;

iii. Tasks and timelines for transition;

iv. Transition activities;

v. All information systems production data, program libraries, and documentation including documentation update procedures during transition; and

vi. Resource requirements associated with transition tasks.

c. The detailed plan for transition shall ensure an orderly transfer of responsibility or the continuity of those services required under the terms of the contract to LDH and shall include the following:

i. A realistic schedule and timeline to hand-off responsibilities to LDH and the successor contractor.

ii. The Contractor shall develop a plan on how to best inform and retain Contractor employees during the transition.

iii. The names of staff that shall be utilized during the hand-off of duties and their responsibilities such that there shall be clear lines of responsibility for the

Contractor and LDH.

iv. The actions that shall be taken by the Contractor and mutually agreed upon actions by LDH to ensure timely transition.

v. Transfer of information will occur in a reasonable manner as agreed between the parties, which may include, but not be limited to, observation, screenshots, walk-throughs, diagrams, etc.

vi. A matrix listing each transition task, the functional unit and the person, agency or Contractor responsible for the task, the start and deadline dates to complete the planned task, and a place to record completion of the task.

vii. All information necessary for reimbursement of outstanding claims.

viii. A plan to transition records and information maintained by the Contractor to LDH or a successor Contractor.

ix. The plan must also address the following:

1. Communication plan to members including but not limited to timelines, contact information, appropriate website links and other applicable information;

2. Communication plan to providers including but not limited to information on claims payment post contract term, information on prior authorizations and other applicable timelines;

3. Communication plan to external stakeholders;

4. Open fraud, waste and abuse investigations;

5. Member transition of care;

6. Resolution of outstanding grievances, appeals, and state fair hearings for both members and providers;

7. Records retention;

8. CMS required reporting;

9. Residential placement transition;

10. Website and phone number transition that shall be maintained by Contractor for an agreed upon period of time after Contractor transitions and contract ends;

11. Contact information including email addresses and phone numbers for the State for transition close out activities that occur after services have been transitioned; and

12. Contacts for providers for questions and billing activities that occur after services have been transitioned.

d. If the contract is not terminated by written notification as provided above, the Contractor shall propose a Transition Plan no later than six (6) months prior to the end of the contract term, including any extensions of such term. The

Plan shall address all the requirements listed above.

e. As part of the Transition Plan, the Contractor must provide LDH with copies of member and core benefits and services data, documentation, or other pertinent information necessary, as reasonably determined by LDH, for LDH to assume the operational activities successfully as set forth below. This includes correspondence and documentation of ongoing outstanding issues. The Plan will describe the Contractor's approach and schedule for transfer of all data, as applicable. The information must be supplied in media and format specified by LDH and according to the schedule approved by LDH.

    i. Relevant CSoC documentation includes current documentation of members and providers at the time of transition and historical information for a time period determined by LDH:

        1. Plans of Care (current and initial);
        2. Assessments;
        3. Freedom of Choice Forms;
        4. Authorizations;
        5. Wraparound Data Spreadsheet or new iterations of member data keeping tools;
        6. Wraparound Scorecards;
        7. Provider PIPs and CAPs;
        8. Training Schedules;
        9. Training materials; and
        10. FSO and WAA documentation including certification status.

f. The Contractor shall promptly report, in writing, to the LDH Contract Monitor problems with any aspect of transition when identified by the Contractor. The Contractor shall follow-up with a timeline for corrective actions to be taken regarding the plan for transition within a reasonable timeframe from the date the issue was reported to the LDH Contract Monitor.

f. Transition Services

a. The Contractor shall complete all work in progress and all tasks called for by the transition plan. If it is not possible to resolve all issues during the end-of-contract transition period, the Contractor shall list all unidentified or held items that could not beresolved, including reasons why they could not be resolved, prior to the end of the contract and provide an inventory of open items along with all supporting documentation. To the extent there are unresolved items that are responsibility of the Contractor, the reasonable and documented cost to complete these items will be collected from the performance bond as applicable. The Contractor shall specify a process to brief LDH on issues before the hand-off of responsibilities.

b. The Contractor shall provide all reports set forth in the contract, a schedule and contact for reporting requirements that occur after Contractor ceases operations, and reports necessary for the transition process.

c. The Contractor shall designate a transition liaison who is

intimately familiar with the daily operations and requirements of services and benefits. The transition liaison shall interact closely with LDH-OBH, LDH-BHSF, and the staff of the Integrated Medicaid Managed Care Program Plans to ensure a safe and orderly transition, and shall participate in all transition meetings.

d. Fiscal Transition Services

i. Upon contract expiration or termination, LDH reserves the right to purchase materials or to complete the required work. LDH may recover any reasonable excess costs resulting from contract cancellation or termination from the Contractor by:

1. Deduction from an unpaid balance;

2. Collection from performance bond as applicable; or

3. Any combination of the above or any other remedies as provided by law.

ii. The Contractor shall return to LDH within thirty (30) days of termination or expiration of the contract any funds advanced to the Contractor for coverage of members for periods after the date of termination to LDH within thirty (30) days of termination of the contract.

iii. The Contractor shall supply all information necessary for reimbursement of outstanding claims.

g. Member and Provider Services Transition

a. The Contractor shall cooperate with LDH during the planning and transition of contract responsibilities from the Contractor to LDH or successor Contractors. The Contractor shall ensure that member services are not interrupted or delayed during the remainder of the contract and the transition planning by all parties shall be cognizant of this obligation. The Contractor shall:

i. Make provisions for continuing all management and administrative services and the provision of services to members until the transition of all members is completed and all other requirements of the contract are satisfied.

ii. Identify mandatory administrative, member and service related tasks required the first month after transition (the first month of the successor Contractor's operations) in order to ensure orderly administration of services and continuity of care for members so as they experience zero interruption of services and benefits.

iii. Upon LDH request, submit for approval an additional detailed plan for the transition of its members, including a communication plan with members.

iv. Notify providers of the contract expiration or termination as directed by LDH.

v. Any inpatient services that may be authorized by the Contractor prior to the end of the contract shall be discussed and a transition plan and payment responsibilities will be determined. Contractor may be responsible for continued payment for services that cross over contract end date for a limited time.

vi. Transfer the toll-free call center line telephone numbers to LDH or successor Contractor to allow for the continuous use of the number for member services and provider services. If the number is not transferred at LDH's direction, the Contractor shall maintain the number for a period of time to be determined by LDH, but not to exceed 4 months with an agreed upon message redirecting members and providers.

vii. Ensure any open fraud, waste, or abuse cases are transitioned appropriately and Contractor shall remain available throughout any appropriate investigation to ensure documents or other information is available to bring cases to closure.

b. In the event of contract termination, the Contractor shall stop all work as of the effective date contained in the Notice of Termination and shall immediately notify all management subcontracts, in writing, to stop all work as of the effective date of the Notice of Termination. Upon receipt of the Notice of Termination, and until the effective date of the Notice of Termination, the Contractor shall perform work consistent with the requirements of the contract and in accordance with a written plan approved by LDH for the orderly transition of members to another Contractor. Unless otherwise directed by LDH, the Contractor shall direct providers to continue to provide services consistent with the member's treatment plan or POC.

h. Transfer of Data

a. The Contractor shall transfer all data regarding the provision of member core benefits, member core services, historic utilization data, and all data and information necessary to transition operations to LDH or a third party, at the sole discretion of and as directed by LDH.

b. Data, information, and services necessary and sufficient to enable LDH to map all Contractor program data from the Contractor's system(s) to the replacement system(s) of LDH, including comprehensive data dictionary. All transfers of data must be compliant with HIPAA.

c. The Contractor must transfer information necessary to transition operations including: data and reference tables; documentation relating to software; functional business flows; and operation information including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operation information regarding subcontractors. For purposes of this provision, "documentation" means all operations, services, and deliverables, that LDH determines are necessary to view and extract application data in a proper format. The Contractor must provide the documentation in the formats in which the documentation exists at the expiration or termination of the contract.

d. All relevant data must be received and verified by LDH. If LDH determines that not all of the data regarding the provision of member core benefits and services to members was transferred to LDH, as required, or the data is not HIPAA compliant, LDH reserves the right to hire an independent contractor to assist LDH in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the Contractor transitioning out.

e. The Contractor shall cooperate fully with LDH during the

Transition Period including, at a minimum, sharing and transferring behavioral health member information and records, as required by LDH, with data dictionary crosswalks for all data to ensure value match.

f. The Contractor shall reasonably cooperate with the Integrated Medicaid Managed Care Program plans during Transition Period including, at a minimum, participation in ongoing workgroup with attendees from Integrated Medicaid Managed Care Program and LDH representation. The Contractor shall provide LDH with relevant service utilization data, member specific POC information, identified service gaps, if any, and a listing of all levels of CSoC service providers.

g. The Contractor will participate in regular case specific transition meetings with OBH and any successor contractor or CSoC program manager at least monthly during transition concerning case staffing to ensure an understanding of needs and practices and provide for an orderly transition of case specific processes and information. A reasonable degree of coordination between the Contractor and the Integrated Medicaid Managed Care Program plans is required as the Integrated Medicaid Managed Care Program plans retain responsibility for physical health including pharmacy, basic behavioral health, and specialized behavioral health immediately upon discharge from CSoC (which is a voluntary program) and upon transition of the program to Contractor's successor or entity identified to manage CSoC.

h. The Contractor shall cooperate with LDH and Medicaid for the transition of data from the Contractor's Information Management System and the Contractor data warehouse. The Contractor shall provide a contact to fully support and expedite this effort to be completed.

i. The Contractor shall provide and securely transmit to the State's FI a claims and authorization file or report, in a frequency to be determined and format identified by LDH, which details all specialty behavioral health services that each member has received. Once receiving such claims, encounter and service histories, from the State's FI, Contractor's successor or entity identified to manage CSoC may then schedule consultation rounds with Care Managers or similar clinical staff to discuss details related to the care management of these members. The information must be in a usable format easily digestible and understandable to the end user.

j. For children/youth transitioning out of CSoC (whether during the contract, during a transition period or at the end of the contract), Contractor's successor or entity identified to manage CSoC will receive the results of the initial comprehensive CANS assessment, IBHA, POC (which includes crisis plan), and the discharging comprehensive CANS assessment. POCs are for not more than 180 days.

i. Post-Transition Services

a. Within thirty (30) days following transition of operations, the Contractor must provide LDH with a Transition Results report documenting the completion and results of each step of the Transition Plan. Transition will not be considered complete until this document is approved by LDH.

b. The Contractor shall provide the required relevant authorization and claims data and reference tables and documentation for LDH.

c. The Contractor must pay any and all additional costs incurred by LDH that are the result of the Contractor's failure to provide the requested records, data or documentation that is currently in existence for the operations of the program and management of members within the time frames agreed to in the Transition Plan and in a usable format for LDH that does not require additional resources to utilize.

d. The Contractor must maintain all files and records related to members and providers for ten (10) years after the date of final payment under the contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the contract on or taken by LDH in any audit of the contract.

e. The expiration, termination or suspension the contract shall not affect the obligation of the Contractor to indemnify LDH for any claim by any third party against the State or LDH arising from the Contractor's performance of the contract and for which the Contractor would otherwise by liable under the contract.

f. LDH may request exit interviews to be conducted seven (7), thirty (30), or sixty (60) days prior to the contract termination date and thirty (30) days post contract termination. These exit interviews will be for the purpose of assessing contract termination readiness. The Contractor must be prepared to provide exit status updates on the following (including, but not limited to): data transition, member transition, and a list of operations to be completed (including care transition and claims status).

j. Transition Deliverables

a. Transition deliverables shall be determined in the transition plan.

b. For any deficiency or failed deliverable, LDH shall provide the Contractor notice and a reasonable opportunity to cure or present a CAP to be approved by LDH, which shall not be unreasonably withheld.

c. If the Contractor fails to correct the deficiency within the timeline approved by LDH, LDH may correct said deficiency. In such situations, the Contractor shall be responsible for LDH's reasonable expenses related to the correction.

B. Personnel Qualification

1. General Requirements

a. The Contractor shall be staffed by qualified persons in numbers appropriate to the Contract in accordance with the size of enrollment.

b. The Contractor shall provide a listing of dedicated corporate resources to LDH upon request.

c. The Contractor shall maintain and provide documentation that all staff have the required training, education, experience, orientation, and credentialing, as applicable, to perform assigned job duties. The Contractor shall maintain current organization charts, resumes, and written job descriptions for both key staff and consultants. All information shall be made available to LDH upon request.

d. The Contractor will employ and maintain for the duration of the Contract sufficient staffing and utilize appropriate resources to achieve contractual compliance. The Contractor's resource allocation must be adequate to achieve outcomes in all functional

areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and LDH policy requirements, including the requirement for providing culturally competent services. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations and LDH determines this is due to lack of resources, additional monitoring of resource allocation may be employed by LDH, including but not limited to requiring the Contractor to hire additional staff.

e. The Contractor shall be responsible for any additional costs associated with on- site audits or other oversight activities as determined by LDH that result when required systems are located outside of the State of Louisiana.

f. The Contractor shall remove or reassign, upon written request from LDH, any Contractor employee or Subcontractor employee that LDH deems to be unacceptable.

g. The Contractor may terminate any of its employees designated to perform work or services under the Contract, as permitted by applicable law.

h. The Contractor shall attest that it shall not employ or contract with or have a financial relationship with any employee or former employee of the State who participated in discussions regarding or assisted in the drafting of the Contract within the prior two (2) years from the date the signed Contract is approved by DOA/OSP.

i. The Contractor shall have a sufficient number of qualified staff to meet the responsibilities of the Contract, including sufficient experience and expertise in working with the eligible members served under the Contract: 1) children and youth with behavioral health needs; and 2) children and youth served by multiple child-serving agencies (child-welfare, juvenile justice, schools, behavioral health) in, or at risk of out-of-home placements.

j. The Contractor shall submit to LDH the following staff related items within 30 days of go-live date unless an extension is agreed upon between Contractor and LDH, at key staff position changes, at any reorganization of the Contractor's operations, and at LDH's request.

a. An organizational chart identifying all key staff positions. The chart must include the staff person's name, title according to the below outlined key staff positions, telephone number, official work location of employee, and portion of time allocated to the Contract, any other Louisiana contracts, and other lines of business.

b. A functional organization chart of the key program areas including the additional required staffing units outlined below, responsibilities, physical work location, and lines of reporting.

c. A list of all functional areas and primary location of work performed in that area.

d. If Contractor key staff are work at home employees or any functional areas of operation allow work at home, indicate so on the organization charts along with any physical location that employee is assigned.

e. If any functional areas, other required staffing units or key staff, are moved outside of Louisiana after Contract go-live, Contractor shall notify LDH.

2. Key Staff Positions

a. The Contractor shall employ key staff to work full-time (full-time equivalent per position) at a location in Louisiana, unless otherwise approved in advance by LDH.

b. The Contractor shall inform LDH in writing when an employee leaves one of the key staff positions listed below (this requirement does not apply to additional required staff, also listed below). The name of the interim contact person should be included with the notification. This notification shall take place within five (5) business days of the resignation/termination, but no later than the first day the key staff is absent.

c. Hiring and replacement of key staff positions shall require prior written approval from LDH. The Contractor shall replace any of the key staff with a person of equivalent experience, knowledge, and talent.

d. If key staff are not available for work under the Contract for a continuous period exceeding thirty (30) days, or are no longer working full-time in the key position(unless previously approved by LDH), the Contractor shall notify LDH within five (5) days after the date of notification by the key staff of the change in availability or change in full-time employment status to the Contractor. The name of the interim contact person should be included with the notification.

e. The Contractor shall fill the vacant positions within ninety (90) days of the notification to LDH or shall be penalized as per the provisions of the *Remediation* section of this Contract

f. Key Staff positions and responsibilities are as follows:

a. The **CSoC Program Director** must be full time (40 hours weekly) and available during LDH working hours to fulfill the responsibilities of the position and to oversee all aspects of the CSoC Program. The CSoC Program Director should devote sufficient time to the Contractor's operations to ensure adherence to program requirements and timely responses to LDH. The CSoC Program Director shall have at least ten (10) years' experience with management of behavioral health services of organizations similar in size and scope to the requirements of this Contract. This position is also responsible for:

i. Serves as a primary point-of-contact for all Contractor operational issues that may include but are not limited to coordinating the tracking and submission of all Contract deliverables; fielding and coordinating responses to LDH inquiries; coordinating the preparation and execution of Contract requirements, random and periodic audits and ad hoc visits and deliverables.

ii. Manages and oversees the Contractor's emergency management plan during disasters and ensures continuity of care benefits and services for members who may need to be evacuated to other areas of the state or out-of-state. Upon prior approval of LDH, these responsibilities may be performed through a consultation contract, be part-time (minimum hours per week to be approved by LDH) or be combined with another key staff position.

iii. Provides oversight and collaboration with Claims Processing Team to ensure claims processing timelines are met; ensure accuracy and appropriateness of claims payments and encounters; research and resolve issues related to denied or improperly paid claims.

iv. The **CSoC Medical Director** must be a physician with a current, unencumbered Louisiana-license as a physician, board-certified in child psychiatry with at least three (3) years of training in a medical

specialty. The Medical Director shall devote sufficient time to the Contractor's operations as evidenced by timely medical decisions, including after- hours consultation as needed. The Medical Director must consult with an Addictionologist as needed. This position shall have the responsibility for effective implementation of the Quality Management (QM) program and the UM of services and associated appeals as these functions relate to children and youth enrolled in CSoC. The Medical Director shall share responsibility for the management of the behavioral health services delivery system, including the 24-hour behavioral health crisis line, with the CSoC Clinical Director, and shall be actively involved in all major clinical and quality management components of the behavioral health services of the Contractor. The CSoC Medical Director shall be responsible for the following:

v. Maintaining medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing, and medical review included in the Contractor Grievance System;

vi. The decision making process for approval and denial of provider credentialing;

vii. Administration of all medical management activities of the Contractor;

viii. Attendance at LDH business reviews, quality meetings, designated medical director meetings, including linkage with the Integrated Medicaid Managed Care Program Contractor/Medical Directors for primary care;

ix. Oversight of all medical management activities including addiction services of the Contractor;

x. Serving as co-chair of the UM committee and as chair or co-chair of the Quality Assessment and Performance Improvement (QAPI) committee;

xi. Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria; and

xii. Providing consultation on member treatment plans/plans of care as requested. However, to maintain consistency with Wraparound practices, the Medical Director shall not mandate services on the plan.

b. The **Finance Director** shall be a Certified Public Accountant with experience and demonstrated success in managed behavioral healthcare responsible for effective implementation and oversight of the budget, accounting systems, and all financial and financial reporting operations of the Contractor in compliance with Federal and State laws and the requirements set forth in this Contract, including all documents incorporated by reference. The Finance Director shall be a full time position devoted to the CSoC Program, unless otherwise approved by OBH, to ensure compliance with Contract requirements.

c. The **Finance Analyst** shall be a full-time position reporting to the Finance Director responsible for performing financial analysis, developing projection and financial reports and billing in compliance with Federal and state laws and the

requirements set forth in this Contract, including all documents incorporated by reference.

d. The **Managed Care Organization Liaison** should have knowledge and experience of Contractor administrative functions and requirements. The MCO Liaison will be responsible for the interface with all Integrated Medicaid Managed Care Program Plans on a day-to-day basis regarding joint initiatives and projects, shared members, issues related to transition in and out of CSoC, and other issues that arise. This position shall work closely with the care management team on member specific issues.

e. The **Contract Manager or Contract Compliance Coordinator** will serve as the primary point-of-contact for all Contract compliance issues, qualified by knowledge, training, and experience in health care or risk management. These primary functions may include but are not limited to coordinating the tracking and submission of all Contract deliverables; fielding and coordinating responses to LDH inquiries, coordinating the preparation and execution of Contract requirements, random and periodic audits, and ad hoc visits. The Contract Manager or Contract Compliance Coordinator shall have access to all persons employed under the Contract. The Contract Manager or Contract Compliance Coordinator shall have experience and expertise in operating a managed care compliance program and shall report directly to the CSoC Program Director. The Contract Manager or Contract Compliance Coordinator is also responsible for the following:

   i. Ensuring that the Contractor's obligations under the terms of the Contract are met;

   ii. Overseeing, administering, and implementing the Contractor's Compliance Program;

   iii. Overseeing all audits related to the Contract;

   iv. Ensuring Contractor compliance with policies and procedures; and

   v. Ensuring tracking and timely closure of compliance actions, including corrective action plans (CAPs) arising from the Contract.

f. The **Program Integrity (PI) Compliance Officer** must qualify by training and experience in health care or risk management. The PI Compliance Officer shall be point of contact for the Contractor on issues related to fraud, waste, abuse, and overpayment issues. The PI Compliance Officer will oversee monitoring and enforcement of the Fraud, Waste, and Abuse compliance program to prevent and detect potential fraud, waste, and abuse activities pursuant to state and Federal rules and regulations. The PI Compliance Officer will have the responsibility for and carry out the provisions of the compliance program and plan including fraud, waste, and abuse policies and procedures, investigate unusual incidents, and implement any corrective action plans. This position, as a management official, shall have the authority to assess records and independently refer suspected member fraud, provider fraud, and member abuse cases to LDH and other duly authorized enforcement agencies. The PI Compliance Officer shall answer directly to the Chief Executive Office of the Contractor's operations and the Board of Directors. The PI Compliance Officer is also responsible for the following:

   i. Developing and implementing written policies, procedures, and standards to ensure compliance

with the requirements of all applicable Federal and state requirements;

ii. Maintaining compliance with 42 CFR §438.608; and

iii. Collaborating with the LDH Fraud and Abuse program, Medicaid Fraud Control Unit (MFCU), and the Louisiana Attorney General's Office.

g. The **Quality and Outcomes Director** must be a Licensed Mental Health Professional (LMHP). This position is responsible for the development of the Contractor's QAPI and Utilization Management (UM) Plan and its effective implementation in collaboration with the Medical Director and the CSoC Program Director, and compliance with Federal and state laws and the requirements in the Contract, including all documents incorporated by reference. The Quality and Outcomes Director shall be responsible for implementation of the Quality Program as specified in 42 CFR §438.330 and as required by LDH. The Quality and Outcomes Director shall have significant experience and expertise in the oversight of effective Quality Improvement (QI) for public sector programs and managed behavioral healthcare delivery systems. The Quality and Outcomes Director shall be responsible for the following:

i. Ensuring individual and systemic quality of care, including grievances;

ii. Integrating quality throughout the organization;

iii. Implementing process improvement;

iv. Resolving, tracking and trending quality of care grievances;

v. Developing and implementing a QAPI plan in collaboration with the Chief Medical Director (CMD);

vi. Monitoring, analyzing and implementing appropriate interventions based on utilization data and grievance investigation outcomes, including identifying and correcting over or under utilization of services;

vii. Focusing organizational efforts on improving clinical quality performance measures;

viii. Developing and implementing performance improvement projects and CAPs;

ix. Utilizing data to develop intervention strategies to improve outcomes;

x. Reporting QI/performance outcomes;

xi. Managing and adjudicating the Grievance System which includes provider complaints and member grievances (including any expressions of dissatisfaction), appeals, and requests for hearings in compliance with Federal and state laws and the requirements in the Contract, including all documents incorporated by reference;

xii. Tracking, reviewing, and investigating critical incidents and other quality of care issues (e.g., seclusion/restraint, accidents, etc.), including reviewing performance measures;

xiii. Measuring treatment outcomes;

xiv. Ensuring timely access to care;

xv. Advocating for member rights within the organization, ensuring grievance and appeal trends are reported to and addressed within the Quality Assessment and Performance Improvement (QAPI) committee;

xvi. Implementing, measuring, and reporting on performance and reporting requirements; and

xvii. Implementing a fidelity monitoring system to ensure the core elements of the wraparound facilitation are maintained in accordance to the standards of practice established by the National Wraparound Initiative (NWI).

h. The **CSoC Clinical Director** shall meet the requirements for a Licensed Mental Health Professional (LMHP) and should have at least seven (7) years of experience and expertise in the special behavioral health needs of children with severe behavioral health challenges and their families. Prior knowledge and experience working in wraparound and system of care practice, as well as other child serving systems, is required, including OBH approved Introduction to Wraparound and Coaching trainings. The ideal candidate will have at least three (3) years of experience with delivering or managing Evidence-Based Practices (EBPs) and best practices for children and youth, including experience within system of care and wraparound environments. The CSoC Clinical Director shall work closely with the CSoC Governance Board, LDH, and the WAAs to ensure a statewide program that meets the goals and values of the CSoC in compliance with Federal and state laws and the requirements set forth in the Contract, including all documents incorporated by reference. The CSoC Clinical Director shall be responsible for resolving clinical care delivery issues. The CSoC Clinical Director shall be responsible for:

i. Monitoring Prior Authorization (PA) functions and ensuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards;

ii. Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services;

iii. Participating in all activities related to Louisiana Medicaid CSoC eligibility in relation to the Contractor;

iv. Possessing a thorough understanding of Louisiana Medicaid CSoC Eligibility policies;

v. Holding responsibility for having a team who can research Louisiana Medicaid issues that arise and provide details to support findings;

vi. Fully reconciling CSoC eligibility data between the Contractor and the Integrated Medicaid Managed Care Program plans at the direction of LDH;

vii. Training and monitoring WAAs to ensure compliance with Wraparound best practices, waiver requirements, and Contract requirements;

viii. Participating in QI activities, including data collection, tracking, and analysis;

ix. Providing information to members and providers regarding mental health and substance abuse benefits, community treatment resources, managed care programs, and policies and procedures;

x. Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted; and

xi. Overseeing the Care Management Program.

i. The **Provider Network Director** will coordinate communications between the Contractor and its network providers. The Provider Network Director must have expertise in network development and recruitment and is responsible for ensuring network adequacy, access and appointment availability, development of network resources in response to unmet needs, and adequacy of the provider network to provide member choice of providers, and contracting with qualified service providers in compliance with Federal and state laws and the requirements in the Contract, including all documents incorporated by reference. To the extent possible, Contractor shall develop and maintain a provider network inclusive of behavioral health providers participating in the Integrated Medicaid Managed Care Program Plans. The Provider Network Director shall have experience and expertise in the development of provider behavioral health services for children and youth involved in multiple services systems (child welfare, juvenile justice and behavioral health and in or at risk of out-of-home placement). This position shall oversee all credentialing and contracting functions and staff to ensure timely correspondence, collection and successful credentialing and re-credentialing of providers. This position will also ensure timely and accurate contracting of providers, prompt response to provider questions on credentialing, LDH certification and licensing requirements, and Contractor contracting and correction of documentation, if needed, in order to not delay the availability of services. The Provider Network Director staff shall provide LDH staff with updates on individual providers' credentialing status upon request. The Provider Network Director shall be responsible for:

i. Educating in-network and out-of-network providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, System of Care values, and the provider's role in the Coordinated System of Care, as well as available Contractor resources such as provider manuals, websites, fee schedules, etc.;

ii. Interfacing with the Contractor's call center to compile, analyze, and disseminate information from provider calls;

iii. Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction;

iv. Frequently communicating (i.e., telephonic and on-site) with providers to ensure the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices and fraud, waste and abuse issues;

v. Ensuring timely inter-provider referrals and associated appointment access, and assisting in

resolving provider complaints, disputes between providers, and the investigation of member grievances regarding providers; coordinating provider site visits; implementing and monitoring CAPs; and ensuring the accuracy of provider service delivery reports (e.g., encounter information verification); and

vi. Provider education, in-service training and orientation.

j. The **Member Services Administrator** will coordinate communications between the Contractor and its members. There shall be sufficient Member Services Staff to enable members to receive prompt resolution of their problems or inquiries and appropriate education about participation in the CSoC program. This position shall work closely with the Grievance System and those identified staff. The Member Service Administrator shall be responsible for the call center operations. The Member Services Administrator shall have significant experience and expertise in member services and grievance resolution, in compliance with Federal and state laws and the requirements in this Contract, including all documents incorporated by reference.

k. The **Information Technology Manager** must be trained and experienced in information systems, data processing, and data reporting to oversee all Contractor information systems functions including, but not limited to, establishing and maintaining connectivity with LDH information systems, sending and receiving encounters to and from the State's Medicaid Fiscal Intermediary (FI) and providing necessary and timely reports to LDH. The Information Technology Manager shall have significant experience and expertise in managed care data systems and will:

i. Support the timely, accurate, and complete submission of encounter data to LDH; and

ii. Meet LDH encounter reporting requirements.

g. Additional Required Staff

a. In addition to the key staff, the Contractor shall have a sufficient number of qualified staff to meet the responsibilities of the Contract, including sufficient experience and expertise in working with children and youth with behavioral health needs. The Contractor shall submit an organizational chart showing how each of the below staffing units reports to an identified key staff position and their physical work location. The Contractor shall have a sufficient number of staff in the following categories:

i. Care Management Staff

1. Care Managers shall be LMHPs licensed in Louisiana.

ii. WAA Coordinator(s) shall:

1. Serve as a point of contact for CSoC WAAs, acting as a liaison and providing oversight and technical assistance activities to the WAAs.

2. Work directly with the WAAs through regular phone calls (at a minimum weekly) and on-site visits in order to monitor WAAs for compliance to waiver requirements, Contract deliverables and fidelity to practice. During

on-site visits, WAA Coordinator shall observe CFT meetings, as well as other phases of the wraparound process, and collect data through record reviews to inform the Contractor monitoring efforts.

3. Work with other state agency offices, both state and regional, and community stakeholders (schools, providers, hospitals, etc.) to promote CSoC.

4. This position(s) shall be located in Louisiana.

iii. Family Support Coordinator(s) shall:

1. Serve as a point of contact for FSO(s), acting as a liaison and providing oversight and technical assistance activities to the FSO(s).

2. Work directly with the FSO(s) through regular phone calls (at a minimum weekly) and on-site visits in order to monitor FSO(s) for compliance to waiver requirements, Contract deliverables and best practice. During on-site visits, FSO Coordinator shall observe FSO staff providing services to parents and youth, and collect data through record reviews to inform their monitoring efforts.

3. Work with the FSO(s) to assist in building collaborative relationships with the WAAs to ensure high quality service delivery.

4. Work with other local family organizations and community resources to promote CSoC.

5. This position shall be located in Louisiana.

iv. A staff person shall be identified to provide liaison activities for the following entities: LDOE, DCFS, OJJ, OCDD, law enforcement, and judicial systems.

1. The liaison shall be available for response to inquiries within one business day of inquiry.

2. This liaison shall also be responsible for outreach, education, and community involvement including for the court systems, education systems, and law enforcement.

3. This position shall be located in Louisiana.

v. Provider Relations Liaisons

vi. Network Coordinators

vii. Quality Management Staff

viii. Member Services Staff/Call Center Staff

ix. Grievance and Appeals Staff

x. Data Analysts

xi. Claims Processing Staff/ Claims Specialist/ Claims Resolution Specialist

xii. Program Integrity Staff and investigators (Fraud and Abuse unit) shall:

1. Be comprised of experienced fraud and

abuse reviewers.

2. Have the primary purpose of preventing, detecting, investigating and reporting suspected fraud and abuse that may be committed by network providers, members, employees, or other third parties with whom the Contractor contracts.

3. Have access to network provider records.

3. Written Policies, Procedures, and Job Descriptions

a. The Contractor shall maintain written policies, procedures, and job descriptions for each functional area, consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions.

b. If LDH deems a Contractor policy or process to be inefficient or to place an unnecessary burden on members or providers, the Contractor will change the policy or procedure within the time period specified by LDH.

4. Staff Training and Meeting Attendance

a. The Contractor shall ensure that all staff members have appropriate training, education, experience, and orientation to fulfill their requirements of the position. LDH may require additional staffing for the Contractor if it has substantially failed to maintain compliance with any provision of the Contract or LDH policies.

a. Any new key staff, provider network liaisons, WAA and FSO Coordinators, and Care Managers employed by the Contractor shall complete OBH approved Introduction to Wraparound training. The Contractor shall organize and sponsor this training.

b. WAA coordinators and care management leadership staff employed by the Contractor shall complete OBH approved CSoC Coaching and Supervision Trainings. LDH reserves the right to require specific Contractor staff to attend the CSoC Coaching and Supervision Training. The Contractor shall organize and sponsor this training.

c. All staff shall complete training related to program integrity issues as outlined in the *Program Integrity* section.

b. The Contractor shall provide initial and ongoing staff training that includes, but is not limited to, an overview of Louisiana Medicaid with special emphasis on CSoC and wraparound principles and practices, and the 1915(c) and 1915(b) waivers currently approved CMS authorities (waivers and Medicaid State Plan), current and applicable EBPs recognized by SAMHSA, CSoC services, program integrity requirements, and any state and Federal requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification, handling of quality of care/service concerns, navigating the grievance and appeal system, and encouraging proper fraud, waste and abuse reporting. All staff working directly with members shall have crisis intervention training. Behavioral health crisis line staff shall complete OBH-approved trainings related to the Louisiana Crisis Response System. Additionally, staff should be trained on other Medicaid services as determined by LDH, including Medicaid transportation. The Contractor shall provide all contractually required training materials and documentation thereof to LDH upon request. Non-contractually required training materials shall be provided to LDH upon demonstration of a reasonable need.

c. All trainings of Contractor staff shall be at the expense of the Contractor. The Contractor agrees to pay for the OBH approved WAA training program as outlined in the *Provider Education and Training* section for Contract year one. For each remaining Contract year, a re- evaluation of the WAA's internal training development plans will be completed by Magellan and OBH to determine further WAA training and coaching needs. Magellan will continue to provide fiscal support for the WAA's required training and coaching as determined by Magellan and OBH following each yearly assessment of the WAA's ongoing training and development needs. Magellan will continue to monitor and ensure that the WAAs complete required trainings.

d. Care management, call center and member services staff must have access to Contractor's provider directory and mapping search engines (e.g., MapQuest, Yahoo Maps, Google Maps, etc.) for the purposes of authorizing services and providing information about available service providers in the most geographically appropriate location.

e. The Contractor shall provide the appropriate staff representation for attendance and participation in meetings or events scheduled by LDH. All meetings shall be considered mandatory unless otherwise indicated. Attendance shall be in person unless otherwise allowed by LDH.

f. LDH reserves the right to attend any and all training programs, meetings, and seminars conducted by the Contractor. The Contractor shall provide LDH with a list of all training dates, times, and locations at least three (3) calendar days prior to the actual date of training.

g. The Contractor shall provide documentation of committee meetings and trainings upon request. Meeting minutes, agendas, and sign-in sheets along with action items must be provided to LDH by the Contractor within five (5) business days from time of request unless otherwise provided for in this Contract or approved by LDH.

VII. LOCATION/HOURS OF OPERATION

A. General Requirements

1. The Contractor is responsible for maintaining a local presence within Louisiana, at a location approved by LDH. Contractor shall indicate on the organizational chart physical locations of staff or office location staff is associated with.

2. The Contractor shall maintain an office in Louisiana, and be available for face-to- face meetings at LDH headquarters in Baton Rouge with twenty-four (24) hours' notice, when requested. This site shall be a smoke-free environment. The Contractor shall employ and contract with individuals in accordance with requirements outlined in this Contract, including employee screens for exclusion and criminal background checks.

3. The Contractor's administrative office shall maintain normal business hours of 8:00 a.m. to 4:30 p.m. Central Time Monday through Friday, excluding recognized State holidays, and be operational on all LDH regularly scheduled business days.

4. The Contractor shall maintain a toll-free member service call center, physically located in Louisiana.

a. The toll-free number must be staffed twenty-four (24) hours per day, seven (7) days per week for crisis response and service authorization by care managers.

5. The Contactor shall have a provider relations function to provide support and assistance to all providers in the Contractor's network that is available Monday through Friday from 8:00 a.m. to 4:30 p.m. Central Time to address

non-emergency provider issues and on a twenty-four (24) hours per day, seven (7) days per week basis for urgent or emergency/crisis requests.

6. The Contractor must operate a toll-free telephone line to respond to provider questions, comments and inquiries. The toll-free number may be the same number members use to contact the Contractor.
   a. The provider access component of the toll-free telephone line must be staffed between the hours of 8:00 a.m. – 4:30 p.m. Central Time Monday through Friday.

7. The Contractor's System Help Desk shall be available via local and toll-free telephone service, and via e-mail at least Monday through Friday, 7 a.m. to 5 p.m. Central Time. After hours, the systems help desk shall provide a means for users to leave voice messages or emails in which the Contractor's stall shall respond to by noon (Central Time) the next business day.

VIII. PERFORMANCE REQUIREMENTS

A. <u>Performance Measurements</u>

1. Network Standards and Guidelines

a. Access Standards

a. Geographic Access Standards

i. Travel distance to behavioral health specialists (i.e. psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in rural parishes shall not exceed thirty (30) miles for one hundred percent (100%) of members.

ii. Travel distance to behavioral health specialists (i.e. psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in urban parishes shall not exceed fifteen (15) miles for one hundred percent (100%) of members.

iii. Travel distance to specialized behavioral health outpatient non-MD services (excluding behavioral health specialists) shall not exceed sixty (60) miles for urban members and ninety (90) miles for rural members. Maximum time for appointment shall not exceed appointment availability requirements for specialized behavioral health emergent, urgent and routine care.

b. Scheduling/Appointment Waiting Times

1. Provisions must be available for obtaining emergent care twenty-four (24) hours per day, seven (7) days per week. Emergent, crisis or emergency services must be available at all times. An appointment shall be available within one (1) hour of request.

2. Provisions must be available for obtaining urgent care twenty-four (24) hours per day, seven (7) days per week. An appointment shall be available within forty-eight (48) hours of request.

3. Routine, non-urgent behavioral healthcare shall be available with an appointment within fourteen (14) days of request.

2. Timing of Service Authorization Decisions

a. Standard Service Authorization

a. Contractor shall provide notice of standard authorizations no later than seven (7) calendar days following receipt of the request for service unless an extension is requested.

b. In no instance shall any determination of standard service authorization be made later than fourteen (14) calendar days from receipt of the request.

b. Expedited Service Authorization

a. Contractor shall provide notice of expedited service authorizations no later than seventy-two (72) hours after receipt of the request for service.

c. Post Authorization

a. The Contractor shall make retrospective review determinations within thirty (30) calendar days of receipt of sufficient medical information necessary to make a determination.

b. Retrospective review determinations shall be completed within one hundred and eighty (180) calendar days from the date of service.

d. Timing of Notice

a. Adverse Benefit Determination

i. The Contractor shall notify the requesting provider of a decision to deny any service authorization request or to authorize a service in an amount, duration, or scope that is less than requested but not more than one (1) business day of making the initial determination.

b. Informal Reconsideration

i. The informal reconsideration shall occur within one (1) business day of the receipt of the request.

3. Claims Processing Requirements

a. The Contractor shall ensure that all provider claims are processed according to the following timeframes:

a. Within five (5) business days of receipt of a claim, the Contractor shall perform an initial screening and either, reject the claim, or assign a unique control number.

b. The Contractor shall process and pay or deny, as appropriate, at least ninety percent (90%) of all clean claims for each claim type, within fifteen (15) calendar days of the date of receipt.

c. The Contractor shall process and pay or deny, as appropriate, at least ninety-nine percent (99%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.

d. The Contractor shall fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

4. Automated Call Distribution (ACD) System

a. The automated call distribution (ACD) system for the customer

service telephone call center shall not have call abandonment rates that exceed 5%.

B. Contract Compliance And Monitoring

1. Contact Personnel

a. LDH will establish an administrative communication protocol and communicate this protocol to the Contractor outlining points and methods of contact for administration and daily operation of the contract. This protocol will be in addition to the reporting requirements of the contract.

b. The Contractor will be notified in writing of any changes to the administrative communication protocol.

2. Contract Monitor

a. All work performed by the contract will be monitored by the LDH Contract Monitor or his/her designee:

Assistant Secretary

Louisiana Department of Health

Office of Behavioral Health

628 North 4th Street

Baton Rouge, LA 70821

3. Designees shall be identified by areas of subject matter in a communication protocol.

4. Notification to Contractor of Policies and Procedures

a. LDH will provide the Contractor with updates to appendices and CSoC policies, procedures and guidelines affecting the provision of services under the contract.

b. LDH will provide the Contractor with interpretation of pertinent Federal and state Medicaid regulations upon request by the Contractor.

c. The Contractor will submit written requests to LDH for additional clarification, interpretation or other information. Provision of such information does not relieve the Contractor of its obligation to keep informed of applicable Federal and state laws related to its obligations under the contract.

5. Contractor Contract and Information Changes

a. The Contractor shall immediately notify LDH of any of the following in writing:

a. Change in business address/location, telephone number, facsimile number, or e-mail address;

b. Change in corporate status or nature, corporate structure, solvency, or incorporation status;

c. Change in corporate officers or executive employees;

d. Change in ownership, including but not limited to the new owner’s legal name, business address, telephone number, facsimile number, or e- mail address;

e. Change in Federal employee identification number or Federal tax identification number; or

f. Change in Contractor litigation history, current litigation, audits and other government investigations both in Louisiana and in other states.

6. Required Submissions

a. The Contractor shall submit documents as specified in the contract. LDH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the Contractor's responsibilities under the terms of the contract.

7. Ongoing Contract Monitoring

a. LDH will monitor the Contractor's performance to ensure that the Contractor is in compliance with the contract provisions. However, this does not relieve the Contractor of its responsibility to continuously monitor its own or its providers' performance in compliance with the contract provisions.

b. LDH or its designee will monitor the operation of the Contractor for compliance with the provisions of the contract, and applicable Federal and state laws and regulations. Inspection may include the Contractor's facilities, as well as auditing or review of all records developed under the contract including, but not limited to, periodic medical audits, grievances, enrollments, utilization and financial records, review of the management systems and procedures developed under the contract, and any other areas or materials relevant or pertaining to the contract. LDH or its designee will provide the Contractor sufficient notice of any monitoring activity.

c. If not specified in the contract, LDH or its designee shall coordinate with the Contractor to establish the scope of review, relevant time frames for obtaining information, and the criteria for review.

d. The Contractor shall provide access to documentation, treatment records, premises, and staff as deemed necessary by LDH.

e. The Contractor shall have the right to review and comment on any of the findings and recommendations resulting from contract monitoring and audits, except in the cases of fraud investigations or criminal action. However, once LDH finalizes the results of monitoring or audit report, the Contractor must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement as directed by LDH may result in monetary penalties, sanctions or enrollment restrictions.

8. Performance Assessment

a. LDH may assess the performance of the Contractor prior to and after the anticipated go-live date for operations. This includes evaluation of all of the Contractor's program components including IT, administrative services, and care management.

9. Monitoring Reports

a. LDH will require Contractors to submit monthly, quarterly, annual, and ad hoc reports that will allow LDH to assess the Contractor's performance.

b. The Contractor shall comply with all court-ordered reporting requirements, currently including but not limited to, Wells v. Gee and Chisholm v. Gee cases in the manner determined by LDH.

C. Remediation

1. Non-Compliance Actions Generally

a. A non-compliance action is a punitive action assessed or applied for a violation in one or more areas of contractual responsibility. The imposition of a non- compliance action indicates that the Contractor has negligently or purposefully violated the contract, failed to comply with lesser compliance actions, or is out of compliance with applicable state and Federal laws.

b. A failure to comply with any requirement contained within these contract documents allows LDH to impose non-compliance action(s).

c. The decision to impose a non-compliance action may include consideration of some or all of the following factors:

a. The duration of the violation;

b. Whether the violation (or one that is substantially similar) has previously occurred;

c. The Contractor's history of compliance;

d. The severity of the violation and whether it imposes an immediate threat to the health or safety of the consumers; and

e. The "good faith" exercised by the Contractor in attempting to stay in compliance.

d. LDH may impose a system of graduated non-compliance actions which includes, but is not limited to:

a. Administrative Actions;

b. Corrective Action Plans (CAPs);

c. Monetary Penalties;

d. Recommendation that CMS impose a denial of payment sanction;

e. Non-compliance actions statutorily enforced by 42 CFR §438 Subpart I – Sanctions:

i. Intermediate Sanctions as per §438.700, §438.702 and §438.710, including but not limited to:

1. Civil Money Penalties;

2. Temporary management in accordance with 42 CFR §438.706; and

3. Suspension of payment;

ii. Termination of contract; and

iii. Other sanctions listed in 42 CFR §438.702.

f. Nothing shall prevent LDH from imposing any level of non-compliance actions which have not previously been addressed by lesser or more informal actions.

g. LDH reserves the right to impose monetary penalties or any other remediation outside the parameters as outlined in The Remediation section of this contract. LDH will determine the appropriate option based on the nature of the deficiency or non- compliance with the requirements of the contract.

h. LDH may impose a non-compliance action, including sanctions and penalties on the Contractor for failure to timely or accurately complete a previous course of remediation.

i. The Contractor shall bear the expense of compliance with any finding of non- compliance under the contract.

2. Administrative Actions

a. Administrative actions exclude monetary penalties, sanctions, and termination and include, but are not limited to:

a. A warning through written notice or consultation;

i. LDH may notify the Contractor through a written Notice to Cure when it is determined the Contractor is deficient or non-compliant with requirements of the contract; and

ii. The Notice to Cure will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements or the imposition of additional compliance actions.

b. Education requirement regarding program policies and procedures. The Contractor may be required by LDH to conduct a staff or provider education program as a condition of continued participation;

c. Review of Contractor policy and processes;

d. Referral to the Louisiana Department of Insurance for investigation;

e. Referral for review by appropriate professional organizations; and

f. Referral to LDH Program Integrity Unit or to the Office of the Attorney General for investigation.

3. Corrective Action Plans (CAPs)

a. To correct or resolve any deficiency or performance related concern, LDH may require the Contractor to develop a CAP.

b. The CAP must provide:

a. A detailed explanation of the reasons for the cited deficiency;

b. The Contractor's assessment of the cause;

c. A specific proposal to remedy or resolve the deficiency;

d. Detailed timelines and deliverables; and

e. A Contractor lead or contact person for the CAP.

c. The CAP must be submitted by the deadline set forth in LDH request for a CAP. The CAP must be approved by LDH in writing.

d. LDH will notify the Contractor in writing of LDH's final disposition of concerns.

e. The CAP shall be monitored by LDH to bring activities of the Contractor into compliance with state and Federal regulations or to address performance related concerns. LDH may monitor the effectiveness of the plan via required reporting on a specified basis, through onsite evaluations or any other source.

f. Nothing herein shall require LDH to request a CAP prior to mandating compliance.

4. Monetary Penalties

a. The purpose of establishing and imposing monetary penalties is to provide a means for LDH to obtain the services and level of performance required for successful operation of the contract. LDH's failure to assess monetary penalties in one or more of the particular instances described herein will in no event waive the right for LDH to assess additional monetary penalties or actual damages or sanctions.

b. A maximum of one hundred thousand dollars ($100,000) may be imposed for each employment or contractual relationship that is prohibited by the *Contractor Prohibited Relationships* section of this contract.

c. LDH may impose monetary penalties when the Contractor is in violation of the provisions of the contract, including, but not limited to, the following:

a. Failure to meet the standards for encounter submissions and resubmissions as outlined in the contract and the failure to complete the scope of work for encounter data projects as outlined in the contract may subject the Contractor to penalties of between five hundred dollars ($500) and two hundred and fifty thousand dollars ($250,000) depending on the severity of non-compliance with the established standards as determined by LDH;

b. Failure to fill vacant key staff positions with an approved employee within ninety (90) days after vacancy occurs:

i. Two hundred and fifty dollars ($250) per day from the 91st day after vacancy occurs until filled or until the 120th day; and

ii. Five hundred dollars ($500) per working day from the 121st day after vacancy occurs until filled;

c. Deliverables (including reports) required in the contract and any other ad hoc deliverables or report requested by LDH that are late, inaccurate, incomplete, inconsistent or submitted in a format not prior approved by LDH – Two thousand and five hundred dollars ($2,500) per calendar day per deliverable;

d. Failure to meet any scope of work requirements as outlined in the contract may subject the Contractor to penalties of between five hundred dollars ($500) and twenty-five thousand dollars ($25,000) based on the severity as determined by LDH; and

e. Late, incomplete or inaccurate submissions to LDH as outlined in the contract regarding actual and potential HIPAA noncompliance may subject the Contractor up to two thousand and five hundred dollars ($2,500) in monetary penalties per day per violation until confirmation from LDH that the deliverable is satisfied.

d. LDH reserves the right to collect monetary penalties using one of the following options:

a. Withholding funds from amounts payable to the Contractor;

b. Billing the Contractor for the appropriate monetary penalty amount; or

c. Withholding funds from retainage, if applicable.

e. Monetary Penalties for HIPAA Violations

a. In accordance, with Section 13410(d) of the HITECH Act and Section 1176(a) of the Social Security Act, penalties for a covered entity or business associate violating HITECH range from one hundred dollars ($100) per violation to one million and five hundred thousand dollars ($1,500,000) for all violations in a calendar year. Criminal penalties for the deliberate mistreatment of Protected Health Information (PHI) or failure of timely breach reporting may apply directly to any Contractor employee responsible for the offense. Penalties for individuals cannot exceed two hundred and fifty thousand dollars ($250,000) or imprisonment not more

than ten years.

b. If the Contractor fails to comply with all applicable HIPAA requirements, the Contractor shall pay all fines or penalties imposed by the U.S. Department of Health and Human Services (HHS) under 45 CFR §160.404.

c. The State may assess additional penalties for HIPAA noncompliance, failure to systemically correct HIPAA noncompliance, or failure to notify required parities (i.e., providers or members).

f. LDH may impose up to twenty-five thousand dollars ($25,000) per occurrence as determined by LDH against the Contractor if it makes any determinations of the following non-exclusive actions/occurrences:

a. The Contractor has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from LDH;

b. The Contractor has presented, or has caused to be presented, any false or fraudulent claim for services or has submitted or has caused to be submitted false information to be furnished to the State or the Secretary of the Federal Department of Health and Human Services;

c. The Contractor has engaged in a practice of charging and accepting payment (in whole or part) from members for services for which a PMPM payment was made by LDH;

d. The Contractor has rebated or accepted a fee or portion of fee or charge for a patient referral;

e. The Contractor has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

f. The Contractor has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

g. The Contractor has failed to furnish any information requested by LDH regarding payments for providing goods or services; and

h. The Contractor has made, or caused to be made, any false statement or representation of a material fact to LDH or CMS in connection with the administration of the contract.

g. LDH may impose up to one hundred thousand dollars ($100,000) per occurrence as determined by LDH against the contractor if it makes any determinations of the following non-exclusive actions/occurrences:

a. The Contractor has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95- 142 (Medicare-Medicaid anti-fraud and abuse amendments); and

b. The Contractor or anyof its owners, officers or directors has been convicted of a criminal offense relating to performance of the contract with LDH or of fraudulent billing practices or of negligent practice resulting in death or injury to the Contractor's member.

h. In the event that Contractor does not provide the services listed under the contract, or only provides a portion of the services, LDH will provide the Contractor fifteen (15) calendar days' notice to cure and should Contractor not cure or propose an acceptable CAP within such fifteen (15) calendar days, LDH reserves the right to

withhold payments until such time as Contractor demonstrates that the services have been provided. Such time period may be extended with agreement of all parties.

5. Sanctions statutorily enforced by 42 CFR §438 Subpart I

a. LDH may use the provisions of 42 CFR §438.700 et seq. as guidance for the imposition of sanctions. LDH may impose sanctions for any determination identified in by 42 CFR §438
Subpart I in accordance with monetary penalties outlined therein.

b. In accordance with 42 CFR §438.704, the limit on or the maximum civil money penalty LDH may impose varies depending on the nature of the Contractor's action or failure to act.

c. A maximum of twenty-five thousand dollars ($25,000) may be imposed upon the Contractor for each determination of any of the following:

a. Failure to substantially provide medically necessary services it is required to provide;

b. Misrepresentation or false statements to members, potential members, or healthcare providers; and

c. Distribution of marketing materials to members not previously approved by the State or that are false or misleading.

d. A maximum of one hundred thousand dollars ($100,000) may be imposed for each of the following:

a. Determination of discrimination among members on the basis of their health status or need for services; and

b. Misrepresentation or false statements to CMS or LDH.

e. A maximum of fifteen thousand dollars ($15,000) may be imposed for each member or recipient LDH determines was not enrolled because of discrimination practice due to the member's health status or need for services (subject to the overall one hundred thousand dollar ($100,000) limit set forth in this section).

f. A maximum of twenty-five thousand dollars ($25,000) or double the amount of the excess charges (whichever is greater) may be imposed for charging premiums or charges in excess of the amounts permitted under the contract. LDH shall reimburse the amount of overcharge to the affected member(s) out of any penalty collected from the Contractor.

6. Termination of Contract Generally

a. LDH may terminate the contract when LDH determines the Contractor or Contractor's subcontractor(s) have failed to perform, or have violated, substantive terms of the contract and have failed to meet Federal or state requirements.

b. In accordance with 42 CFR §438.708 and §438.710(b), LDH has the authority and may terminate the Contractor's contract and enroll that entity's members in another Contractor or provide their Medicaid benefits through other options, if LDH determines that the Contractor failed to do either of the following:

a. Carry out substantive terms of its contract; or

b. Meet applicable requirements in Sections 1932, 1903(m), and 1905(t) of the Social Security Act.

c. If LDH chooses to terminate the contract, the termination will be effective no less than thirty (30) calendar days from the date of the Notice of Intent to Terminate. The Contractor may, at the discretion of LDH, be allowed to correct the deficiencies within the thirty (30)

calendar day notice period or prior to the issuance of a Notice of Termination.

d. After LDH notifies the Contractor that it intends to terminate the contract, LDH will notify members of the Contractor in writing the notice of the termination and information, consistent with 42 CFR §438.10 and §438.722, on their options for receiving Medicaid services following the effective date of termination.

7. Termination of Contract Due to Serious Threat to Health of Members

a. LDH may terminate the contract immediately if it is determined that actions by the Contractor, its network providers or subcontractor(s) pose a serious threat to the health of members.

8. Termination of Contract for Contractor Insolvency, Bankruptcy, or Instability of Funds

a. The Contractor's insolvency or the filing of a petition in bankruptcy by or against the Contractor shall constitute grounds for termination for cause. If LDH determines the Contractor has become financially unstable, LDH will immediately terminate the contract upon written notice to the Contractor effective the close of business on the date specified.

b. The Contractor shall cover continuation of services to members for the duration of any period for which payment has been made, as well as for inpatient admissions up until discharge. Subject to provisions in 42 CFR §438.106 and pursuant to Section 1932(b)(6) of the Social Security Act (as enacted by Section 4704 of the Balanced Budget Act of 1997), if the Contractor becomes insolvent, the Contractor shall not hold members liable and members shall not be held liable for the following:

a. The Contractor’s debts in the event of insolvency.

b. Covered services provided to the member, for which the State does not pay the Contractor.

c. Covered services provided to the member, for which LDH or the Contractor does not pay the individual or healthcare provider that furnishes the services under a contractual, referral or other arrangement.

d. Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.

9. Provider Sanctions

a. Nothing contained herein shall prohibit LDH from imposing sanctions, monetary penalties, license revocation, and Medicaid termination, upon a healthcare provider for its violations of Federal or state law, rule or regulations.

10. Non-Waiver of Breach

a. The failure of LDH at any time to require performance by the Contractor of any provision of the contract, or the continued payment of the Contractor by LDH, shall in no way affect the right of LDH to enforce any provision of the contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable.

b. The waiver by LDH of any breach of any provision contained in the contract shall not be deemed to be a waiver of such provision on

any subsequent breach of the same or any other provision contained in the contract and shall not establish a course of performance between the parties contradictory to the terms hereof. No term or condition of the contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

IX. TRANSITION REQUIREMENTS

A. Introduction

1. Transition is defined as those activities that the Contractor is required to perform upon initiation of, expiration of, or termination of the contract. The transition requirements in this section shall become applicable upon any termination/change in the scope of the contract that 1) is initiated by LDH; 2) is initiated by the Contractor; or 3) occurs at the expiration of the contract term. This section addresses the Contractor's fulfillment of the following responsibilities:

a. Developing an implementation plan;

b. Transition and development of a transition plan;

c. Providing transition services and related information;

d. Providing member and network transition information including member correspondence and provider lists and contacts;

e. Providing transfer of data; and

f. Providing post-transition services.

B. General Requirements

1. The Contractor shall have a transition of care policy prior to go-live to ensure continued access to services during a transition.

2. The Contractor may be required to update information submitted in its implementation or transition plan at the request of LDH.

3. Failure to timely or correctly perform implementation or transition requirements shall subject the Contractor to monetary penalties or sanctions as outlined in The Remediation section of this contract.

C. Implementation Plan

1. The Contractor is required to create a written implementation plan due to be submitted to LDH at a date to be determined by LDH based on the contract award date but no later than thirty (30) days after contract award. The implementation plan shall present the scope of work for the activities that must occur between the contract award and the go-live date when services must be provided.

2. The Contractor shall designate a full time project manager for implementation within ten (10) days of contract award announcement.

3. The Contractor agrees to provide all materials required to complete the implementation plan by the dates established by LDH, as agreed to in the implementation plan, or as required by a Readiness Review Contractor, if applicable.

4. If LDH determines the Contractor does not fully meet any area of readiness prior to the go-live date, LDH may impose monetary penalty for each day beyond the go-live date.

5. The implementation plan shall include, at a minimum, all requirements in this section and specifically address the following elements: administration and personnel, financial readiness, system readiness and contingency plan, member transition, operational readiness and network adequacy by go-live date.

6. Implementation deadlines may be amended upon agreement of LDH.

D. General Transition Requirements

1. In the event the contract or any portion thereof expires or is terminated for any reason, the Contractor shall:

a. Comply with all terms and conditions stipulated in the contract, including continuation of core benefits and services under the contract, until the termination effective date;

b. Promptly supply all information necessary for the reimbursement of any outstanding claims;

c. Comply with direction provided by LDH in consultation with LDH to assist in the orderly transition of data, equipment, services, software, leases, etc. to LDH;

d. Participate in a transition planning team as established by LDH. The Contractor's transition planning team shall include care management staff, program evaluation staff, provider network staff, claims administration staff, and program monitoring staff, as well as staff that supports all automated and computerized systems and databases; and

e. Assist LDH in the notification to and transition of its members and providers at the Contractor's own expense.

2. The Contractor shall cooperate with LDH to ensure timely transition to any successor Contractor. The Contractor shall designate a full time transition liaison to work with LDH during transition. This transition liaison shall work with LDH, the successor Contractor, or the Integrated Medicaid Managed Care Program Plans on projects including, but not limited to, transition work groups.

E. Transition Plan

1. In the event of written notification of termination of the contract by LDH, the Contractor shall submit a Transition Plan within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the Contractor and LDH. In the event the Contractor terminates the contract, a transition plan shall be submitted for approval with notification of contract termination. Six (6) months prior to expiration of the contract term, a transition plan shall be submitted to LDH. The Plan shall address the transition of records and information maintained by the Contractor relative to core benefits and services and supports provided to CSoC members. The Transition Plan must be mutually agreed upon and approved by LDH.

2. The transition plan must comprehensively detail:

a. Proposed approach to transition, addressing both members' and providers' needs as well as LDH's perspective and needs;

b. Proposed schedule for transition;

c. Tasks and timelines for transition;

d. Transition activities;

e. All information systems production data, program libraries, and documentation including documentation update procedures during transition; and

f. Resource requirements associated with transition tasks.

3. The detailed plan for transition shall ensure an orderly transfer of responsibility or the continuity of those services required under the terms of the contract to LDH and shall include the following:

a. A realistic schedule and timeline to hand-off responsibilities to LDH and the successor contractor.

b. The Contractor shall develop a plan on how to best inform and

retain Contractor employees during the transition.

c. The names of staff that shall be utilized during the hand-off of duties and their responsibilities such that there shall be clear lines of responsibility for the Contractor and LDH.

d. The actions that shall be taken by the Contractor and mutually agreed upon actions by LDH to ensure timely transition.

e. Transfer of information will occur in a reasonable manner as agreed between the parties, which may include, but not be limited to, observation, screenshots, walk-throughs, diagrams, etc.

f. A matrix listing each transition task, the functional unit and the person, agency or Contractor responsible for the task, the start and deadline dates to complete the planned task, and a place to record completion of the task.

g. All information necessary for reimbursement of outstanding claims.

h. A plan to transition records and information maintained by the Contractor to LDH or a successor Contractor.

i. The plan must also address the following:

a. Communication plan to members including but not limited to timelines, contact information, appropriate website links and other applicable information;

b. Communication plan to providers including but not limited to information on claims payment post contract term, information on prior authorizations and other applicable timelines;

c. Communication plan to external stakeholders;

d. Open fraud, waste and abuse investigations;

e. Member transition of care;

f. Resolution of outstanding grievances, appeals, and state fair hearings for both members and providers;

g. Records retention;

h. CMS required reporting;

i. Residential placement transition;

j. Website and phone number transition that shall be maintained by Contractor for an agreed upon period of time after Contractor transitions and contract ends;

k. Contact information including email addresses and phone numbers for the State for transition close out activities that occur after services have been transitioned; and

l. Contacts for providers for questions and billing activities that occur after services have been transitioned.

4. If the contract is not terminated by written notification as provided above, the Contractor shall propose a Transition Plan no later than six (6) months prior to the end of the contract term, including any extensions of such term. The Plan shall address all the requirements listed above.

5. As part of the Transition Plan, the Contractor must provide LDH with copies of member and core benefits and services data, documentation, or other pertinent information necessary, as reasonably determined by LDH, for LDH to assume the operational activities successfully as set forth below. This includes correspondence and documentation of ongoing outstanding issues. The Plan will describe the Contractor's approach and schedule for transfer of all data, as applicable. The information must be supplied in

media and format specified by LDH and according to the schedule approved by LDH.

a. Relevant CSoC documentation includes current documentation of members and providers at the time of transition and historical information for a time period determined by LDH:

a. Plans of Care (current and initial);

b. Assessments;

c. Freedom of Choice Forms;

d. Authorizations;

e. Wraparound Data Spreadsheet or new iterations of member data keeping tools;

f. Wraparound Scorecards;

g. Provider PIPs and CAPs;

h. Training Schedules;

i. Training materials; and

j. FSO and WAA documentation including certification status.

6. The Contractor shall promptly report, in writing, to the LDH Contract Monitor problems with any aspect of transition when identified by the Contractor. The Contractor shall follow-up with a timeline for corrective actions to be taken regarding the plan for transition within a reasonable timeframe from the date the issue was reported to the LDH Contract Monitor.

F. Transition Services

1. The Contractor shall complete all work in progress and all tasks called for by the transition plan. If it is not possible to resolve all issues during the end-of-contract transition period, the Contractor shall list all unidentified or held items that could not be resolved, including reasons why they could not be resolved, prior to the end of the contract and provide an inventory of open items along with all supporting documentation. To the extent there are unresolved items that are responsibility of the Contractor, the reasonable and documented cost to complete these items will be collected from the performance bond as applicable. The Contractor shall specify a process to brief LDH on issues before the hand-off of responsibilities.

2. The Contractor shall provide all reports set forth in the contract, a schedule and contact for reporting requirements that occur after Contractor ceases operations, and reports necessary for the transition process.

3. The Contractor shall designate a transition liaison who is intimately familiar with the daily operations and requirements of services and benefits. The transition liaison shall interact closely with LDH-OBH, LDH-BHSF, and the staff of the Integrated Medicaid Managed Care Program Plans to ensure a safe and orderly transition, and shall participate in all transition meetings.

4. Fiscal Transition Services

a. Upon contract expiration or termination, LDH reserves the right to purchase materials or to complete the required work. LDH may recover any reasonable excess costs resulting from contract cancellation or termination from the Contractor by:

a. Deduction from an unpaid balance;

b. Collection from performance bond as applicable; or

c. Any combination of the above or any other remedies as provided by law.

b. The Contractor shall return to LDH within thirty (30) days of

termination or expiration of the contract any funds advanced to the Contractor for coverage of members for periods after the date of termination to LDH within thirty (30) days of termination of the contract.

c. The Contractor shall supply all information necessary for reimbursement of outstanding claims.

G. Member and Provider Services Transition

1. The Contractor shall cooperate with LDH during the planning and transition of contract responsibilities from the Contractor to LDH or successor Contractors. The Contractor shall ensure that member services are not interrupted or delayed during the remainder of the contract and the transition planning by all parties shall be cognizant of this obligation. The Contractor shall:

a. Make provisions for continuing all management and administrative services and the provision of services to members until the transition of all members is completed and all other requirements of the contract are satisfied.

b. Identify mandatory administrative, member and service related tasks required the first month after transition (the first month of the successor Contractor's operations) in order to ensure orderly administration of services and continuity of care for members so as they experience zero interruption of services and benefits.

c. Upon LDH request, submit for approval an additional detailed plan for the transition of its members, including a communication plan with members.

d. Notify providers of the contract expiration or termination as directed by LDH.

e. Any inpatient services that may be authorized by the Contractor prior to the end of the contract shall be discussed and a transition plan and payment responsibilities will be determined. Contractor may be responsible for continued payment for services that cross over contract end date for a limited time.

f. Transfer the toll-free call center line telephone numbers to LDH or successor Contractor to allow for the continuous use of the number for member services and provider services. If the number is not transferred at LDH's direction, the Contractor shall maintain the number for a period of time to be determined by LDH, but not to exceed 4 months with an agreed upon message redirecting members and providers.

g. Ensure any open fraud, waste, or abuse cases are transitioned appropriately and Contractor shall remain available throughout any appropriate investigation to ensure documents or other information is available to bring cases to closure.

2. In the event of contract termination, the Contractor shall stop all work as of the effective date contained in the Notice of Termination and shall immediately notify all management subcontracts, in writing, to stop all work as of the effective date of the Notice of Termination. Upon receipt of the Notice of Termination, and until the effective date of the Notice of Termination, the Contractor shall perform work consistent with the requirements of the contract and in accordance with a written plan approved by LDH for the orderly transition of members to another Contractor. Unless otherwise directed by LDH, the Contractor shall direct providers to continue to provide services consistent with the member's treatment plan or POC.

H. Transfer of Data

1. The Contractor shall transfer all data regarding the provision of member core benefits, member core services, historic utilization data, and all data and information necessary to transition operations to LDH or a third party,

at the sole discretion of and as directed by LDH.

2. Data, information, and services necessary and sufficient to enable LDH to map all Contractor program data from the Contractor's system(s) to the replacement system(s) of LDH, including comprehensive data dictionary. All transfers of data must be compliant with HIPAA.

3. The Contractor must transfer information necessary to transition operations including: data and reference tables; documentation relating to software; functional business flows; and operation information including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operation information regarding subcontractors. For purposes of this provision, "documentation" means all operations, services, and deliverables, that LDH determines are necessary to view and extract application data in a proper format. The Contractor must provide the documentation in the formats in which the documentation exists at the expiration or termination of the contract.

4. All relevant data must be received and verified by LDH. If LDH determines that not all of the data regarding the provision of member core benefits and services to members was transferred to LDH, as required, or the data is not HIPAA compliant, LDH reserves the right to hire an independent contractor to assist LDH in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the Contractor transitioning out.

5. The Contractor shall cooperate fully with LDH during the Transition Period including, at a minimum, sharing and transferring behavioral health member information and records, as required by LDH, with data dictionary crosswalks for all data to ensure value match.

6. The Contractor shall reasonably cooperate with the Integrated Medicaid Managed Care Program plans during Transition Period including, at a minimum, participation in ongoing workgroup with attendees from Integrated Medicaid Managed Care Program and LDH representation. The Contractor shall provide LDH with relevant service utilization data, member specific POC information, identified service gaps, if any, and a listing of all levels of CSoC service providers.

7. The Contractor will participate in regular case specific transition meetings with OBH and any successor contractor or CSoC program manager at least monthly during transition concerning case staffing to ensure an understanding of needs and practices and provide for an orderly transition of case specific processes and information. A reasonable degree of coordination between the Contractor and the Integrated Medicaid Managed Care Program plans is required as the Integrated Medicaid Managed Care Program plans retain responsibility for physical health including pharmacy, basic behavioral health, and specialized behavioral health immediately upon discharge from CSoC (which is a voluntary program) and upon transition of the program to Contractor's successor or entity identified to manage CSoC.

8. The Contractor shall cooperate with LDH and Medicaid for the transition of data from the Contractor's Information Management System and the Contractor data warehouse. The Contractor shall provide a contact to fully support and expedite this effort to be completed.

9. The Contractor shall provide and securely transmit to the State's FI a claims and authorization file or report, in a frequency to be determined and format identified by LDH, which details all specialty behavioral health services that each member has received. Once receiving such claims, encounter and service histories, from the State's FI, Contractor's successor or entity identified to manage CSoC may then schedule consultation rounds with Care Managers or similar clinical staff to discuss details related to the care management of these members. The information must be in a usable format easily digestible and understandable to the end user.

10. For children/youth transitioning out of CSoC (whether during the contract, during a transition period or at the end of the contract), Contractor's

successor or entity identified to manage CSoC will receive the results of the initial comprehensive CANS assessment, IBHA, POC (which includes crisis plan), and the discharging comprehensive CANS assessment. POCs are for not more than 180 days.

I. Post-Transition Services

1. Within thirty (30) days following transition of operations, the Contractor must provide LDH with a Transition Results report documenting the completion and results of each step of the Transition Plan. Transition will not be considered complete until this document is approved by LDH.

2. The Contractor shall provide the required relevant authorization and claims data and reference tables and documentation for LDH.

3. The Contractor must pay any and all additional costs incurred by LDH that are the result of the Contractor's failure to provide the requested records, data or documentation that is currently in existence for the operations of the program and management of members within the time frames agreed to in the Transition Plan and in a usable format for LDH that does not require additional resources to utilize.

4. The Contractor must maintain all files and records related to members and providers for ten (10) years after the date of final payment under the contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the contract on or taken by LDH in any audit of the contract.

5. The expiration, termination or suspension the contract shall not affect the obligation of the Contractor to indemnify LDH for any claim by any third party against the State or LDH arising from the Contractor's performance of the contract and for which the Contractor would otherwise by liable under the contract.

6. LDH may request exit interviews to be conducted seven (7), thirty (30), or sixty (60) days prior to the contract termination date and thirty (30) days post contract termination. These exit interviews will be for the purpose of assessing contract termination readiness. The Contractor must be prepared to provide exit status updates on the following (including, but not limited to): data transition, member transition, and a list of operations to be completed (including care transition and claims status).

J. Transition Deliverables

1. Transition deliverables shall be determined in the transition plan.

2. For any deficiency or failed deliverable, LDH shall provide the Contractor notice and a reasonable opportunity to cure or present a CAP to be approved by LDH, which shall not be unreasonably withheld.

3. If the Contractor fails to correct the deficiency within the timeline approved by LDH, LDH may correct said deficiency. In such situations, the Contractor shall be responsible for LDH's reasonable expenses related to the correction.

X. TERMS AND CONDITIONS

A. General Requirements

1. In the event LDH exercises its right to renew the contract beyond the initial three year term, all terms and conditions, requirements and specifications of the contract shall remain the same and apply during the renewal period, pursuant to the following:

a. LDH will contract with an actuarial firm to calculate actuarially sound capitation rate ranges for each year of the contract.

b. If LDH elects to renew the contract, the Contractor shall accept or reject in writing the amount of rate adjustment(s) developed by LDH. The contracted rates will be within the actuarially sound rate range developed by LDH's actuary. If the Contractor does not

accept such rates, the contract shall not renew.

c. LDH, at its discretion, may adjust the rate to reflect trends occurring in the healthcare market that fall within the actuarial sound rate range, subject to available funds.

2. The Contractor agrees to comply with all state and Federal laws, regulations, and policies as they exist or as subsequently amended that are or may be applicable to the contract, not specifically mentioned in this section, including those in the LDH pro forma contract. Any provision of the contract which is in conflict with Federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and Federal policy. Such amendment will be effective on the effective date of the statutes, regulations, or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The Contractor may request LDH to make policy determinations required for proper performance of the services under the contract.

B. Amendments

1. The contract may be amended at any time as provided in this paragraph. The contract may be amended whenever appropriate to comply with state and Federal requirements or state budget reductions, provided however, that rates must be certified as actuarially sound. No modification or change of any provision of the contract shall be made or construed to have been made unless such modification is mutually agreed to in writing by the Contractor and LDH and incorporated as a written amendment to the contract. Any amendment to the contract shall require approval by LDH and DOA/OSP and may require approval of the CMS Regional Office prior to the amendment implementation.

2. LDH reserves the right to provide written clarification for non-material changes of contract requirements whenever deemed necessary, at any point in the contract period, to ensure the operations of the CSoC. Such clarifications shall be implemented by the Contractor and will not require an amendment to the contract.

C. Applicable Laws and Regulations

1. The Contractor agrees to comply with all applicable Federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

a. Title 42, Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);

b. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970, 42 USC §7401, et seq., and 20 USC §6082(2) of the Pro-Children Act of 1994 (Pub.L 103-227);

c. Title VI and Title VII of the Civil Rights Act of 1964, as amended by the Equal Opportunity Act of 1972, Federal Executive Order 11246;

d. The Vietnam Era Veteran's Readjustment Assistance Act of 1974, 38 USC §4212;

e. Title IX of the Education Amendments of 1972, 20 USC §1681, the Age Act of 1975, 42 USC §6101 et seq.;

f. Contractor agrees not to discriminate in its employment practices, and will render services under the contract without regard to race, color, religion, sex, sexual orientation, age, national origin, veteran status, political affiliation, disability, or any other non-merit factor. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of the contract.

g. Title VI of the Civil Rights Act of 1964, 42 USC §2000d et seq., and its implementing regulations at 45 CFR Part 80; the Contractor must

take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the contract;

h. Title VII of the Civil Rights Act of 1964, 42 USC §2000e, in regard to employees or applicants for employment;

i. The Federal Rehabilitation Act of 1973, as amended, specifically Section 504 of the Rehabilitation Act of 1973, 29 USC §794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from Federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;

j. The Age Discrimination Act of 1975, 42 USC §6101 et seq., as implemented by regulations at 45 CFR Part 91, which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from Federal financial assistance;

k. The Omnibus Budget Reconciliation Act of 1981, Pub.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from Federal financial assistance;

l. The Balanced Budget Act of 1997, Pub.L. 105-33 (111 Stat. 251), and the Balanced Budget Refinement Act of 1999, Pub.L. 106-113;

m. The Americans with Disabilities Act of 1990 as amended, specifically Titles II and III, 42 USC §12101 et seq., Pub. L. 101-336, and regulations issued pursuant thereto;

n. Section 1557 of the Patient Protection and Affordable Care Act;

o. Sections 1128, 42 USC 1320a-7, and 1156 of the Social Security Act, 42 USC 1320c-5, relating to exclusion of the Contractor for fraudulent or abusive activities involving the Medicare or Medicaid programs;

p. The Federal Drug Free Workplace Act of 1988, 41 USC §81, Pub.L. 100-690, as implemented in 45 CFR Part 82;

q. Title IX of the Education Amendments of 1972 regarding education programs and activities; and

r. The Contractor shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan. The Contractor shall comply with 42 CFR Part 438, Subpart K, specifically §§438.900, 905, 910, and 915 for all Medicaid managed care enrollees.

a. For the purposes of parity, the State shall define the benefit classifications for parity analysis.

b. The Contractor may cover, in addition to state plan required services, any service necessary for compliance with the requirements for parity in mental health and substance use disorder benefits based on parity analysis. The State may, based on initial parity analysis and ongoing parity review, require the Contractor to cover or change services necessary for compliance including type and amount, duration and scope of services and change policy or operational procedures in order to achieve and maintain compliance.

c. The Contractor shall ensure enrollees receive a notice of adverse benefit determination as per parity availability of information requirements in 42 CFR §438.915(b) and other

sections of this contract which extend notice requirements beyond denials. The Contractor shall make available the criteria for medical necessity determinations for mental health and substance use disorder benefits to any enrollee, potential enrollee or provider as per 42 CFR

a. §438.915 and §438.236. This shall be available in hard copy upon request at no costs to the requestor and available on the Contractor website.

b. The Contractor shall require that all providers and all subcontractors take such actions as are necessary to permit the Contractor to comply with mental health parity requirements listed in this contract. To the extent that the Contractor delegates oversight responsibilities to a third party, the Contractor shall require that such third party comply with the provisions of this contract relating to mental health parity. The Contractor agrees to require, via contract, that such providers comply with regulations and any enforcement actions, including but not limited to termination and restitution.

c. The Contractor shall provide LDH and its designees, which may include auditors and inspectors, with access to Contractor service locations, facilities, or installations, including any and all records, policies and procedures and files produced, electronic and hardcopy. Access described in this section shall be for the purpose of examining, auditing, or investigating mental health parity.

d. The State may require the Contractor to reassess, attest and report to the State, at a frequency to be determined by the State, that all services delivered to enrollees meet parity requirements. Ongoing reports and monitoring may be required as determined after the initial parity analysis. The Contractor must submit all documentation and reporting required by the State to establish and demonstrate compliance as determined by the State.

e. The Contractor shall comply with all other applicable state and federal laws and regulations relating to mental health parity and LDH established policies and procedures.

D. Taxes

1. Contractor is responsible for payment of all applicable taxes from the funds to be received under the contract. In accordance with La. R.S. 39:1624(A)(10), the Louisiana Department of Revenue must determine that the contractor is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the state and collected by the Department of Revenue prior to the approval of the contract by the Office of State Procurement.. The contractor further acknowledges understanding that issuance of a tax clearance certificate by the Louisiana Department of Revenue is a necessary precondition to the approval and effectiveness of the contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to this contract without penalty and proceed with alternate arrangements should the vendor fail to resolve any identified apparent outstanding tax compliance discrepancies with the Louisiana Department of Revenue within seven (7) days of such notification.

E. Assessment of Fees

1. The Contractor and LDH agree that LDH may elect to deduct any assessed fees, fines, penalties, or sanctions specified in this contract or applicable law from payments due or owing to the Contractor or direct the Contractor to make payment directly to LDH for any and all assessed fees, fines, penalties, or sanctions. The choice is solely and strictly at LDH's discretion.

2. The Contractor shall be responsible for payment of all premium taxes paid

through the capitation payments by LDH to the Louisiana Department of Insurance according to the schedule established by LDH.

F. Attorney's Fees

1. In the event LDH should prevail in any legal action arising out of the performance or non-performance of the contract, the Contractor shall pay, in addition to any monetary fines, damages, penalties, or sanctions, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

G. Insurance Requirements

1. Insurance shall be placed with insurers with an A.M. Best's rating of no less than A-: VI. This rating requirement shall be waived for Workers' Compensation coverage only.

2. General Insurance Information

a. The Contractor shall not commence work under the contract until it has obtained all insurance required herein including but not limited to Automobile Liability Insurance, Workers' Compensation Insurance and General Liability Insurance. Certificates of Insurance, fully executed by officers of the Insurance Company shall be filed with the Department for approval. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the Department before work is commenced.

b. Said insurance policies shall not be canceled, permitted to expire, or be changed without thirty (30) days' notice in advance to LDH and consented to by LDH in writing.

c. The Contractor shall not allow any subcontractor to commence work on a subcontract until all similar insurance required for the subcontractor has been obtained and approved.

d. Subcontractor's Insurance. The Contractor shall require that any and all subcontracts, which are not protected under the Contractor's own insurance policies, take and maintain insurance of the same nature and in the same amounts as required of the Contractor.

e. The Contractor and its subcontractors shall procure and maintain, until all of their obligations have been discharged, including until any warranty periods under the contract are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representatives, employees, or subcontractors. The insurance requirements herein are minimum requirements for the contract and in no way limit the indemnity covenants contained in the contract. The State in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might arise out of the performance of the work under the contract by the Contractor, its agents, representatives, employees, or subcontractors, and Contractor is free to purchase additional insurance.

3. Workers' Compensation Insurance

a. Before any work is commenced on the contract, the Contractor shall obtain and maintain during the life of the contract, Workers' Compensation Insurance for all of the Contractor's employees that provide services under the contract.

b. The Contractor shall require that any subcontractor or network providers obtain all similar insurance prior to commencing work unless such employees are covered by the protection afforded by the Contractor. In case any class of employees engaged in work under the contract at the site of the project is not protected under the Workers' Compensation Statute, the Contractor shall provide

for any such employees, and shall further provide or cause any and all subcontracts to provide Employer's Liability Insurance for the protection of such employees not protected by the Workers' Compensation Statute.

c. The Contractor shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to LDH prior to contract go-live and annually thereafter or upon change in coverage or carrier.

d. LDH shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the Contractor, subcontractor or provider obtaining such insurance.

e. Failure to provide proof of adequate coverage before work is commenced may result in the contract being terminated.

4. Commercial General Liability Insurance

a. The Contractor shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect the Contractor, LDH, and any subcontractor during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from operations under the contract, whether such operations be by the Contractor or by a subcontractor, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to LDH.

b. Such insurance shall name LDH as additional insured for claims arising from or as the result of the operations of the Contractor or its subcontractors.

c. In the absence of specific regulations, the amount of coverage shall be as follows: Commercial General Liability Insurance, including bodily injury, property damage and contractual liability, with combined single limits of one million dollars ($1,000,000).

5. Insurance Covering Special Hazards

a. Special hazards as determined by the Department shall be covered by rider or riders in the Commercial General Liability Insurance Policy or policies herein elsewhere required to be furnished by the Contractor, or by separate policies of insurance in the amounts as defined in any Special Conditions of the contract included therewith.

6. Licensed and Non-Licensed Motor Vehicles

a. The Contractor shall maintain during the life of the contract, Automobile Liability Insurance in an amount not less than combined single limits of one million dollars ($1,000,000) per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the contract on the site of the work to be performed thereunder, unless such coverage is included in insurance elsewhere specified.

7. Subcontractor's Insurance

a. The Contractor shall require that any and all subcontractors, which are not protected under the Contractor's own insurance policies, take and maintain insurance of the same nature and in the same amounts as required of the Contractor.

8. Errors and Omissions Insurance

a. The Contractor shall obtain, pay for, and keep in force for the duration of the contract period, errors and omissions insurance in the amount of at least one million dollars ($1,000,000) per occurrence.

H. Bond Requirements

1. Fidelity Bond

a. The Contractor shall secure and maintain during the life of the contract a blanket fidelity bond on all personnel in its employment.

b. The bond shall include but not be limited to coverage for losses sustained through any fraudulent or dishonest act or acts committed by any employees of the Contractor and its subcontractors.

c. The Contractor must submit to LDH a photocopy of the fidelity bond at least thirty (30) days prior to the go-live date of the contract unless this time requirement is reduced by mutual agreement of the parties.

2. Performance Bond

a. The Contractor must establish and maintain a performance (surety) bond in the amount of three million dollars ($3,000,000) to insure the successful performance under the terms and conditions of the contract negotiated between the successful proposer and LDH. The bond amount may be reevaluated and adjusted based upon the average monthly capitation payments paid to the Contractor during the initial twelve (12) month term of the contract.

b. Any performance bond furnished shall be written by a surety or insurance company currently on the U.S. Department of the Treasury Financial Management Service list of approved bonding companies which is published annually in the Federal Register, or by a Louisiana domiciled insurance company with at least an A- rating in the latest printing of the A.M. Best's Key Rating Guide to write individual bonds up to ten percent (10%) of policyholders' surplus as shown in the A.M. Best's Key Rating Guide or by an insurance company that is either domiciled in Louisiana or owned by Louisiana residents and is licensed to write surety bonds.

c. No surety or insurance company shall write a performance bond which is in excess of the amount indicated as approved by the U.S. Department of the Treasury Financial Management Service list or by a Louisiana domiciled insurance company with an A-rating by A.M. Best up to a limit of ten percent (10%) of policyholders' surplus as shown by A.M. Best; companies authorized by this Paragraph who are not on the treasury list shall not write a performance bond when the penalty exceeds fifteen percent (15%) of its capital and surplus, such capital and surplus being the amount by which the company's assets exceed its liabilities as reflected by the most recent financial statements filed by the company with the Department of Insurance. In addition, any performance bond furnished shall be written by a surety or insurance company that is currently licensed to do business in the State of Louisiana.

d. The Contractor shall be required to establish and maintain the bond for as long as the Contractor has contract-related liabilities of fifty thousand dollars ($50,000) or more outstanding, or fifteen (15) months following the termination date of the contract, whichever is earlier, to guarantee: 1) payment of the Contractor's obligations to LDH and 2) performance by the Contractor of its obligations under the contract.

e. The bond must be submitted to LDH within thirty (30) days of contract approval by DOA/OSP.

f. The performance bond must be made payable to the State. The contract and dates of performance must be specified in the performance bond. The original performance bond must be submitted to LDH. The original performance bond will have the raised engraved seal on the bond and on the Power of Attorney page. The Contractor must retain a photocopy of the performance bond.

g. The performance bond must be rated at least A by A.M. Best Company, of a standard commercial scope. The Contractor shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor shall be in material breach of the contract if it fails to maintain or renew the performance bond as required by LDH.

h. In the event that LDH exercises the option to renew the contract for an additional period, the Contractor shall be required to maintain the validity and enforcement of any required bond for the specified period, pursuance to the provisions of this paragraph, in an amount stipulated at the time of contract renewal.

i. The Contractor agrees that if it is declared to be in default of any material term of the contract, the Contractor shall:

a. Make any payments or expenditures deemed necessary to LDH, in its sole discretion, incurred by LDH in the direct operation of the contract pursuant to the terms of the contract and to reimburse LDH for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor.

b. Reimburse LDH for expenses exceeding the performance bond amount.

c. In the event of a default by the Contractor, LDH may, in addition to any other remedies it may have under the contract, obtain payment under the performance bond for the purposes of the following:

i. Paying any damages because of a breach of the Contractor's obligations under the contract;

ii. Reimbursing LDH for any payments made by LDH on behalf of the Contractor; or

iii. Reimbursing LDH for administrative expenses incurred by reason of a breach of the Contractor's obligations under the contract, including, but not limited to, expenses incurred after termination of the contract for reasons other than the convenience of the State by LDH.

I. Safeguarding Information

1. The Contractor shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members to purposes directly connected with the performance of the contract. The Contractor's written safeguards shall:

a. Be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S 46:56;

b. State that the Contractor will identify and comply with any stricter state or Federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c. Require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR §164.508;

d. Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e. Specify appropriate personnel actions to sanction violators.

J. Board Resolution/Signature Authority

1. The Contractor, if a corporation, shall secure and attach to the contract a formal Board Resolution, dated within three (3) years, indicating the

signatory to the contract is a corporate representative and authorized to sign said contract.

K. Confidentiality of Data

1. All financial, statistical, personal, technical and other data and information relating to the State's operation which are designated confidential by LDH and made available to the Contractor in order to carry out the contract, or which become available to the contractor in carrying out the contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to LDH. The identification of all such confidential data and information as well as LDH's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by LDH in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor's data and information are deemed by LDH to be adequate for the protection of LDH's confidential information, such methods and procedures may be used, with the written consent of LDH, to carry out the intent of this paragraph. The Contractor shall not be required under the provisions of the paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Contractor's possession, is independently developed by the Contractor outside the scope of the contract, or is rightfully obtained from third parties.

2. Under no circumstance shall the Contractor discuss or release information to the media concerning this project without prior express written approval of the Louisiana Department of Health.

L. Confidentiality of Information

1. The Contractor shall ensure that treatment records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through the Contractor's performance under the contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under the Federal regulations known as the “HIPAA Rules”, comprising the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 CFR Parts 160 and 164, which were originally promulgated by the U.S. Department of Health and Human Services (DHHS) pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”) of 1996 and subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health (“HITECH”) Act of the American Recovery and Reinvestment Act of 2009, and any other applicable state and Federal laws, LDH policies, or the contract. The Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the contract.

2. All information as to personal facts and circumstances concerning members or potential members obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of LDH or the member/potential member, unless otherwise permitted by HIPAA or required by applicable state or Federal law or regulations, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of the contract.

3. Individually identifiable health information is to be protected in accordance with the HIPAA Rules and as agreed upon in the HIPAA Business Associate Addendum per the Attachment to this contract.

4. The Contractor, its agents, employees, and subcontractors shall comply with the HIPAA Rules and ensure compliance with all HIPAA requirements across all systems and services related to the contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

5. The Contractor is required to submit an incident report to LDH with remediation plan and timelines for implementation of correction for approval by LDH within three (3) business days of Contractor discovery of any HIPAA violation, breach or use or disclosure of PHI as defined in 45 CFR §164.402, or potential violation, breach, or disclosure within three (3) days of LDH notifying the Contractor of a HIPAA violation, breach, use, or disclosure of PHI as defined in 45 CFR §164.402 or potential violation, breach, or disclosure. The incident report shall include, at a minimum:

a. Date of discovery;

b. Date or date range of violation/potential violation;

c. Cause of the incident including sequence and mechanisms;

d. Number of unauthorized individuals who viewed PHI;

e. Number of affected individuals whose PHI was compromised;

f. Steps taken to correct this incident to date, and planned steps to correct incident;

g. Steps taken to prevent reoccurrence from happening in the future;

h. Steps taken to mitigate any harmful effects caused by the unauthorized disclosure;

i. Any training or other corrective action targeted to Contractor staff or providers subsequent to this incident;

j. Plans for notification of CMS/HHS; and

k. Notification plan to individuals.

6. A Breach Risk Assessment will be provided in a timely manner on all unauthorized disclosures which includes the following:

a. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

b. The unauthorized person who used the PHI or to whom the disclosure was made;

c. Whether the PHI was actually acquired or viewed; and

d. The extent to which the risk to the PHI has been mitigated.

M. Effect of Termination on Contractor's HIPAA Privacy Requirements

1. Upon termination of the contract for any reason, the Contractor shall return or destroy all PHI received from LDH, or created or received by the Contractor on behalf of LDH. This provision shall also apply to PHI that is in the possession of subcontractors or agents of the Contractor. The Contractor shall not retain any copies of the PHI.

2. In the event that the Contractor determines that returning or destroying the PHI is not feasible, the Contractor shall provide to LDH notification of the conditions that make return or destruction not feasible. Upon a mutual determination that return or destruction of PHI is not feasible, the Contractor shall extend the protections of the contract to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as the Contractor maintains such PHI.

N. Contract Language Interpretation

1. The Contractor and LDH agree that in the event of a disagreement regarding, arising out of, or related to, contract language interpretation, LDH's interpretation of the contract language in dispute shall control and govern.

O. Contract Controversies

1. Any claim or controversy arising out of the contract shall be resolved by the provisions of Louisiana Revised Statutes 39:1672.2-1672.4.

P. Contract Modification

1. No amendment or variation of the terms of the contract shall be valid unless made in writing, signed by the parties and approved as required by law. No oral understanding or agreement not incorporated in the contract is binding on any of the parties.

Q. Governing Law and Place of Suit

1. It is mutually understood and agreed that the contract shall be governed by the laws of the State of Louisiana except its conflict of laws provisions, both as to interpretation and performance. Any administrative proceeding, action at law, suit in equity, or judicial proceeding for the enforcement of the contract or any provision thereof shall be instituted only in the administrative tribunals and courts of the State of Louisiana. Specifically, any state court suit shall be filed in the 19th Judicial District Court for the Parish of East Baton Rouge as the exclusive venue for same, and any Federal suit shall be filed in the U.S. District Court for the Middle District of Louisiana as the exclusive venue for same. This section shall not be construed as providing a right or cause of action to the Contractor in any of the aforementioned Courts.

R. Severability

1. If any term or condition of the contract or the application thereof is held invalid, such invalidity shall not affect other terms, conditions, or applications which can be given effect without the invalid term, condition, or application; to this end, the terms and conditions of the contract are declared severable.

S. Cooperation with Other Contractors

1. In the event that LDH has entered into, or enters into, agreements with other Contractors for additional work related to the services rendered hereunder including but not limited to FI and enrollment broker services, the Contractor agrees to cooperate fully with such other Contractors. The Contractor shall not commit any act that will interfere with the performance of work by any other Contractor.

2. The Contractor's failure to cooperate and comply with this provision shall be sufficient grounds for LDH to halt all payments due or owing to the Contractor until it becomes compliant with this or any other contract provision. LDH's determination on the matter shall be conclusive and not subject to Appeal.

T. Copyrights

1. If any copyrightable material is developed in the course of or under the contract, LDH shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for LDH purposes.

U. Corporation Requirements

1. In accordance with Louisiana law, all corporations (see, La. R.S. 12:262.1) and limited liability companies (see, La. R.S. 12:1308.2) must be registered and in good standing with the Louisiana Secretary of State in order to hold a purchase order or a contract with the State.

2. If the Contractor is a corporation, the following requirement must be met prior to execution of the contract:

    a. If a for-profit corporation whose stock is not publicly traded, the Contractor must file a Disclosure of Ownership form with the Louisiana Secretary of State.

    b. If the Contractor is a corporation not incorporated under the laws of the State, the Contractor must obtain a Certificate of Authority pursuant to La. R.S. 12:301-302 from the Louisiana Secretary of

State.

c. The Contractor must provide written assurance to LDH from the Contractor's legal counsel that the Contractor is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the contract.

V. Employment of Personnel

1. In all hiring or employment made possible by or resulting from the contract, the Contractor agrees that:

a. There shall be no discrimination against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, age, national origin, disability, political affiliation, veteran status, or any other non-merit factor; and

b. Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable state and Federal laws regarding employment of personnel.

2. The requirements of this Section 24.23 shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The Contractor further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, age, national origin, disability, political affiliation, veteran status, or any other non-merit factor. All inquiries made to the Contractor concerning employment shall be answered without regard to such non-merit factors. All responses to inquiries made to the Contractor concerning employment made possible as a result of the contract shall conform to Federal, state, and local regulations.

W. Non-Discrimination

1. In accordance with 42 CFR §438.3(d)(1), the Contractor shall not discriminate in the enrollment of Medicaid individuals into the Contractor. The Contractor agrees that no person, on the grounds of age, race, color, religion, sex, sexual orientation, gender identity, national origin, disability, or basis of health status or need for healthcare services shall be excluded from participation in, or be denied benefits of the Contractor's program or be otherwise subjected to discrimination in the performance of the contract or in the employment practices of the Contractor. The Contractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts.

X. Emergency Management Plan

1. The Contractor shall maintain its current EMP and will have any material changes thereto approved by LDH within forty-five (45) days from the date the signed contract is approved by DOA/OSP to LDH for approval. The emergency management plan shall specify actions the Contractor shall conduct to ensure the ongoing provision of health services in an epidemic, natural disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, state-required shelter in place orders, and technological or attack- related emergencies. Revisions to the LDH approved emergency plan shall be submitted to LDH for approval no less than thirty (30) days prior to implementation of requested changes. The Contractor shall submit an annual certification (from the date of the most recently approved plan) to LDH certifying that the emergency plan is unchanged from the previously approved plan.

2. At a minimum, the plan shall include the following:

a. How the Contractor will educate its members and providers regarding hurricane preparedness and evacuation planning (must include plan for accessing services at alternate locations if evacuated);

b. Examples of the Contractor outreach campaign information for both members and providers. Information should include references, contact information and websites for local and state resources including, but not limited to, LDH Office Of Public Health (OPH), Red Cross, Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP), Federal Emergency Management Agency (FEMA), Louisiana State Police, and National Weather Services Offices;

c. A Contractor contact list (phone and email) for members/providers to contact to determine where healthcare services may be accessed/rendered;

d. How the Contractor will identify members who require evacuation assistance and informing local officials of those identified;

e. Information regarding other types of emergencies (epidemics, man-made disasters);

f. Information regarding the business continuity plan and internal disaster training of the Contractor;

g. Information regarding how members and providers will interact with Contractor's call center prior to, during, and after an event. The Contractor shall provide examples to LDH regarding the scripts that will be released to members during the aforementioned times;

h. A plan to disseminate information to members regarding the availability status of Contractor's providers (ex: closed permanently or temporarily) and any alternate providers that may be available in the event of a disaster;

i. Emergency contracting with out-of-state healthcare providers to provide healthcare services to evacuated members;

j. A plan to ensure appropriate members have access to EPSDT services currently not in the Medicaid Behavioral Health Services Provider Manual but medically necessary from out-of-network or out-of-state providers in a timely manner; and

k. A plan for the continuation of Contractor operations, including but not limited to, member verification, claims processing, provider/member complaints handling, and PA.

3. The Contractor shall participate in any appropriate disaster/emergency trainings meetings that are provided by LDH or its partners (including, but not limited to, GOHSEP, DCFS, FEMA, Red Cross, Local/Parish Governing Authorities).

Y. Political Activity

1. None of the funds, materials, property, or services provided directly or indirectly under the contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act."

2. The Contractor shall not use funds paid to the Contractor by LDH, or interest earned, for the purpose of influencing or attempting to influence any officer or employee of any state or Federal agency; or any member of, or employee of a member of, the United States Congress or the Louisiana State Legislature:

a. In which it asserts authority to represent LDH or advocate the official position of LDH in any matter before a state or Federal agency; or any member of, or employee of a member of, the United States Congress or the Louisiana State Legislature.

b. In connection with the awarding of any Federal or state contract, the making of any Federal or state grant, the making of any Federal or state loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or state contract, grant, loan, or cooperative agreement.

3. The Contractor shall file the required certification that each tier will not use Federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tear up to the recipient (45 CFR Part 3).

4. By signing the contract, the Contractor signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the State of Louisiana, the Government Accountability Office, DHHS, CMS, or any other Federal agency has or shall benefit financially or materially from the contract. The contract may be terminated by LDH if it is determined that gratuities of any kind were offered to, or received by, any officials or employees from the State, its agents, or employees.

5. Contractor agrees not to use contract proceeds to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition on any election ballot or a proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority.

Z. Entire Agreement

1. The Contractor shall comply with all provisions of the contract and with the performance of the provisions of said contract. The Contractor shall be bound by all applicable Department issued guides. The Contractor agrees that failure to comply with the provisions of the contract may result in the assessment of monetary penalties, sanctions or termination of the contract in whole or in part, as set forth in the contract. The Contractor shall comply with all applicable LDH policies and procedures in effect throughout the duration of the contract period. The Contractor shall comply with all applicable LDH provider manuals, rules and regulations and guides.

2. LDH, at its discretion, will issue correspondence to inform the Contractor of changes in Medicaid policies and procedures which may affect the contract. The Contractor shall implement changes in accordance with a mutually agreeable timeline. However, LDH shall enforce any mandatory timelines per state or Federal regulations that would impact the receipt of Federal dollars or state appropriations necessary for payments related to the execution of this contract.

AA. Force Majeure

1. The Contractor and the Department are excused from performance under contract for any period they may be prevented from performance by an Act of God, strike, war, civil disturbance, epidemic or court order.

BB. Independent Assurances

1. LDH may also require the Contractor or subcontractors, if performing a key internal control, to submit to financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation.

2. These audits will require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the

party selected to perform the independent audit. The audit firm will submit to LDH or the Contractor a final report on controls placed in operations for the project and includes a detailed description of the audit firm's tests of the operating effectiveness of controls.

3. The Contractor shall supply LDH with an exact copy of the report within thirty (30) calendar days of completion. The Contractor shall agree to implement recommendations as suggested by the audits within three months of report issuance at no cost to the State. Cost of the audit is to be borne by the Contractor.

CC. Integration

1. The contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The Contractor also agrees to be bound by the contract and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

DD. Indemnification and Limitation of Liability

1. Neither party shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. The parties shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under contract.

2. The Contractor shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and hold harmless the State and its authorized users from suits, actions, damages and costs of every name and description relating to personal injury and damage to real or personal tangible property caused by the Contractor, its agents, employees, partners or subcontractors, without limitation; provided, however, that the Contractor shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the State. If applicable, the Contractor will indemnify, defend and hold the State and its authorized users harmless, without limitation, from and against any and all damages, expenses (including reasonable attorneys' fees), claims, judgments, liabilities and costs which may be finally assessed against the State in any action for infringement of a United States Letter Patent with respect to the products furnished, or of any copyright, trademark, trade secret or intellectual property right, provided that the State shall give the Contractor:

a. Prompt written notice of any action, claim or threat of infringement suit, or other suit;

b. The opportunity to take over, settle or defend such action, claim or suit at Contractor's sole expense; and

c. Assistance in the defense of any such action at the expense of the Contractor.

3. Where a dispute or claim arises relative to a real or anticipated infringement, the State or its authorized users may require the Contractor, at its sole expense, to submit such information and documentation, including formal patent attorney opinions, as the Commissioner of Administration shall require.

4. The Contractor shall not be obligated to indemnify that portion of a claim or dispute based upon:

a. Authorized user's unauthorized modification or alteration of a product, material or service;

b. Authorized user's use of the product in combination with other products not furnished by the Contractor; and

c. Authorized user's use in other than the specified operating conditions and environment.

5. In addition to the foregoing, if the use of any item(s) or part(s) thereof shall be enjoined for any reason or if the Contractor believes that it may be enjoined, the Contractor shall have the right, at its own expense and sole discretion as the authorized user's exclusive remedy to take action in the following order of precedence:

a. To procure for the State the right to continue using such item(s) or part(s) thereof, as applicable;

b. To modify the component so that it becomes non-infringing equipment of at least equal quality and performance;

c. To replace said item(s) or part(s) thereof, as applicable, with non-infringing components of at least equal quality and performance, or

d. If none of the foregoing is commercially reasonable, then provide monetary compensation to the State up to the dollar amount of the contract.

6. For all other claims against the Contractor where liability is not otherwise set forth in the contract as being "without limitation," and regardless of the basis on which the claim is made, the Contractor's liability for direct damages, shall be the greater of one hundred thousand dollars ($100,000), the dollar amount of the contract, or two (2) times the charges rendered by the Contractor under the contract. Unless otherwise specifically enumerated herein or in the work order mutually agreed between the parties, neither party shall be liable to the other for special, indirect or consequential damages, even if the party has been advised of the possibility of such damages. Neither party shall be liable for lost profits, lost revenue or lost institutional operating savings.

7. The State and its authorized user, in addition to other remedies available to them at law or equity and upon notice to the Contractor, may withhold funds from amounts due to Contractor, or may proceed against the performance and payment bond, if any, as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against them.

8. In the event of circumstances not reasonably within the control of the Contractor or LDH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the Contractor, LDH, or any subcontractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services. Notwithstanding, as long as the contract remains in full force and effect, the Contractor shall be liable for the core benefits and services required to be provided or arranged for in accordance with the contract.

9. Contractor will warrant all materials, products or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against LDH, LDH shall promptly notify Contractor in writing and Contractor shall defend such claim in LDH's name, but at Contractor's expense and shall indemnify and hold harmless LDH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.

EE. Hold Harmless as to the Contractor Members

1. The Contractor hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, Contractor members, or persons acting on their behalf, for healthcare services which are rendered to such members by the Contractor and its subcontractors.

2. The Contractor further agrees that the Contractor's member shall not be

held liable for payment for CSoC benefits and services furnished under a provider contract, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the Contractor provided the service directly. The Contractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by Contractor and insolvency of the Contractor.

3. The Contractor further agrees that the Contractor's member shall not be held liable for the costs of any and all services provided by a provider whose service is not covered by the Contractor or does not obtain timely approval or required prior-authorization.

4. The Contractor further agrees that this provision shall be construed to be for the benefit of Contractor's members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Contractor and such members, or persons acting on their behalf.

FF. Safety Precautions

1. LDH assumes no responsibility with respect to accidents, illnesses or claims arising out of any activity performed under the contract. The Contractor shall take necessary steps to ensure or protect its members, itself, and its personnel. The Contractor agrees to comply with all applicable local, state, and Federal occupational and safety acts, rules, and regulations.

GG. Homeland Security Considerations

1. The Contractor shall perform the services to be provided under the contract entirely within the boundaries of the United States. In addition, the Contractor will not hire any individual to perform any services under the contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

2. If the Contractor performs services, or uses services, in violation of the foregoing paragraph, the Contractor shall be in material breach of the contract and shall be liable to LDH for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Contractor shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of the contract.

3. The prohibitions in this section shall also apply to any and all agents and subcontractors used by the Contractor to perform any services under the contract.

HH. Independent Contractor

1. It is expressly agreed that the Contractor and any subcontractors and agents, officers, and employees of the Contractor or any subcontractors in the performance of the contract shall act in an independent capacity and not as officers, agents, express or implied, or employees of LDH or the State. It is further expressly agreed that the contract shall not be construed as a partnership or joint venture between the Contractor or any subcontractor and LDH and the State.

II. Interest

1. Interest generated through investments made by the Contractor under the contract shall be the property of the Contractor and shall be used at the Contractor's discretion.

JJ. Assignment

1. No contractor shall assign any interest in this contract by assignment, transfer or novation, without prior written consent of LDH. This provision shall not be construed to prohibit the contractor from assigning to a bank, trust company, or other financial institution any money due from approved contracts without such prior written consent. Notice of any such assignment or transfer shall be furnished promptly to LDH.

KK. Loss of Federal Financial Participation (FFP)

1. The Contractor may be liable for any loss of FFP suffered by LDH due to the Contractor's, or its subcontractors', failure to perform the services as required under the contract. Payments provided for under the contract may be denied for new members as determined by LDH when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR §438.730.

LL. Misuse of Symbols, Emblems, or Names in Reference to Medicaid

1. No person or Contractor may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words “Louisiana Medicaid,” or “Louisiana Department of Health” or “Office of Behavioral Health,” unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint, or distribute any LDH form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or LDH terms does not provide a defense. Each piece of mail or information constitutes a violation.

MM. Moral and Religious Objections

1. If the Contractor objects to a service on moral or religious grounds, it is not required to provide, reimburse for, or provide coverage of that service, though it would otherwise be required to do so. Contractor shall comply with 42 CFR §438.102. Failure to do so will subject Contractor to sanctions.

2. If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the Contractor must furnish information about the services it does not cover in accordance with 1932(b)(3)(B)(ii) of the Social Security Act and 42 CFR §438.102(b)(1) by notifying:

a. LDH prior to signing the contract;

b. LDH whenever it adopts the policy during the term of the contract;

c. Members within ninety (90) days after adopting the policy with respect to any particular service, but thirty (30) days prior to the effective date of the policy; and

d. Members through the inclusion of the information in the member’s information manual/handbook.

3. If the Contractor elects not to provide, reimburse for, or provide coverage of a core benefit or service because of an objection on moral or religious grounds, the monthly capitation payment for the Contractor will be recalculated.

4. The Contractor shall inform members how they can obtain information from the State about how to access the services excluded by the Contractor.

NN. Non-Allowable Costs

1. LDH follows the Federal guidelines for allowable and non-allowable costs as outlined in OMB Circular A-87. This applies to any charitable contribution, donation or support from the Contractor to an organization or entity in the form of cash, property or services rendered from Contractor funds. In addition, the Contractor:

a. Shall not make charitable donations or contributions from Contractor program funds.

b. Is allowed to make charitable contributions or donations from its general revenue, earned income funds, or other corporate income funds without LDH approval, as long as the Contractor does not report such charitable contributions or donations as an Allowable Expense.

OO. Physician Incentive Plans

1. The Contractor shall comply with requirements for physician incentive plans, as required by 42 CFR §438.3(i), 42 CFR §438.10(f)(3) and set forth (for Medicare) in 42 CFR §422.208 and §422.210.

2. The Contractor will provide assurance satisfactory to LDH that the requirements of 42 CFR §422.208 are met.

PP. Rate Adjustments

1. The Contractor and LDH both agree that the monthly capitation rates identified in the contract shall be in effect during the period identified on the Contractor Rate Schedule that will be posted on LDH's website and incorporated into this Agreement by reference as set forth herein. At the sole discretion of LDH, rates may be adjusted during the contract period based on LDH and actuarial analysis, subject to CMS review and approval, and availability of funds.

2. In the event of any changes to the scope of Contractor's responsibilities under this contract, whether resulting from a change in applicable law, LDH policies or requirements, or otherwise, LDH shall adjust the capitation rates effective upon the effective date of the change in an actuarially sound manner. In the event that the parties do not agree upon revised capitation rates, either party may terminate this contract upon sixty (60) days prior written notice.

3. The Contractor and LDH both agree that the adjustments to the monthly capitation rate(s) required pursuant to this Section 20.43 shall occur only by written amendment to the contract. Should the Contractor refuse to accept the revised monthly capitation rate, the revised rates shall not become effective and the Contractor may terminate this contract upon sixty (60) days prior written notice.

QQ. Record Retention for Awards to Recipients

1. Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of six (6) years from the date of submission of the final expenditure report, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

a. If any litigation, claim, financial management review, or audit is started before the expiration of the six (6) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken;

b. Records for real property and equipment acquired with Federal funds shall be retained for six (6) years after final disposition;

c. When records are transferred to or maintained by LDH, the six (6) year retention requirement is not applicable to the recipient; and

d. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR §74.53(g).

RR. Release of Records

1. The Contractor shall release treatment records upon request by members or authorized representatives, as may be directed by authorized personnel of LDH, appropriate agencies of the State, or the United States Government. Release of treatment records shall be consistent with the provisions of confidentiality as expressed in the contract. The ownership and procedure for release of treatment records shall be controlled by the Louisiana Revised Statutes, including but not limited to La. R.S. 40:1165.1, La. R.S. 13:3734, and La. C.Ev. Art. 510; and 45 CFR Part 160 and Part 164, Subparts A and E (HIPAA Privacy Rule) and subject to reasonable charges. The Contractor shall not charge LDH or its designated agent for any copies of records requested.

SS. Right to Audit

1. The State Legislative Auditor, agency, or Federal auditors and internal auditors of the Division of Administration shall have the option to audit all accounts directly pertaining to the contract for a period of three (3) years from the date of the last payment made under the contract. Records shall be made available during normal working hours for this purpose.

TT. Termination

1. Termination For Cause

a. The State may terminate the contract for cause based upon the failure of Contractor to comply with the terms or conditions of the contract; provided that the State shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the State may, at its option, place the Contractor in default and the contract shall terminate on the date specified in such notice. Failure to perform within the time agreed upon in the contract may constitute default and may cause cancellation of the contract.

b. Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the State to comply with the terms and conditions of the contract provided that the Contractor shall give the State written notice specifying the State agency's failure and a reasonable opportunity for the State to cure the defect.

2. Termination for Convenience

a. LDH may terminate the contract for convenience and without cause upon sixty (60) calendar day's written notice. LDH shall not be responsible to the Contractor or any other party for any costs, expenses, or damages occasioned by said termination, i.e., this termination is without penalty. In no case, shall the contract continue beyond the specified termination date.

3. Termination for Non-Appropriation of Funds

a. The continuation of the contract is contingent upon the appropriation of funds by the Legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act or Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds have not been appropriated.

b. In the event that Federal or state funds to finance the contract become unavailable after the effective date of the contract and in the middle of a SFY, or prior to the anticipated contract expiration date; or in the event of a reduction in the State budget appropriation for any allocation, including but not limited to, the required Maintenance of Effort (MOE) in support of the Block Grant, LDH may either renegotiate the contract, including PMPM capitation rates, or terminate the contract without penalty. Availability of funds shall be determined solely by LDH. Notification will be made with thirty (30) days written notice when possible.

c. The Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to

the State when requested. This applies even if an eventual contract is terminated or a lawsuit is filed. Specifically, the Contractor does not have the right to limit or impede the State's right to audit or to withhold State owed documents.

UU. Time is of the Essence

1. Time is of the essence in the contract. Any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

X. Titles

1. All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

WW. Transfer of Ownership

1. The Contractor shall not sell or transfer any rights or interest relative to its ownership interest as the management entity serving the State of Louisiana through the CSoC during the life of the contract without prior written approval of LDH.

2. Any action by the Contractor in contradiction of this section may subject the Contractor to legal action or remediation.

XX. Use of Data

1. LDH shall have at least user-defined access to and training on all Contractor data systems as needed for verification of data. LDH shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the Contractor resulting from the contract.

YY. Conflict of Interest Provisions

1. The Contractor shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The Contractor shall quarterly inquire of its officers and employees concerning such conflicts, and shall inform LDH promptly of any potential conflict. The Contractor shall warrant that it shall remove any conflict of interest prior to signing the contract.

2. Statements, acts and omissions made by or on behalf of the Commissioner of Administration regarding the contract, Contractor or any subcontractor shall not be deemed a conflict of interest when the Commissioner is discharging his duties and responsibilities under law, including, but not limited, to the Commissioner of Administration's authority in procurement matters.

ZZ. Code of Ethics

1. The Contractor acknowledges that Chapter 15 of Title 42 of the Louisiana Revised Statutes (R.S. 42:1101 et seq., Code of Governmental Ethics) applies to the Contracting Party in the performance of services called for in the contract. The Contractor agrees to immediately notify the State if potential violations of the Code of Governmental Ethics arise at any time during the term of the contract.

2. Contractor is responsible for determining that there will be no conflict or violation of the Code of Governmental Ethics. The Louisiana Board of Ethics is the only entity that can officially rule on ethics issues.

AAA. Warranty to Comply with State and Federal Regulations

1. The Contractor shall warrant that it shall comply with all State and Federal laws, rules, regulations, policies, procedures, guidance, and manuals during the term of the Contract.

BBB. Prohibition of Discriminatory Boycotts of Israel

1. 20.54.1 In accordance with La. R.S. 39:1602.1, for any contract for

$100,000 or more and for any Contractor with five (5) or more employees, Contractor, or any Subcontractor, shall certify it is not engaging in a boycott of Israel, and shall, for the duration of this Contract, refrain from a boycott of Israel.

The State reserves the right to terminate this Contract if the Contractor, or any Subcontractor, engages in a boycott of Israel during the term of the Contract.

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GLOSSARY

Abuse (as in Fraud, Waste, and Abuse) – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

Actively Enrolled – The status of a member who has met full clinical and financial eligibility requirements for Coordinated System of Care (CSoC) and is participating in the CSoC process.

Actuary – An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

Adjudicate - To deny or pay a claim.

Advance Directive – A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Adverse Benefit Determination – The denial, reduction, suspension, delay, or termination of a request for admission, availability of care, continued stay or other health care service upon review by the Contractor of information provided that the requested services does not meet the Contractor's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness. Specific examples include:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of a payment for a service, excluding when the denial by the Contractor, in whole or in part, is due to the claim not meeting the definition of a clean claim in accordance with 42 CFR §438.400.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of a Contractor to act with the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, premiums, deductible, coinsurance and other member

financial liabilities.

Age Discrimination Act of 1975 – Prohibits discrimination on the basis of age in programs and activities receiving Federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements. The Age Discrimination Act is enforced by the Civil Rights Center.

Age of Majority – Louisiana Civil Code, Article 29, provides that majority is attained upon reaching the age of eighteen years.

Agent – Any person or entity with delegated authority to obligate or act on behalf of another party.

Americans with Disabilities Act of 1990 (ADA) – The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. The ADA also establishes requirements for telecommunications relay services.

Appeal – A request for a review of an adverse benefit determination.

Appeal Procedure – A formal process whereby a member has the right to contest an adverse determination/action rendered by the Contractor, which results in the denial, reduction, suspension, termination, or delay of healthcare benefits/services. The appeal procedure shall be governed by Federal and Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Authorized Representative – An individual or organization designated by a Beneficiary, or authorized under State law, including, but not limited to, a court order establishing legal guardianship or a power of attorney, to act responsibly on their behalf, in accordance with 42 C.F.R. §435.923.

Average Speed to Answer – All calls (pooled) answered within an average of thirty (30) seconds. This is measured using monthly system-generated reports from first ring to live answer on 24/7 single point of entry 800 line.

Basic Behavioral Health Services – Services provided in the member's Primary Care Provider (PCP) or medical office by the member's (non-behavioral health specialist) physician (i.e., DO, MD, APRN) as part of routine physician evaluation and management activities (e.g., screening, prevention and referral).

Behavioral Health Specialists – Psychologists, Medical Psychologists, APRNs (NPs and CNSs specializing in psychiatry/mental health), and LCSWs.

Board Certified – An individual who has successfully completed all prerequisites of a medical specialty board and has successfully passed the required examination for certification.

Bureau of Health Services Financing (BHSF) – The agency within the Louisiana Department of Health, Office of Management and Finance (OMF) that has been designated as Louisiana's single state Medicaid agency to administer the Medicaid and CHIP programs.

Business Day – Monday, Tuesday, Wednesday, Thursday, and Friday, excluding State-designated holidays. In computing a period of time prescribed in Business Days, the date of the triggering act or event is not to be included. The last day of the period is to be included, unless it is a Saturday, a Sunday, or a State-designated holiday, in which event the period shall run until the end of the next day that falls on a Business Day.

Calendar Days – All seven (7) days of the week. Unless otherwise specified, the term "day" in this document refers to calendar days. In computing a period of time prescribed in Calendar Days, the date of the triggering act or event is not to be included, and the last day of the period is to be included.

Call Abandonment – The number of calls abandoned by callers after being placed in the Automated Call Distribution (ACD) call queue and before being answered by a live customer service representative.

Can – Denotes a preference, but not a mandatory requirement.

Capitation Payment – A payment the State makes periodically to the Contractor on behalf of each beneficiary enrolled under the Contract and based on the actuarially sound capitation rate for the provision of services under the State plan or applicable waiver.

Care Coordination – Deliberate organization of member care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in a member's care. This coordination may include care provided by network or non-network providers. Organizing care involves the marshaling of personnel and other resources needed to carry out all required member care activities; it is often facilitated by the exchange of information among participants responsible for different aspects of the member's care.

Care Management – Overall system of medical management encompassing utilization management (UM), referral, case management, care coordination, continuity of care and transition care, chronic care management, quality care management, and independent review.

Case Management – A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services; these services may include medical, social, educational, and other support services. Case management services include an individual needs and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and outcomes monitoring.

Centers for Medicare and Medicaid Services (CMS) – The agency within the U.S. Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. This agency was formerly known as the Health Care Financing Administration (HCFA).

CHIP – The Children's Health Insurance Program (CHIP) was created in 1997 by Title XXI of the Social Security Act. This program is known in Louisiana as LaCHIP.

Child and Adolescent Needs and Strengths Assessment (CANS) – is a multipurpose tool developed to support care planning and level of care (LOC) decision-making, to facilitate quality improvement (QI) initiatives, and to allow for the monitoring of outcomes. The CANS was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. Domains assessed include general symptomology, risk behaviors, developmental functioning, personal/interpersonal functioning, and family functioning. The CANS is intended to support the development of the individualized plan of care.

Child and Adolescent Needs and Strengths (CANS) Certification – Requires participation in the PRAED Foundation's online training at www.canstraining.com. This interactive training and certification site provides a full training experience with videos, quizzes, practice vignettes with feedback and certification testing.

Chisholm Class Members – All current and future recipients of Medicaid in the State of Louisiana, under age 21, who are now on, or will in the future be placed on, the Developmental Disabilities Request for Services Registry.

Claim – A request for payment for benefits received or services rendered.

Clean Claim – A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity. Claims with errors that originated in the State's or Contractor's claim system, and through no error on the part of the provider, also qualify as a clean claim

CMS 1500 – A universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.

Community Psychiatric Support and Treatment (CPST) – Refers to services and supports that are goal directed and solution focused interventions intended to achieve identified goals or objectives as set forth in the individual's individualized treatment plan.

Contract – The written agreement between LDH and the Contractor, which is comprised of the terms and conditions set forth herein, the executed CF-1, including any appendices, attachments, and exhibits thereto or incorporated therein by reference, and any amendments thereof.

Contract Dispute – A circumstance whereby the Department and the Contractor are unable

to arrive at a mutual interpretation of the requirements, limitations, provisions or compensation for the performance of services under the Contract.

Contractor – The entity that enters into this Contract with LDH for the provision of services described herein.

Convicted – A judgment of conviction entered by a Federal, state or local court, including a conviction based on a plea of guilty or nolo contendere, regardless of whether an appeal from that judgment is pending.

Co-Occurring Disorders (COD) – The presence of both mental and substance use disorders. Clients said to have COD have one or more substance use disorders, as well as one or more mental disorders.

Coordinated System of Care (CSoC) – Program focused on responding to the needs of young people who have significant behavioral health challenges who are in or at imminent risk of out-of-home placement, and their families; a collaborative effort among families, youth, the Department of Children and Family Services (DCFS), the Department of Education (DOE), the Louisiana Department of Health (LDH), and the Office of Juvenile Justice (OJJ).

Coordination of Benefits (COB) – The activities involved in determining Medicaid benefits when a recipient has other coverage through an individual or group insurance plan or other program that is liable to pay for the member's healthcare services.

Cost Avoidance – A method of paying claims in which the provider is not reimbursed until the provider has demonstrated that all available health insurance has been exhausted.

Corrective Action Plan (CAP) – A plan that is designed to ameliorate an identified deficiency and prevent recurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.

CPT® – **Current Procedural Terminology**, current version, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other healthcare professional services and procedures under HIPAA.

Credentialing Verification Organization (CVO) - An organization that conducts credential verification, reports the credentialing information to clients and has systems in place to protect the confidentiality and integrity of the information.

Crisis Mitigation Services – A provider's assistance to enrollees during a crisis that provides 24-hour on call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute Crisis Mitigation Services.

CSoC Eligible – Children and youth eligible for services under the Coordinated System of Care waiver program.

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

Culture – Refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Denied Claim – A claim for which no payment is made to the network provider by the Contractor for any of several reasons, including but not limited to, the claim is for non- covered services, the provider or member is ineligible, the claim is a duplicate of another transaction, or the claim has failed to pass a significant requirement (or edit) in the claims processing system.

Department or LDH – Louisiana Department of Health.

Department of Health and Human Services (DHHS; also HHS) – The U.S. government's principal agency for protecting the health of all Americans and providing essential human

services, especially for those who are least able to help themselves. DHHS provides oversight for more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; ensuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families.

Developmental Disability - According to statute reference – La. R.S 28:451.2
"Developmental Disability" means either:

a.) A severe, chronic disability of an individual that:

i. Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.

ii. Is manifested before the individual reaches age twenty-two (22).

iii. Is likely to continue indefinitely.

iv. Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

aa) Self-care.

bb) Receptive and expressive language.

cc) Learning.

dd) Mobility.

ee) Self-direction.

ff) Capacity for independent living.

gg) Economic self-sufficiency.

v. Is not attributed solely to mental illness.

vi. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are lifelong or extended duration and are individually planned and coordinated.

b.) A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine (9) which, without services or support, has a high probability of resulting in those criteria in Subparagraph (a) of this paragraph later in life that may be considered to be a developmental disability.

Duplicate Claim – A claim that is either a total or partial duplicate of services previously paid.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – A Federally- required Medicaid benefit for individuals under age twenty- one (21) years that expands coverage for children and adolescents beyond adult limits to ensure availability of: 1) screening and diagnostic services to determine physical or mental defects and 2) healthcare, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (42 CFR §440.40(b)). EPSDT requirements help to ensure access to all medically necessary healthcare services within the Federal definition of “medical assistance.”

Eligible – An individual qualified to receive services through the Contractor, consistent with any applicable eligibility requirements of LDH and Medicaid.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish these services under 42 CFR §438.114(a) and§1932(b)(2) of the Social Security Act and that are needed to screen, evaluate, and stabilize an emergency medical condition.

Emergent – Serious or extreme risk of harm, such as current suicidal ideation with expressed intentions; recent use of substances resulting in decreased inhibition of harmful behaviors; repeated episodes of violence toward self and others; or extreme compromise of ability to care for oneself leading to physical injury.

Encounter Data – Records or data of medically related services rendered by a provider to a Contractor member on a specified date of service. This data is inclusive of all services for which there is any financial liability to a provider (Medicaid).

Enrollee – A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program.

Enrollment – The process conducted by LDH to enroll a Medicaid or CHIP eligible into the Louisiana Medicaid Program.

Evidence-Based Practice – Clinical interventions that have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired goals of health and wellness.

Experimental Treatment/Service – A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific data may be limited or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

External Quality Review (EQR) – An analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to health care services that the Contractor, or their Subcontractors, furnish to Medicaid beneficiaries.

External Quality Review Organization (EQRO) — An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs EQR or other related activities for states with Medicaid managed care programs.

Family – For the purpose of the CSoC, family is defined as the primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of the psycho-education service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual. Services may be provided individually or in a group setting.

Family Support Organization (FSO) – The role of the Family Support Organization (FSO) in the CSoC is to provide support, education and advocacy for children/youth with significant emotional and behavioral health challenges and their families. The FSO provides intensive face-to-face support to families and caregivers at the time and place that is most convenient for the family. The FSO employs Parent Support and Training and Youth Supporting and Training staff.

Federal Financial Participation (FFP) – Also known as Federal match or the percentage of Federal matching dollars available to a state to provide Medicaid and CHIP services. The Federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher Federal matching rate to states with lower per capita income.

Federal Poverty Level (FPL) – Poverty guidelines issued annually, typically in late January or early February, by DHHS for the purpose of determining financial eligibility for certain programs, including Medicaid and CHIP. The guidelines are based on household size, and are updated from the Census Bureau's latest published weighted average poverty thresholds.

Federally Qualified Health Center (FQHC) – An entity that receives a grant under Section 330 of the Public Health Service Act, as amended (Also see Section 1905(1)(2)(B) of the Social Security Act) to provide primary healthcare and related diagnostic services to individuals on a sliding fee schedule. The FQHC may also provide dental, optometric, podiatry, chiropractic, and behavioral health services.

Fee-for-Service (FFS) – A method of provider reimbursement based on payments for specific services rendered to an enrollee.

FFS Provider – An institution, facility, agency, person, corporation, partnership, or association approved by LDH that accepts payment in full for providing care to a Medicaid or CHIP eligible person. The amounts paid are specified in the State's approved Medicaid reimbursement provisions, regulations, and schedules.

Fiscal Intermediary for Medicaid (FI) – LDH's designee or agent currently responsible for an array of support services, including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization (PA) and utilization management (UM), fraud and abuse systems, and decision support.

Fiscal Year (FY) – Refers to budget year. The Federal fiscal year (FFY) is October 1 through September 30, and the state fiscal year (SFY) is July 1 through June 30.

Fraud – As it relates to the Medicaid program, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility, providing false information concerning costs or conditions to obtain reimbursement or certification, or claiming payment for services, which were never delivered or received.

Freedom of Choice (FOC) – The right afforded an individual who is determined to be likely to require a level of care specified in a waiver to choose either institutional or home and community-based services, as provided in §1915(c)(2)(C) of the Act and in 42 CFR §441.302(d). Specific processes associated with obtaining the FOC are delineated in the SOP.

Full-Time Equivalent (FTE) Position – Refers to the equivalent of one individual full-time employee who works forty (40) hours per week. The definition can also include a full-time PCP who delivers outpatient preventive and primary (routine, urgent, and acute) care for thirty-two (32) hours or more per week (exclusive of travel time), during a minimum of four days per week.

GEO Mapping – The process of finding associated geographic coordinates (often expressed as latitude and longitude) from other geographic data, such as street addresses or ZIP codes. With geographic coordinates, the features can be mapped and entered into Geographic Information Systems or embedded into media.

Grievance - An expression of member dissatisfaction about any matter other than an adverse benefit determination and includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decisions. Examples of grievances include dissatisfaction with quality of care, dissatisfaction with quality of service provided, aspects of interpersonal relationships such as rudeness of a provider or a network employee or failure to respect a member's rights regardless whether a remedial action is requested and dissatisfaction with network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Grievance and Appeal System – Processes implemented to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them in accordance with this Contract and 42 CFR §438.400(b).

Healthcare Professional – A physician or other healthcare practitioner licensed, accredited, or certified to perform specified health services consistent with state law.

Healthcare Provider – A healthcare professional or entity that provides healthcare services or goods.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR Parts 160 and 164) – Federal regulations imposing standards for the privacy of individually identifiable health information.

Health Insurance Portability and Accountability Act (HIPAA) Security Rule (45 CFR Parts 160 and 164) – Federal regulations requiring covered entities to maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their electronic protected health information against any reasonably anticipated risks.

Home and Community-Based Services Waiver (HCBS) – Under Section 1915 (c) of the Social Security Act (SSA), a state may apply for a "waiver" from CMS to provide care and

services in addition to those offered under the State plan. CMS will "waive" certain requirements of Title XIX if it finds that the State's proposal is cost-effective and efficient and not inconsistent with the purposes of Title XIX. States can offer a variety of services under these types of waivers, including standard medical services and non-medical services. Standard medical services include but are not limited to case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health, habilitation (both day and residential), and respite care. States can also propose other types of services that may assist in diverting or transitioning individuals from institutional settings into their homes and community. Additionally, states may request a waiver of state wideness, comparability of services, and income and resource eligibility rules for the medically needy.

ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) – Codes currently used to identify diagnoses and inpatient procedures.

Incurred But Not Reported (IBNR) – Services rendered for which a claim/ encounter has not been received by the Contractor.

Independent Behavioral Health Assessment (IBHA) – is based on a thorough, face-to- face assessment of the individual's most recent behavioral/mental status, any relevant history, including findings from the CANS comprehensive, treatment records, objective evaluation of functional ability, and any other available records. The IBHA is completed by a Licensed Mental Health Professional (LMHP) who is also certified as a CANS assessor.

Information Systems (IS) – A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange, or transmission of information, i.e., structured data (which may include digitized audio and video) and documents; or (b) the processing of such information for the purposes of enabling or facilitating a business process or related transaction.

Insolvency – A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets, or as determined by the Louisiana Department of Insurance, pursuant to Title 22 of the Louisiana Revised Statutes.

Integrated Medicaid Managed Care Program (IMMC) – Louisiana's Managed Care Organization (MCO) model of Medicaid managed care for members who are mandated to enroll for physical or behavioral health, formerly known as Bayou Health and currently referred to as Healthy Louisiana.

Local Governing Entity (LGE) – A system of independent healthcare districts and authorities with local accountability and management of behavioral health, intellectual disability and developmental disability services. Also known as LDH regions in this Contract. LGE Regions

LMHP – A Licensed Mental Health Professional (LMHP) is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance disorder acting within the scope of all applicable state laws and their professional license. An LMHP includes individuals licensed to practice independently:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric and Mental Health, and Family Psychiatric and Mental Health, or Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice).

Louisiana Children's Health Insurance Program (LaCHIP) – Louisiana's name for the Children's Health Insurance Plan created by Title XXI of the Social Security Act in 1997. Provides healthcare coverage for uninsured children up to age 19 through a Medicaid expansion program up to and including 217% Federal Poverty Level (FPL) and a separate

state CHIP program for the unborn prenatal option for uninsured pregnant women up to and including 214% FPL and for children with income from 218% up to and including 255% FPL.

Louisiana Medicaid State Plan – The binding written agreement between LDH and CMS that describes how the Medicaid program is administered and determines the covered services for which LDH will receive Federal financial participation (FFP). Also referred to as the Medicaid State Plan.

Managed Care Organization (MCO) – A private entity contracted with LDH to provide core benefits and services to Enrollees in exchange for a monthly prepaid capitated amount per Enrollee.

Managed Care Program – A managed care delivery system operated by a State as authorized under Sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.

Material Change – Changes affecting the delivery of care or services provided under this Contract. Material changes include, but are not limited to, changes in composition of the provider network; healthcare delivery systems, services, or expanded services; benefits; enrollment of a new population; procedures for obtaining access to or approval for healthcare services; any and all policies and procedures that require LDH approval prior to implementation; and the Contractor's capacity to meet minimum enrollment levels. LDH shall make the final determination as to whether a change is material.

May – Denotes a preference, but not a mandatory requirement.

Medicaid – A means tested Federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers Federal matching funds to states for costs incurred in paying healthcare providers for serving eligible individuals.

Medicaid/CHIP Eligible – Refers to an individual determined eligible, pursuant to Federal and state law, to receive medical care, goods and services for which LDH may make payments under the Medicaid or CHIP programs.

Medicaid/CHIP Recipient – An individual who has been determined eligible for the Medicaid or CHIP program that may or may not be currently enrolled in the Program**,** and on whose behalf payment is made.

Medicaid Eligibility Determination – The process by which an individual may be determined eligible for Medicaid or Medicaid-expansion CHIP program.

Medicaid Eligibility Office – LDH offices located within select parishes of the State that are responsible for making initial and ongoing Medicaid financial eligibility determinations.

Medicaid Enrollee – Refers to an individual determined eligible, pursuant to Federal and state law, to receive medical care, goods or services for which LDH may make payments under the Medicaid program, who is enrolled in the Medicaid program, and on whose behalf payments may or may not have been made.

Medicaid Managed Care Plan – Denotes either a managed care organization, prepaid inpatient health plan (PIHP) as defined in this Glossary, prepaid ambulatory health plan, or primary care case management.

Medicaid Management Information System (MMIS) – Mechanized claims processing and information retrieval system, which all state Medicaid programs are required to have and must be approved by the Secretary of DHHS. This system pays claims for Medicaid services and includes information on all Medicaid providers and enrollees.

Medicaid State Plan – The binding written agreement between LDH and CMS that describes how the Medicaid program is administered and determines the covered services for which LDH will receive FFP. Also, Louisiana Medicaid State Plan.

Medically Necessary Services – Healthcare services that are in accordance with generally accepted evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) Deemed reasonably necessary to diagnose, correct, cure, alleviate, or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity, or malfunction. 2) Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or

injury under treatment and neither more nor less than what the recipient requires at that specific point in time.

Member – Children/youth enrolled by the Contractor in the CSoC.

Member Bill of Rights – 42 CFR §438.100.

Mercer (Mercer Government Human Services Consulting) – The consulting firm with which the State has contracted to provide expertise in specific aspects of healthcare management such as actuarial rate development and analysis, encounter reporting and analysis, healthcare reform and risk adjustment.

Monetary Penalties – Monetary sanctions that may be assessed whenever the Contractor, its providers, or its subcontractors fail to achieve certain performance measures and other requirements defined in the terms and conditions of the network provider agreement.

Must – Denotes a mandatory requirement.

Near Real Time – Denoting or relating to information systems that incur a slight delay between automated data processing and transmission, which shall be within minutes for the purposes of this Contract.

Network –A group of participating providers linked through contractual arrangements to the Contractor to supply a range of behavioral healthcare services. The term “provider network” may also be used.

Network Adequacy – Refers to the network of behavioral healthcare providers for the Contractor (whether in- or out-of-network) that is sufficient in numbers and types of providers/facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, provider/patient ratios, geographic accessibility, waiting times for appointments, and hours of provider operations.

Network Provider – An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and Subcontractors, that has a contract with the Contractor for the delivery of covered services to Members.

Notice to Cure – Notice issued by LDH to inform the Contractor of a deficiency or non-compliance with the Contract requirements. The Notice to Cure specifies a period of time for the Contractor to bring its performance back into compliance with the Contract. If the Contractor’s compliance is not corrected within the Notice to Cure time period, the Contractor may face further remediation.

OBH – Office of Behavioral Health, Louisiana Department of Health.

Original – Denotes must be signed in ink.

Out-of-Home Placements – Arrangements for children and youth that have significant behavioral health challenges or Co-occurring Disorders (COD) that are in, or at imminent risk of, placement in any of the following settings including, but not limited to: 1) detention, 2) secure care facilities, 3) psychiatric hospitals, 4) residential treatment facilities, 5) developmental disabilities facilities, 6) addiction facilities, 7) alternative schools, 8) homeless, as identified by Louisiana Department of Education (LDOE), and 9) foster care.

Overpayment – Any payment made by the Contractor to a network provider that exceeds the amount that is allowable under 42 USC 1396a.

Ownership Interest – The possession of stock, equity in the capital, or any interest in the profits of the Contractor.

Parent Support and Training (PST) – Designed to benefit children/youth experiencing a serious emotional disturbance (SED) that are enrolled in the CSoC and are in or at risk of out-of-home placement. This service provides the training and support necessary to ensure engagement and active participation of the family in the child and family team planning process and with the ongoing implementation and reinforcement of skills learned throughout this process. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth.

Per Member Per Month (PMPM) Rate – The PMPM rate paid to the Contractor for the provision of services to Members. PMPM refers to the amount of money paid or received on a monthly basis for each enrolled individual.

Performance Improvement Projects (PIPs) – Projects to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement, and which is sustained over time, with favorable effect on health outcomes and member satisfaction.

Performance Measure – Statement identifying an activity, input, output, outcome, achievement, ratio, efficiency, or quality to be measured relative to a particular goal or objective in order to assess performance.

Plan of Care (POC) – The Plan of Care identifies individualized strategies designed to guide the development of an individual-specific plan to address the behavioral health and natural support needs of the member. The POC is intended to ensure optimal outcomes for individuals during the course of their care. Waiver services, as well as other services and supports that a person needs in order to live successfully in the community and, therefore, avoid institutionalization are identified on the POC. It must reflect the full range of a participant's service needs and include both the Medicaid services, along with informal supports that are necessary to address those needs. When non-waiver services and supports are needed to meet the needs of the participant, their provision must be monitored. The POC must contain, at a minimum, the services that are furnished, the amount and frequency of each service, and the type of provider to furnish each service. The POC must be revised, as necessary, to add or delete services or modify the amount and frequency of services. The POC must be reviewed at least every 180 days, or whenever necessary, due to a change in the participant's needs.

Policies – The general principles which guide decisions and outcomes; high-level overall plans embracing general goals and acceptable procedure. As used herein in reference to LDH, policies are the general principles by which LDH is guided in its management of the Medicaid program.

Post-payment Recovery – In the event that health insurance is not on file at the time of the claim submission, a recovery from other health insurance is made after the Plan has paid on a claim.

Post-stabilization Services – Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition.

Prepaid Ambulatory Health Plan (PAHP) – Any entity contracting with the State that meets the requirements for a PAHP contained in 42 CFR §438.2 and that 1) provides services to enrollees under contract with the state agency, and on the basis of capitation payments, or other payment arrangements that do not use Medicaid State Plan payment rates; 2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and 3) does not have a comprehensive risk contract.

Prepaid Inpatient Health Plan (PIHP) – An entity contracting with the State that meets the requirements for a PIHP contained in 42 CFR §438.2 and that: 1) provides services to enrollees under contract with the state agency, on the basis of capitation payments, or other payment arrangements that do not use Medicaid State Plan payment rates; 2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and 3) does not have a comprehensive risk contract.

Presumptive Eligibility – A child/youth who meets the clinical criteria for CSoC, according to the Brief CANS and is subsequently formally referred for CSoC, enters into a period of Presumptive Eligibility for a maximum of thirty (30) calendar days. During this time the child/youth is presumed to be eligible for CSoC and is eligible to receive the specialized waiver services.

Prior Authorization (PA) – The process of determining medical necessity for specific services before they are rendered.

Prospective Payment System (PPS) – A method of payment in which the Medicaid payment is made based on a predetermined, fixed amount.

Prospective Review – Utilization review conducted prior to an admission or a course of treatment.

Protected Health Information (PHI) – Individually-identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are

defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR Parts 160 and 164.

Provider – Either (1) for the Fee-For-Service (FFS) Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency or (2) for the Medicaid managed care plan, any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the state in which it delivers services.

Provider Complaint – Any verbal or written expression, originating from a provider and delivered to any employee of the Contractor, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the Contractor.

Provider Preventable Condition – Preventable healthcare-acquired or other provider-preventable conditions and events, also known as never events, identified by LDH for nonpayment, including but not limited to, bed pressure ulcers or decubitus ulcers; or events such as surgical or invasive procedures performed on the wrong body part or wrong patient in accordance with 42 CFR §447.26.

Qualified Service Provider – Any individual or entity that is engaged in the delivery of behavioral healthcare services that meets the credentialing standards of the Contractor and all state licensing and regulatory requirements. It also applies to the delivery of Medicaid services, if certified by the Medicaid agency to participate in the Medicaid program.

Quality – As it pertains to external quality review, the degree to which the Contractor increases the likelihood of desired health outcomes of its members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assessment and Performance Improvement Program (QAPI Program) – Program that objectively and systematically defines, monitors and evaluates the quality and appropriateness of care and services and promotes improved patient outcomes through performance improvement projects, treatment record audits, performance measures, surveys, and related activities.

Quality Assurance Committee (QAC) – Promote, coordinate, and facilitate the active exchange of successful programs, practices, procedures, lessons learned, and other pertinent information of common interest to QA based on a quarterly review of the Quality Improvement (QI) strategy, including discovery activities and system improvement activities.

Quality Improvement Project (QIP) – A project that must be completed by the Contractor whenever a performance measure falls below the required threshold to determine the cause of non-compliance, interventions to address the cause of non-compliance, including timelines, and a plan for measuring the impact to determine whether the intervention was effective. If the intervention was not effective, other interventions must be explored.

Quality Improvement Strategy – A document developed by the Office of Behavioral Health, in accordance with 42 CFR Part 438, subpart D, intended to serve as a blueprint or roadmap for assessing the quality of care members receive, as well as set forth measureable goals for improvement.

Quality Management (QM) – The ongoing process of ensuring that the delivery of covered services is appropriate, timely, accessible, available, medically necessary, in keeping with established guidelines and standards, and reflective of the current state of medical and behavioral health knowledge.

Recipient – An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.

Related Party – A party that has, or may have, the ability to control or significantly influence the Contractor; or a party that is, or may be, controlled or significantly influenced by the Contractor. Related parties include, but are not limited to, agents, management employees, persons with an ownership or controlling interest in the entity, and their immediate families, contractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Relationship – For the purposes of any business affiliations discussed in this document, a director, officer, or partner of the Contractor; a person with beneficial ownership of 5% or more of the Contractor's equity; or a person with an employment, consulting or other arrangement (e.g., providers) with the Contractor obligations under this Contract.

Representative – Any person who has been delegated the authority to obligate or act on behalf of another.

Routine – With regard to urgency of need for services, minimal to low risk of harm, such as absence of current suicidal ideation; substance use without significant episodes of potentially harmful behavior.

Rural Area – Any area outside an urban area.

Rural Health Clinic (RHC) – A clinic located in an area with a healthcare provider shortage that provides primary healthcare and related diagnostic services. It may also provide optometric, podiatric, chiropractic, and behavioral health services. A RHC must be reimbursed on a prospective payment basis.

Second Opinion – Subsequent to an initial medical opinion, an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally recommending a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

Section 1915(b)(3) – This section of the Social Security Act allows the State to share cost savings resulting from the use of more cost-effective medical care with members by providing them with additional services. The savings must be expended for the benefit of the Medicaid member enrolled in the waiver.

Secure File Transfer Protocol (SFTP) – Software protocol for transferring data files from one computer to another with added encryption.

Shall – Denotes a mandatory requirement.

Should – Denotes a preference, but not a mandatory requirement.

Significant – Important in effect or meaning.

Single Point of Entry – A site where individuals may obtain information about all specialized behavioral health services they might qualify for, as was as referrals to services as needed.

Social Security Act – The Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended, which encompasses the Medicaid program (Title XIX) and CHIP Program (Title XXI).

Solvency – The minimum standard of financial health for a Contractor, in which assets exceed liabilities, and timely payment requirements can be met.

Span of Control – Information systems and telecommunications capabilities that the Contractor itself operates, or for which it is otherwise legally responsible, according to the terms and conditions of the agreement with LDH. The span of control also includes systems and telecommunications capabilities outsourced by the Contractor.

Special Needs – An individual of any age with a mental disability, physical disability, or other circumstances that place his/her health and ability to fully function in society at risk, requiring individualized healthcare requirements.

Specialized Behavioral Health Services – Mental health services and substance use disorder services that include, but are not limited to, services specifically defined by Louisiana Medicaid and provided by a Psychiatrist or Licensed Mental Health Professional (LMHP) as defined in the glossary.

Standard Operating Procedure Manual (SOP) – A manual established to provide guidance for conducting the day to day activities that are necessary in developing, implementing and sustaining the Coordinated System of Care in Louisiana. Guidance is provided to the areas of CSoC eligibility, referrals, screening/assessment, enrollment, services, quality assurance and training requirements.

State – The State of Louisiana.

State Fair Hearing – LDH and the Contractor shall comply with the applicable requirements of 42 CFR §431.200(b), §431.220(4), §438.414 and §438.10(g)(1).

State General Fund (SGF) – Refers to funding appropriated by the State of Louisiana from non–Federal sources.

Stratification – The process of partitioning data into distinct or non-overlapping groups.

Subcontractor – An individual or entity that has a contract with the Contractor.

System Availability – Measured within the Contractor's information system span of control. A system is considered not available when a system user does not obtain the complete, correct full-screen response to an input command within three minutes after depressing the "Enter" or other function key.

Third Party Liability (TPL) – Refers to the legal obligation of third parties (i.e., certain individuals, entities, or programs) to pay all or part of the expenditures for medical assistance furnished under the Medicaid State Plan.

Timely – Existing or taking place within a designated period; or within the time required by statue or rules and regulations, Contract terms, or policy requirements.

Title XIX – Section of the Social Security Act of 1935 that encompasses and governs the Medicaid program.

Title XXI – Section of the Social Security Act of 1935 that encompasses and governs the CHIP.

Treatment Record – A single complete record kept at the site of the member's service provider or care management entity, which documents all treatment plans developed, including, but not limited to, outpatient and emergency medical healthcare services, provided by the Contractor, Subcontractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR §456.111 and 42 CFR §456.211. Treatment record and medical record have the same meaning in this document.

Tribal 638 Clinic – Those facilities owned and operated by American Indian and Alaska Native tribes and tribal organizations with funding authorized by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended).

TTY/TDD – Telephone Typewriter and Telecommunication Device for the Deaf, which allows for interpreter capability for deaf callers.

United States – The term "United States" includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Urban Area – A Metropolitan Statistical Area (MSA), as defined by the Executive Office of Management and Budget and applied to Census Bureau data. The most recent delineation files and maps are located at https://www.census.gov.

Urgent – Moderate risk of harm, such as suicidal ideation without intent; or binge use of substances, resulting in potentially harmful behaviors without current evidence of such behavior.

Utilization Management (UM) – Refers to the process of evaluation of medical necessity, appropriateness, and efficiency of healthcare services, procedures, and facilities. UM is inclusive of utilization review and service authorization.

Validation – The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias, and in accordance with standards for data collection and analysis.

Warm Transfer – A type of referral that involves phone contact between the person/agency making the referral and the person/agency receiving the referral to ensure effective sharing of information and continuity of care.

Waste (as in Fraud, Waste and Abuse) – Over utilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Weekly Enrollment Report – A reporting tool used to collect and report current week and cumulative enrollment information for CSoC. This tool is used to provide the management organization and LDH with information on the newest and total referrals and enrollees, per CSoC region. This report includes those referred to wraparound and to FSO services, and referral sources. The Contractor completes and updates this tool weekly, and provides it to LDH.

Will – Denotes a mandatory requirement.

Wraparound Agency (WAA) – WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination and management for children within the CSoC needing such supports. The WAA employs Wraparound Facilitators (WF), clinical directors, supervisors/coaches who are trained in the wraparound model, in accordance to the standards of practice established by the National Wraparound Initiative (NWI) and deliver wraparound facilitation to the children, youth and families enrolled in CSoC. With the goal of "one family, one plan of care, and one WF."

Wraparound Data Spreadsheet – A reporting tool used to collect and report child specific information. This tool is used to provide the management organization and LDH with information on the population of children served in wraparound, wraparound process measures, and the impact of wraparound. Data domains include, but are not limited to, demographics, enrollment, plan of care, timely access to services, utilization of services and supports, and education. The Wraparound Agency completes/updates this tool on each enrollee monthly and submits it to the management organization.

Wraparound Model – Wraparound is a philosophy of care with defined planning process used to build constructive relationships and support networks among youth with complex behavioral health needs and their families. It is guided by System of Care values including community based, culturally relevant, individualized, strength-based, and family-centered. The wraparound model is consistent with the wraparound standards and principles outlined by the National Wraparound Initiative.

Wraparound Scorecard – A quarterly report, issued to reflect calendar quarters, that provides regional and system aggregate achievement on identified metrics, which may be derived using claims data. The report is compiled approximately 60 days after the reporting period to accommodate claims lag. The metrics are subject to change, per LDH authority and approval. Current reporting categories include: POC Compliance Rate; # of Admits to Inpatient Psych Hospital per 1000; Inpatient Psych Hospital ALOS; Inpatient Psych Hospital readmit Rate; % of Members with Improved Clinical Functioning on CANS; % of Members with Improved School Functioning on CANS; % of Members with at Least 1 Natural/Informal Support on CFT; % of Members Whose Living Situation at Discharge is HCB; % of Members with Timely Initial Contact (48 hours); % of Members with Timely Face to Face Contact (7 days).

Youth Support and Training (YST) – Child-/youth-centered services that provide the training and support necessary to ensure engagement and active participation of the youth in the child and family team planning process and with the ongoing implementation and reinforcement of skills learned throughout the process. Services shall have a recovery focus that is designed to promote the skills necessary for both coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills.

GLOSSARY OF ACRONYMS

ACD	Automated Call Distribution
ADHD	Attention Deficit Hyperactivity Disorder
APRN	Advanced Practice Registered Nurse
ASAM	American Society of Addiction Medicine
BH	Behavioral Health
BHSF	Bureau of Health Services Financing, Louisiana Department of Health
CANS	Child and Adolescent Needs and Strengths assessment tool
CAP	Corrective Action Plan
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHIP	Children's Health Insurance Program
CFR	Code of Federal Regulations
CFT	Child and Family Team
CM	Care Manager or Care Management
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COD	Co-occurring Disorders
CPST	Community Psychiatric Support and Treatment
CPT	Current Procedural Terminology
CSoC	Coordinated System of Care
DCFS	Department of Children and Family Services
DD	Developmentally Disabled
DHHS	Department of Health and Human Services
DO	Doctor of Osteopathic Medicine
DOA/OSP	Division of Administration, Office of State Procurement
DSM	Diagnostic Statistical Manual of Mental Disorders
EBP	Evidence-Based Practices
ECM	Electronic Claims Management
ED	Emergency Department
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
FEMA	Federal Emergency Management Agency
FFP	Federal Financial Participation
FFS	Fee-for-Service
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standard
FOC	Freedom of Choice
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSO	Family Support Organization
FTE	Full-Time Equivalent
GAAP	Generally Accepted Accounting Principles
GEO	Geographic location or area

GOHSEP	Governor's Office of Homeland Security and Emergency Preparedness
HCBS	Home and Community-Based Services Waiver
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
IBHA	Independent Behavioral Health Assessment
ICF/DD	Intermediate Care Facilities for Individuals with Developmental Disabilities
I/DD	Intellectual and Developmental Disabilities
ILSB	Independent Living Skills Building
IMD	Institution for Mental Diseases
IMMCP	Integrated Medicaid Managed Care Program
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
LAC	Licensed Addiction Counselors
LaCHIP	Louisiana Children's Health Insurance Program
LCSW	Licensed Clinical Social Worker
LDH	Louisiana Department of Health
LDOE	Louisiana Department of Education
LMFT	Licensed Marriage and Family Therapist
LMHP	Licensed Mental Health Professional
LOC	Level of Care
LPC	Licensed Professional Counselor
MCO	Managed Care Organization
MD	Doctor of Medicine
MFCU	Medicaid Fraud Control Units
MHSD	Metropolitan Human Services District
MIS	Management Information System
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
NDC	National Drug Code
NCQA	National Committee for Quality Assurance
NWI	National Wraparound Initiative
OBH	Office of Behavioral Health, Louisiana Department of Health
OCDD	Office for Citizens with Developmental Disabilities, Louisiana Department of Health
OJJ	Office of Juvenile Justice
OMB	Office of Management and Budget
OMF	Office of Management and Finance
OOH	Out-of-Home
PA	Prior Authorization
PAHP	Prepaid Ambulatory Health Plan
PCP	Primary Care Provider
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMPM	Per Member Per Month
POC	Plan of Care
PPS	Prospective Payment System
PRTF	Psychiatric Residential Treatment Facility
PST	Parent Support and Training

QA	Quality Assurance
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIP	Quality Improvement Project
QM	Quality Management
QOC	Quality of Care
RHC	Rural Health Clinic
SAMHSA	Substance Abuse and Mental Health Services Administration
SCA	Single Case Agreement
SED	Serious Emotional Disturbance
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
SMM	State Medicaid Manual
SOC	Service Organization Control
SOP	Standard Operating Procedure Manual
SPA	State Plan Amendment
SQL	Structured Query Language
SUD	Substance Use Disorder
SURS	Surveillance and Utilization Review Subsystem
TDD	Telecommunication Device for the Deaf
TFC	Therapeutic Foster Care
TGH	Therapeutic Group Home
TPL	Third Party Liability
TRR	Treatment Record Review
UM	Utilization Management
USC	United States Code
VPN	Virtual Private Network
WAA	Wraparound Agency
WF	Wraparound Facilitator
YST	Youth Support and Training

Magellan Complete Care of Louisiana – Fee Schedule

Contract Term: 11 Months
Unduplicated Monthly Recipients: 2,900
Per Member Per Month (PMPM) Rate: $2,364.36
Total Contract Value: $75,423,084.00

Service Description

This fee schedule supports the administration and delivery of services under the Coordinated System of Care (CSoC) for Medicaid-eligible youth with significant behavioral health needs. The model promotes care coordination, crisis intervention, and community-based treatment services as part of Louisiana's effort to reduce institutionalization and improve outcomes for youth and families.

Justification of Fees

The $2,364.36 PMPM rate is supported by the actuarially certified capitation rates included in **Attachment 2a – Louisiana Coordinated System of Care Managed Care Rate Certification**, dated February 17, 2025. This certification outlines the methodology and assumptions used in developing these rates, including:

- Historical service utilization patterns
- Projected enrollment trends
- Medical and administrative cost estimates
- Risk-adjustment and actuarial soundness standards in accordance with CMS requirements

These documented factors justify the per-member rate and align with anticipated costs for delivering required services to the target population.

Payment Terms

- **Method:** Monthly capitation payment
- **Basis:** Number of enrolled, unduplicated recipients per month
- **Payment Frequency:** Monthly
- **Payment Due:** LDH will pay Contractor by the second Tuesday of each month retrospectively
- **Accepted Payment Method:** Electronic Funds Transfer (EFT)

MILLIMAN CLIENT REPORT

Calendar Year 2025 Louisiana Medicaid Coordinated System of Care Managed Care Capitation Rate Certification

State of Louisiana Department of Health

February 17, 2025

Anders Larson, FSA, MAAA, Principal and Consulting Actuary
Zach Fohl, FSA, MAAA, Senior Consulting Actuary
Amine Elmeghni, FSA, MAAA, MSc, Consulting Actuary

Milliman


Milliman

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Introduction & Executive Summary

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Louisiana, Department of Health (LDH) to provide actuarial and consulting services related to the development of capitation rates for the Medicaid Coordinated System of Care (CSoC) managed care program. This report documents the development of the actuarially sound capitation rates for the calendar year (CY) 2025 rating period. It also includes the required actuarial certification in Appendix 1.

To facilitate review, this document has been organized in the same manner as the 2024-2025 Medicaid Managed Care Rate Development Guide, finalized by the Centers for Medicare and Medicaid Services in January 2024 (CMS guide). Section II of the CMS guide is not applicable to the CSoC managed care program in Louisiana because long-term care supports and services (LTSS) are not covered. Section III of the CMS Guide is not applicable to the CSoC managed care program in Louisiana because Medicaid Expansion populations are not covered by this program.

CONTRACTED MANAGED CARE ENTITIES AND PAYMENT METHODOLOGY

Magellan is the only managed care entity to participate in the CSoC managed care program during CY 2025. Magellan participates on a statewide basis and will receive a single capitation payment for children enrolled in the CSoC managed care program.

FISCAL IMPACT ESTIMATE

The certified capitation rate and total expected payments for the CSoC managed care program are illustrated in Figure 1. The capitation rate is the risk-based rate that will be paid on a monthly basis. The total expected payments also include the estimated value of separate payment terms, including state directed payments. The rates are effective from January 1, 2025 through December 31, 2025 (CY 2025). The amended rates for the CY 2024 time period are consistent with the rate documented in the Louisiana Coordinated System of Care Rate Certification Amendment effective January 1, 2024 through December 31, 2024, dated December 26, 2024. Separate total values are shown for capitation rates and total expected payments, but the state and federal expenditures are only shown for total expected payments.

FIGURE 1: COMPARISON WITH AMENDED CY 2024 PMPM RATE AND TOTAL EXPECTED PAYMENTS

FINANCIAL METRIC	Amended CY 2024	CY 2025	CHANGE
Capitation Rate PMPM	$ 2,241.75	$ 2,364.36	5.5%
Expected Payment PMPM	$ 2,363.00	$ 2,370.58	0.3%
Total Expected Payments ($ Millions)	$ 69.2	$ 69.4	$ 0.2
Federal Total Expected Payments ($ Millions)	$ 47.0	$ 47.2	$ 0.2
State Total Expected Payments ($ Millions)	$ 22.2	$ 22.2	$ 0.0

Notes: 1. Amended CY 2024 and CY 2025 composite rates were developed based on CY 2025 projected monthly enrollment of approximately 2,400.
2. State expenditures based on Federal Fiscal Year (FFY) 2025 FMAP of 68.06% for 9 months and FFY 2026 FMAP of 67.83% for 3 months.

Section I. Medicaid Managed Care Rates

1. General Information

This section provides information listed under the General Information section of CMS guide, Section I.

The capitation rates provided under this certification are "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for all Practice Areas)); ASOP 23 (Data Quality); ASOP 41 (Actuarial Communications); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F and CMS-2408-F) for the provisions effective for the CY 2025 managed care program rating period.
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.

Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

- *"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."*[1]

Since there is only one health plan participating in the CSoC managed care program during CY 2025, the capitation rates developed should be appropriate based on benefits that it will be obligated to provide. The CSoC health plan should evaluate the rate in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State.

A. RATE DEVELOPMENT STANDARDS

i. All standards and documentation expectations for rate ranges

Unless otherwise stated, all standards and documentation outlined in the CMS guide apply to the development of the rates in this certification. This certification does not include rate ranges.

[1] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

ii. 12-month rating period

The actuarial certification contained in this report is effective for the capitation rates for the one-year rating period from January 1, 2025, through December 31, 2025.

iii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Anders Larson, FSA, is in Appendix 1. Mr. Larson meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, and certifies that the rates meet the applicable standards in 42 CFR 438 that are effective for the CY 2025 managed care program rating period.

(b) Certified capitation rates for each rate cell

The certified rate is contained in Appendix 7. The capitation rate is the same for all CSoC members. This rate represents the contracted capitation rate that will be paid to the managed care entity participating in the CSoC managed care program.

(c) Program information

(i) Managed care program

This certification was developed for the CSoC managed care program operated by the State of Louisiana.

LDH has operated a managed care CSoC managed care program for Medicaid at-risk youth since March 1, 2012. LDH contracts with Magellan in the CSoC managed care program on a statewide basis. Magellan receives a capitation payment for each child enrolled in the CSoC managed care program. The CSoC managed care program helps children and youth from ages 5 through 20 who have serious mental health and substance use challenges and are in or at risk of out-of-home placement.

(ii) Rating period

This actuarial certification is effective for the one-year rating period of January 1, 2025, through December 31, 2025.

(iii) Covered populations

The CSoC managed care program provides coverage for children and youth from ages 5 through 20 who have serious mental health and substance use challenges and are in or at risk of out-of-home placement.

(iv) Eligibility criteria

Eligibility criteria for the covered populations are described above. Additional detail regarding the eligibility criteria for the CSoC managed care program can be found in Appendix 2.

(v) Special contract provisions

This rate certification report contains documentation of the following special contract provisions related to payment included within rate development.

- Minimum medical loss ratio requirement
- Directed payments made as a separate payment term
- Incentive program

Please see Section I, subsection 4 for additional detail and documentation.

(vi) Retroactive adjustment to capitation rates

This rate certification report is for prospective CY 2025 capitation rates.

iv. Differences among capitation rates

The CSoC managed care program only has one rate cell.

v. Cross-subsidization of rate cell payment

The CSoC managed care program only has one rate cell.

vi. Effective dates

To the best of our knowledge, the effective dates of changes to the CSoC managed care program are consistent with the assumptions used in the development of the certified CY 2025 contracted capitation rate.

vii. Minimum medical loss ratio

The capitation rate was developed such that the managed care entity is reasonably expected to achieve a medical loss ratio (MLR), as calculated under 42 CFR 438.8, greater than 85 percent for the rate year. The capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

The CSoC contract has remittance provisions with a minimum MLR of 85 percent. The terms and conditions are outlined in Section I, subsection 4.C.ii.(b).

viii. Conditions for actuarially sound rate ranges

This certification does not include rate ranges.

ix. Documentation for actuarially sound rate ranges

This certification does not include rate ranges.

x. Generally accepted actuarial practices and principles

(a) Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rate, or to any portion of the capitation rate, reflect reasonable, appropriate, and attainable costs. To our knowledge, there are no reasonable, appropriate, and attainable costs that have not been included in the certification.

(b) Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process.

(c) Final contracted rates

The CY 2025 capitation rates certified in this report represent the final contracted rate.

xi. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period of January 1, 2025, through December 31, 2025.

xii. COVID-19 public health emergency

Please see Section 1, subsection 1.B.x for details on rate adjustments related to the COVID-19 public health emergency (PHE).

xiii. Procedures for rate certification and amendment

In general, a new rate certification will be submitted when the capitation rates change. The following exceptions are allowed per §438.7 of CMS 2390-F:

1. A contract amendment that does not affect the rates.
2. A de minimis increase or decrease of up to 1.5% in the capitation rate per rate cell.

In cases 1 and 2, a contract amendment must still be submitted to CMS. In the event program provisions are invalidated by courts of law or by changes in statutes, regulations, or approvals, an amendment will be submitted.

B. APPROPRIATE DOCUMENTATION

i. Actuarial certification

The actuary is certifying capitation rates for the managed care entity. This certification does not include rate ranges.

ii. Documentation of required elements

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

iii. Ranges of assumptions

The specific assumptions underlying the capitation rates have been disclosed in this certification. We have not developed ranges around assumptions used in the capitation rate development.

iv. Requirements for a certified capitation rate range

This certification does not include rate ranges.

v. Index

The index to this rate certification is the table of contents, found immediately after the title page. The index includes section numbers and related page numbers. Sections not relevant to this certification continue to be provided, with an explanation of why they are not applicable.

vi. Consistency with rate of FFP

The capitation rate was developed in a manner consistent with 42 CFR 438.4(b)(1), including that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and that these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs.

vii. Different FMAP

All capitated payments made receive the regular state FMAP of 68.06% for FFY 2025 and 67.83% for FFY 2026.

viii. Comparison to prior rates

(a) Comparison to prior rates

Figure 1 above provides a summarized comparison of the CY 2025 capitation rates to the prior amended rates for CY 2024.

The following are the key drivers of the rate changes:

- New base period benefit expenses
- Fee schedule changes and trend
- Wraparound agency payments
- Removal of state directed payment for wraparound agencies and LMHPs

(b) Description of other material changes

There are no material changes to the capitation rates or the rate development process that are not otherwise addressed in this report.

(c) De minimis adjustment in prior rating period

LDH did not adjust the actuarially sound capitation rates in the previous rating period by a *de minimis* amount using the authority in 42 C.F.R 438.7(c)(3).

ix. Known amendments

There are currently no known amendments that are not accounted for in this rate certification. If a known amendment exists, the state will submit the expected amendment and its anticipated changes to the rates to CMS along with an explanation as to why the amendment is not currently reflected in the rate certification.

x. COVID-19

We considered the impact of COVID-19 on the estimated utilization and service mix for the covered population in CY 2025. As part of the Consolidated Appropriations Act, 2023, continuous enrollment requirements were decoupled from the public health emergency (PHE), allowing eligibility reviews to begin prior to the expiration of the PHE. The resumption of Medicaid eligibility redeterminations in Louisiana began May 1, 2023, with the disenrollment of ineligible members starting July 1, 2023. We note that there continues to be uncertainty related to the impact of COVID-19 on capitation rates, but we have not made an explicit adjustment to the benefit expense for purposes of the CY 2025 rate development.

(a) State specific, and other applicable national or regional data

For the base data summaries, calendar year 2023 experience was utilized and summarized in Appendix 3. We compared state specific data given the variance observed in experience in other Louisiana Medicaid programs during the PHE.

(b) Direct and indirect impacts reflected in capitation rates

The capitation rate accounts for changes in the projected enrollment due to the public health emergency. Also directly accounted for are changes in utilization patterns as a result of the COVID-19 pandemic by utilizing CY 2023 as the base data period. The CY 2023 period was observed to represent materially stable expenditures in the CSoC managed care program and was estimated to be the most appropriate representation of estimated CY 2025 experience.

The base data was adjusted to reflect estimated changes between the base data period and the rating period.

We reviewed the potential impact of enrollment changes in the CSoC managed care program on the acuity of the covered population. Given the eligibility requirement for the CSoC managed care program and a review of emerging enrollment and expenditure experience through end of the unwinding period in June 2024, we do not believe that the CSoC managed care program was materially impacted by the unwinding process. At this time, we have opted not to make an acuity adjustment for the CSoC managed care program.

(c) COVID-19 costs covered on non-risk basis

Treatment, testing, and vaccines for COVID-19 are outside the scope of the CSoC managed care program.

(d) Risk mitigation strategies

As documented in Section 1, subsection 4.C.ii.(b), LDH has elected to maintain its minimum medical loss ratio (MLR) requirement at 85% for the CY 2025 contract year.

2. Data

This section provides information on the base data used to develop the capitation rates. The base experience data described in this section is illustrated in Appendix 3.

A. RATE DEVELOPMENT STANDARDS

In accordance with 42 CFR §438.5(c), we have followed the rate development standards related to base data. The remainder of Section 1, subsection 2 provides documentation of the data types, sources, validation process, material adjustments, and other information related to the documentation standards required by CMS.

B. APPROPRIATE DOCUMENTATION

i. Requested data

We requested and received data specifically for the capitation rate development. In addition, we intake and summarize monthly eligibility and expenditure data using information provided by LDH. The remainder of this section details the base data and validation processes utilized in the CY 2025 capitation rate development. In addition, Appendix 3 summarizes the adjusted base data.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The CY 2025 capitation rate development utilized the following data sources:

- Historical eligibility files provided by LDH
- Encounter data submitted by the participating managed care entity
- LDH fee schedules applicable to services affected by reimbursement changes
- Financial reporting templates submitted by the participating managed care entity
- Historical rate developments

The capitation rate was developed from historical CY 2023 claims and enrollment data from the CSoC managed care enrolled population. We used utilization and expenditures from the encounter data with runout through September 2024. We applied an adjustment to complete and true-up the expenditures to the level reported in the financial reporting template data. This adjustment is described in more detail in Section I, subsection 2.B.iii.

(ii) Age of the data

The data utilized as the base experience in the rate development for this report represents benefit expenses incurred during CY 2023 (claims runout through September 2024). We used encounter data corresponding to the same time period for the purposes of evaluating the impact of policy and program adjustments.

For the purposes of trend development, we reviewed and completed monthly managed care entity financial data experience on an incurred basis over the period from January 2019 through June 2024. Judgment was applied when reviewing the data due to disruptions related to the COVID-19 pandemic.

(iii) Data sources

Capitation payment and eligibility information

We received eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) for encounters, fee-for-service claims, and eligibility data from January 2019 through September 2024. After this initial data transfer, we established a process to receive updated MMIS data on a monthly basis.

Managed care entity encounter data

We received managed care entity encounter data extracts from the State's MMIS concurrently with the eligibility and enrollment extracts noted above. Our analysis was based on data submitted to the MMIS.

LDH fee schedules

We received LDH fee schedules for services affected by reimbursement changes during or after the base experience period.

Financial reports

On a quarterly basis, the managed care entity was requested to complete a financial reporting template. The recent submission includes data paid through June 2024. Utilization and expenditures were reported for each service. The financial reporting template also captured information related to third party liability, non-benefit costs, and other information pertinent to the CY 2025 rate development.

(iv) Sub-capitation

There were no sub-capitated claims identified in the historical encounter data or within the information reported by the managed care entity.

(b) Availability and quality of the data

(i) Steps taken to validate the data

We received eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) for encounters, fee-for-service claims, and eligibility data from January 2019 through September 2024. The actuary, the managed care entity, and LDH all play a role in validating the quality of encounter and financial reporting information used in the development of the capitation rates. The managed care entity plays the initial role, collecting and summarizing data sent to the State. In addition, LDH focuses on encounter data quality. We perform independent analysis of encounter data and financial reporting information to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by either Milliman or LDH.

Completeness

We first validated that we had received complete transmissions by comparing summarized values to control totals provided by the state's fiscal agent contractor (FAC).

Accuracy

Encounter data was reviewed relative to utilization and expenditures reported in the financial reports provided by the managed care entity. As the state actuary, we also review the encounter data to ensure each claim is related to a covered individual and a covered service. Claims utilized in the rate development process are those that have matching beneficiary IDs that are eligible for the noted service date.

We summarize the encounter data into an actuarial cost model format. Base period data summaries are created to ensure that the data for each service is consistent with prior historical periods. This process helps to identify any potential issues with the submitted data.

Consistency of data across data sources

We compared data across all sources during our base data review and analysis. Through the data validation process, we identified minor inconsistencies in reported data across sources. We addressed these deviations through the data completion factors.

(ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that we have relied upon certain data and information provided by LDH and its vendors, primarily the managed care entity. The values presented in this report are dependent upon this reliance.

We find the data used to develop the CY 2025 capitation rates to be suitable for the purpose of developing actuarially sound rates, with certain adjustments as outlined in the following sections. The data has been reviewed by multiple parties for completeness, accuracy, and consistency. The managed care experience base data used in the development of the CY 2025 certified rates is reasonably consistent with the reported financial experience of managed care entity.

(iii) Data concerns

Some data adjustments were made to the data submitted by the managed care entity to account for various issues identified during the review process and described in more detail in section d.iii below.

(c) Appropriate data

(i) Use of encounter and fee-for-service data

Fee-for-service data was not used during the rate development process.

(ii) Use of managed care encounter data

Managed care encounter data in CY 2023 was used as base experience in the rate development.

(d) Reliance on a data book

We did not rely on a data book for the CY 2025 capitation rate development.

iii. Data adjustments

The capitation rates were developed from CY 2023 experience reported in managed care encounter data. Adjustments were made to the base experience to gross-up expenditures to the level reported in the MCO surveys. Additional adjustments were made for credibility, completion, policy/program changes, and other data adjustments.

True-up to managed care entity surveys

The encounter data submitted by the managed care entity served as the base data. However, due to concerns with the completeness of the encounter data, we adjusted the data such that the total expenditures are consistent with the managed care entity surveys. This process is summarized below.

1. We summarized the expenditures from the encounter data by major service type (inpatient vs. outpatient) for claims incurred during CY 2023.
2. We summarized comparable expenditures from the managed care entity surveys by major service type. The expenditures included values reported by the managed care entity for benefit expenses after removing expenditures for FSO services, WWA services, and fraud, waste, and abuse, based on the information reported by the managed care entity. FSO and WAA services were excluded because these services will be paid through a daily rate in CY 2025.
3. We developed initial factors to apply to the encounter data. These factors were equal to the total expenditures from the managed care entity surveys divided by the total expenditures from the base data, by major service type. The true-up adjustments were 1.083 for inpatient, and 1.598 for outpatient.

(a) Credibility adjustment

No credibility adjustments were applied in the development of the CY 2025 CSoC capitation rate.

(b) Completion adjustment

The capitation rates are based on CY 2023 managed care entity experience. In the managed care entity financial reports, the managed care entity was requested to provide monthly incurred but not paid (IBNP) estimates by population.

We analyzed reported managed care entity claims lag data and developed completion estimates by major service category, which were applied to the CY 2023 base data with runout through September 2024. In aggregate, the completion adjustment increases the base data by approximately 1.0%.

The impact of applying the claim completion factors can be found in Appendix 3 of this report. Please note that completion was applied subsequent to the true-up to the managed care entity surveys.

(c) Errors found in the data

Overall, we believe that the financial reporting template experience adequately reflects the managed care entity's expenditures for CY 2023, so we have determined that the base encounter data with adjustments described in this section was appropriate for use as the base experience.

(d) Program change adjustments

Figure 2 lists program and reimbursement changes that occurred since the beginning of the base experience period used in rate development. It includes the program change, the effective date of the change, the percentage impact to the CY 2025 medical (non-daily rate) benefit expense, and the equivalent PMPM impact. The impacts shown in Figure 2 are prior to the application of trend.

INDEX	ADJUSTMENT	EFFECTIVE DATE	PERCENTAGE IMPACT
2.a	Short term respite fee schedule	9/1/2023	2.1%
2.b	Youth Crisis Response	4/1/2024	0.7%
2.c	Inpatient fee schedule	7/1/2024	0.3%
2.d	FQHC fee schedule	7/1/2024	0.1%
2.e	ILSB fee schedule	1/1/2025	3.1%

Notes: 1. The percentage impact is illustrated as a percentage of the CY 2025 medical (non-daily rate) expenses.

2. The PMPM impact is an estimate and is included for illustrative purposes.

Retrospective Program Adjustments

Retrospective program changes include all program and reimbursement changes that occurred during CY 2023, the base period used for the development of the capitation rates and are included in Appendix 3.

2.a. Short term respite fee schedule

Reimbursement for short term respite services in the CSoC fee schedule was updated effective September 1, 2023. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective September 1, 2023.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the fee schedule effective dates.

Prospective Program Adjustments

Prospective program changes include all program and reimbursement changes that occurred after December 2023, the end of the base period used for the development of the capitation rates and are included in Appendix 4.

2.b. Youth Crisis Response Adjustment

Effective April 1, 2024, LDH added mobile crisis response and community brief crisis support services for children to the Louisiana Medicaid State Plan. As a result, Magellan will be responsible for covering these services for the CSoC population. We estimated the cost of covering these services by reviewing projected total expenditures in SFY 2025 and SFY 2026 estimated by LDH. We allocated a portion of the total projected expenditures to the CSoC program by comparing the relative prevalence of other SBH services in the CSoC population compared with the Healthy Louisiana program. We estimated that coverage of these services for CSoC members will increase medical expenditures by approximately $120,000 during the rating period.

2.c. Inpatient fee schedule

The inpatient fee schedule was updated, effective July 1, 2024. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective on July 1, 2024.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

2.d. FQHC fee schedule

The federally qualified health center (FQHC) fee schedule was updated, effective July 1, 2024. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective on July 1, 2024.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

2.e. Independent living / skills building fee schedule

Reimbursement for independent living skills building services in the CSoC fee schedule was recently updated, effective January 1, 2025. To model these reimbursement changes, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under two fee schedule time periods:

1. Using the fee schedule effective on the date of service.
2. Using the fee schedule effective on January 1, 2025.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the two fee schedule effective dates.

Daily Rate Service Adjustments

Wraparound Agency (WAA) daily rate

Effective January 1, 2025, the daily rate for wraparound agencies (WAAs) will be updated to be $40.16 for each enrolled member. The base daily rate is based upon guidance received from OBH. WAAs are still able to receive up to an additional $1.00 per day per performance measure based on their performance in relation to the following two measures defined by OBH.

- Plan of Care Submission Timeliness: Providing an electronic copy of the current plan of care to applicable providers within five business days after each convening of the Child and Family Team.
- Discharge Notification Timeliness: Submitting electronic notification of discharge to all formal behavioral health providers, including waiver service providers, within five business days of discharge.

We still estimate that the WAAs will be able to achieve 80% or $1.60 per member per day of the performance-based add-ons, based upon guidance received from OBH.

We have also updated the assumptions for the development of the WAA load included in the capitation rates to reflect emerging utilization experience. Members use this service every day in which they are enrolled in the CSoC program. Members may be enrolled or disenrolled in the middle of a month. As a result, on average, members are not expected to utilize this service for all days in each month. Based on emerging encounter and financial reporting template data, we observe that wraparound agencies receive a daily rate for CSoC members for approximately 90% of days in a given month on average.

The increase in the daily rate and the adjustment for the monthly utilization frequency combine to decrease the capitation rate load for WWAs by approximately 3.3% relative to the previous rates.

Development of the PMPM capitation rate loads for the daily rates for WAAs are provided in Appendix 6.

The development of the PMPM capitation rate loads for the Family Support Organizations (FSOs) daily rates remains unchanged from the previous rate certification amendment. The assumptions for the percentage of members receiving family support services and youth support services are based on a review of data through June 2024. The daily rate for both services remains $11.00. The development of the PMPM load for FSO daily rates is provided in Appendix 5.

Program changes deemed immaterial to benefit expenses in the rate period

We define a program or policy adjustment to be "material" if the total benefit expense is impacted by more than 0.10% and the effects are not fully reflected in the base experience.

All policy changes provided to us by LDH were analyzed for their effect on the CSoC managed care program. Program adjustments that were made in this rate certification had policy or reimbursement changes that were deemed to have a material cost impact to the MCO. Adjustment factors that did not meet this minimum threshold criteria were deemed immaterial and were not applied to the base experience. The following is a list of program adjustments deemed immaterial based on our review of the experience data and policy change.

- *Dialectical Behavioral Therapy (DBT).* Based on guidance from LDH, DBT services will be covered at full risk under the CSoC capitation rates effective March 1, 2025. DBT services were added to the provider manual as an evidence-based practice. Based on a review of emerging utilization data, we have determined that the impact of this change is immaterial to the limited rates for the CY 2025 rating period.
    - Note that we have not adjusted the value of the separate payment term, which is still consistent with the amount in the submitted DBT preprint for CY 2025.

(e) Exclusion of payments or services from benefit expense data

Encounters without a corresponding eligibility record were excluded from the data provided by LDH. In addition, we excluded services provided by FSOs because these organizations receive a daily rate effective January 1, 2024.

In the financial reports, the managed care entity provided information about fraud, waste, and abuse (FWA) and third-party liability (TPL) recoveries. These amounts were reported separately for recoveries reflected in the encounter data (as a reduction to the paid amount on each claim) and recoveries outside of the encounter data. We adjusted the base experience downward to account for recoveries outside of the encounter data. This adjustment was applied as a uniform multiplicative factor across all categories of service and included in the true-up adjustment. Please note that the financial reports projected benefit expense net of TPL. Therefore, a specific adjustment to account for TPL claims was not necessary.

No other specific payments or services were excluded from the data.

3. Projected Benefit Cost and Trends

This section provides information on the development of projected benefit costs in the capitation rates.

A. RATE DEVELOPMENT STANDARDS

i. Final capitation rate compliance

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). Non-covered services provided by the managed care entity as value-added are not included in the capitation rate development.

ii. Benefit cost trend assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the covered populations. In addition, consideration of other factors and data sources appropriate for benefit cost trend development is further documented in Section I, item 3.B.iii.

iii. In lieu of services

There are no in lieu of services (ILOSs) for the CSoC managed care program.

iv. ILOS Cost Percentages

There are no ILOSs for the CSoC managed care program.

v. Benefit expenses associated with members residing in an IMD

There are no members covered over the age of 21 in the CSoC managed care program; therefore, no adjustment for IMD services for individuals ages 21-64 is required.

B. APPROPRIATE DOCUMENTATION

i. Projected benefit costs

This section provides documentation of the methodology utilized to develop the benefit cost component of the capitation rate.

ii. Development of projected benefit costs

(a) Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

Step 1: Create per member per month (PMPM) cost summaries

The capitation rate was developed from historical CY 2023 claims and enrollment data.

We used utilization and expenditures from the financial reporting template with runout through June 2024. We applied adjustments to complete the expenditures to represent fully completed experience for the base time period. Utilization and costs are reported by service category.

The base data was described further in Section 1, item 2.B.ii.

Step 2: Adjust for program and policy changes to calendar year 2025

We adjusted the base experience for known program and reimbursement changes that have occurred or are expected to be implemented between the beginning of the base data experience period and the end of the CY 2025 rate period. In Section 1, item 2.B.iii(d), we documented these items.

Step 3: Trend to calendar year 2025

Assumed trend factors were applied for 24 months to the adjusted utilization and unit cost values, or per member per month (PMPM) values, as appropriate, from the midpoint of the base experience period (July 1, 2023) to the midpoint of the rate period (July 1, 2025).

(b) Material changes to the data, assumptions, and methodologies

Material adjustments were applied to recognize changes to provider reimbursement, historical program adjustments, prospective program adjustments, and changes to covered populations and most were documented in Section I, item 2.B.iii (Data Adjustments).

All material assumptions are documented in this rate certification report.

(c) Overpayments to providers

We are not aware of any overpayments to providers reflected in the base experience period.

iii. Projected benefit cost trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period to the rating period of this certification. We evaluated prospective trend rates using base and emerging experience, as well as external data sources. Note, trend rates do not reflect any specific considerations in population acuity due to the PHE unwinding.

(a) Required elements

(i) Data

The primary data used to develop benefit cost trends is historical claims and reported financial template expenditures from the covered populations. Data used for trend development includes cost and utilization experience from January 2019 through June 2024 adjusted for completion and known program changes.

We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries, specific to the services covered by the CSoC managed care program.

(ii) Methodology

Using financial reporting template data, historical utilization and per member per month cost data was stratified by month and service category. The data was adjusted for completion and normalized for historical program changes and reimbursement changes. We developed trend rates to adjust the base experience data (midpoint of July 1, 2023) forward 24 months to the midpoint of the contract period, July 1, 2025. Rolling trends were calculated to identify changes in the underlying patterns over time after adjusting for seasonality, and two-year annualized trends were utilized to smooth out significant fluctuations from year to year.

As a result of the COVID-19 PHE, we analyzed both experience prior to the PHE and emerging experience by service category to gain an understanding of the impact of COVID-19 and subsequent utilization changes on the managed care program experience. Based on our review, patterns did not indicate the need for an emerging experience adjustment in addition to trend. The annual trend rates selected for service category included a review of emerging utilization patterns and trends. The selected trends also account for any anticipated changes in utilization levels as a result of significant reimbursement increases.

We applied our selected trend to each service category. For all service categories, the trend rates do not account for known reimbursement changes as they were explicitly addressed in Section I, item 2.B.iii of this certification report.

Based on a review of the available data, we grouped services into two service categories for trend development: Inpatient Psychiatric Facilities and Outpatient & HCBS.

Historical trends should not be used in a simple formulaic manner to determine future trends; actuarial judgment is also required. We also referred to alternative sources, both publicly available and internal Milliman information.

(iii) Comparisons

We referred to the sources listed in the prior section as well as estimated changing practice patterns and the impact of reimbursement changes on utilization.

Explicit adjustments were made outside of trend to reflect all recent or planned changes in benefits and reimbursement from the base experience period to the rating period.

(iv) Documentation of Trends

Figure 3 illustrates the utilization trend by category of service grouping for the CY 2025 capitation rate development. The mix and intensity component is captured in the utilization trend assumption.

FIGURE 3: UTILIZATION TREND BY SERVICE CATEGORY

SERVICE CATEGORY	UTILIZATION
Inpatient Psych Facilities	10.0%
Outpatient/HCBS	14.0%

(b) Required elements

Figure 3 above illustrates the utilization trend. Please note that known program changes are not applied as trend adjustments, instead each claim is repriced and adjusted based on reimbursement updates that have occurred or are anticipated to be implemented after the end of the base period. The repricing and reimbursement update analyses are described further in Section I, item 2.B.iii.(d).

(c) Variation

We evaluated historical trend patterns by category of service grouping. We observed variation across the category of service groupings. The trend rate assumptions outlined in the previous section were applied at the category of service grouping level.

(d) Material adjustments

No material adjustments were noted in the data utilized for calculating trends.

(e) Any other adjustments

(i) Impact of managed care

We did not adjust the trend rates to reflect impacts related to managed care efficiencies for utilization or unit cost.

(ii) Trend changes other than utilization and cost

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

LDH assessed the State's compliance with the parity standards of the Mental Health Parity and Addiction Equity Act (MHPAEA) as required by 42 CFR 438.3(c)(1)(ii).

v. In Lieu of Services

The projected benefit costs do not include costs for ILOSs.

vi. Retrospective Eligibility Periods

(a) Managed care entity responsibility

During the base period, the managed care entity was responsible for periods of retroactive eligibility. Managed care entity requirements for the rating period are consistent with the base period and continue to be responsible for periods of retroactive eligibility.

(b) Claims treatment

As noted earlier, claims for retrospective eligibility periods are reflected in the managed care entity base data.

(c) Enrollment treatment

Enrollment is treated consistently with claims.

(d) Adjustments

It was not necessary to make any adjustments to the managed care entity base data for retroactive eligibility.

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the January to December 2024 rating period.

(a) Change to covered benefits

Material changes to covered benefits have been described in program adjustments described in Section I, item 2.B.iii (Program Change Adjustments).

(b) Recoveries of overpayments

No overpayment issues were indicated to have been reflected in the historical paid encounter data and therefore no adjustment has been made to the base experience for overpayment recoveries.

(c) Change to payment requirements

Material changes to required provider payments have been described in program adjustments in Section I, item 2.B.iii (Program Change Adjustments).

(d) Change to waiver requirements

There were no material changes related to waiver requirements or conditions.

(e) Change due to litigation

There were no material changes due to litigation.

viii. Documentation of Material Changes

Material changes to covered benefits and provider payments have been described in program adjustments described in Section I, item 2.B.iii (Program Change Adjustments). This information includes the data, assumptions, and methodology used in developing the adjustment, estimated impact by population, and aggregate impact on the managed care program's benefit expense.

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate development standards

This section provides documentation of the incentive payment structure in the CSoC managed care program.

ii. Appropriate documentation

(a) CSoC Incentive Program

During CY 2025, the managed care entity will be able to earn up to $750,000 above the approved capitation payment attributable to enrollees or services covered by the incentive arrangements implemented by LDH. These incentives will support the activities, targets, performance measures, or quality-based outcomes specified in LDH's quality strategy.

(i) Time period

The incentive arrangement is in effect on a calendar year basis.

(ii) Covered enrollees, services, and providers

The incentive arrangement covers enrollees in the CSoC managed care program.

(iii) Purpose

The purpose of the incentive is to improve the quality of care provided to CSoC program enrollees.

(iv) Payments will not exceed 105 percent

LDH will evaluate total capitation payments after the calendar year and ensure that the total incentive payments does not exceed 105 percent of the total capitation payments during the calendar year.

(v) Effect on capitation rates

The incentive arrangement has no effect on the development of the capitation rates.

B. WITHHOLD ARRANGEMENTS

i. Rate development standards

This section provides documentation of the withhold arrangements in the CSoC managed care program.

ii. Appropriate documentation

There are currently no withhold arrangements in the contract between the managed care entity and LDH for the CSoC managed care program.

C. RISK SHARING MECHANISMS

i. Rate development standards

This section provides documentation of the risk-sharing mechanisms in the CSoC managed care program.

ii. Appropriate documentation

(a) Description of the risk-sharing mechanism

There are currently no risk-sharing mechanisms in the CSoC managed care program outside of the minimum Medical Loss Ratio described in Section I, item 4.C.ii.(b).

(b) Medical loss ratio

Description

LDH requires the managed care entity participating in the CSoC managed care program to maintain a minimum medical loss ratio (MLR) of 85%. The MLR is defined as the ratio of the numerator, as defined in accordance with 42 CFR 438.8(e), to the denominator, as defined in accordance with 42 CFR 438.8(f), plus a credibility adjustment, as defined in accordance with 42 CFR 438.8(h). These items will be accrued on an incurred year basis for the MLR calculation. MLR will be measured on a calendar year basis starting on January 1, 2025.

Financial consequences

If a managed care entity does not meet the minimum MLR threshold, then LDH will recoup the capitation revenue that represents the difference between the total capitation revenue multiplied by the minimum medical loss ratio, less actual benefit expenses incurred.

(c) Reinsurance requirements and effect on capitation rates

LDH does not require that the managed care entity participating in the Medicaid managed care program maintain a specific stop-loss reinsurance policy. Reinsurance premiums and recoveries have not been reflected in the rate development.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate development standards

This section provides information on directed payments for certain providers which are pertinent to the CY 2025 capitation rates.

(a) Description of Managed Care Plan Requirement

Effective January 1, 2024 and continuing through February 28, 2025, the managed care entity will pay qualifying licensed mental health professionals (LMHPs) an add-on when providing dialectical behavioral therapy (DBT) services.

All directed payments described in this report are consistent with LDH descriptions of the 438.6(c) pre-prints which have been submitted to CMS, if required.

(b) Approval by CMS and consistency with preprints

All directed payments described in this rate certification have been submitted to CMS. The descriptions in this rate certification are consistent with the 438.6(c) pre-prints that have been submitted to CMS.

(c) Contract arrangements with MCOs

All contract arrangements that direct managed care entity expenditures were developed in accordance with 42 CFR §438.4 and 42 CFR §438.5.

(d) Inclusion of Provider Payment Initiatives in Capitation Rates

The payments for the DBT directed payment are made on a retrospective basis to the managed care entity.

(i) Documentation related to separate payment term included in the rate certification

Documentation related to the separate payment term is addressed in Section I, Item 4.D.ii.a.iii.

(ii) PMPM estimate of directed payments addressed through separate payment term

The estimated rating period PMPM amounts of the directed payment is provided in Figure 4.

(iii) Final documentation of total directed payment amount

After the rating period is complete, a separate report documenting the actual directed payment amounts by region and rate cell will be provided to CMS.

ii. Appropriate documentation

(a) Description of Delivery System and Provider Payment Initiatives

(i) Description of delivery system and provider payment initiatives included in the capitation rate

(ii) State directed payments incorporated in the capitation rates are listed in Figure 4 below.

FIGURE 4: SUMMARY OF NEW DIRECTED PAYMENTS INCLUDED IN CERTIFICATION

CONTROL NAME OF THE STATE DIRECTED PAYMENT	TYPE OF PAYMENT	BRIEF DESCRIPTION	IS THE PAYMENT INCLUDED AS A RATE ADJUSTMENT OR SEPARATE PAYMENT TERM?
LA_Fee_BHO2_Renewal_20250101-20251231	Add-on based on utilization	Add-on paid to LMHPs for each DBT service provided	Separate payment term

Separate payment term directed payments included in this report:

- **LA_Fee_BHO2_Renewal_20250101-20251231**

  LMHPs that are certified to provide DBT services will be paid an add-on for each DBT service provided. The add-ons are structured so that the total reimbursement per visit will be $200.00 for individual therapy and $177.68 per member for group therapy.

  This separate payment term is only applicable through February 28, 2025. DBT services will be covered at full risk under the CSoC capitation rates effective March 1, 2025. DBT services were added to the provider manual as an evidence-based practice.

(iii) Description of payment arrangements incorporated as a rate adjustment

There are no new state directed payments incorporated in the capitation rates as a rate adjustment.

(iv) Description of payment arrangements incorporated as a separate payment term

State directed payments incorporated in the capitation rates as a separate payment term are listed in Figure 4 below, with more description following the table.

FIGURE 4: DIRECTED PAYMENTS INCORPORATED AS SEPARATE PAYMENT TERMS

CONTROL NAME OF THE STATE DIRECTED PAYMENT	AGGREGATE AMOUNT INCLUDED IN THE CERTIFICATION	STATEMENT THE ACTUARY IS CERTIFYING THE SEPARATE PAYMENT TERM	MAGNITUDE ON A PMPM BASIS	CONFIRMATION THE RATES ARE CONSISTENT WITH PREPRINT	CONFIRMATION THE ACTUARY WILL SUBMIT REQUIRED DOCUMENTATION AT END OF RATING PERIOD
LA_Fee_BHO2_Renewal_20250101-20251231	$172,000	Yes	$5.87	Yes	Yes

Note: Values shown are net of premium tax.

Actuarial certification of separate payment terms.

The actuary certifies the amounts of the separate payment terms provided in this document.

Provider types receiving the payment

Providers who are part of the DBT directed payment include psychiatrists, advanced practice registered nurses (APRN), physician assistants (PA), clinical nurse specialists (CNS), psychologists, medical psychologists, licensed clinical social workers (LCSW), licensed professional counselors (LPC), licensed marriage and family therapists (LMFT), and licensed addiction counselors (LAC), limited to those who are trained and/or certified to provide DBT as an evidence-based therapy option.

Distribution methodology

Providers trained in DBT and who otherwise meet the provider class definition that bill the specific codes for psychotherapy services will receive reimbursement from the managed care organization upon processing the initial claim that represents the current reimbursement rate for psychotherapy services plus the DBT state directed payment add-on. The managed care entity will then invoice LDH quarterly for the state directed payment add-on portion of the reimbursement. LDH will pay the managed care entity based on the invoices.

This separate payment term is only applicable through February 28, 2025. DBT services will be covered at full risk under the CSoC capitation rates effective March 1, 2025. DBT services were added to the provider manual as an evidence-based practice.

Estimated PMPM payout by rate cell

The estimated PMPM payout is illustrated in Figure 4. The CSoC managed care program only has a single rate cell. Although the separate payment term is only applicable through February 28, 2025, the PMPM value in Figure 4 represents an average over the entire rating period.

Consistency with 438.6(c) preprint

The directed payments, as described in this rate certification, are consistent with 438.6(c) preprints submitted to CMS.

Statement that certification will be amended if rates vary from initial estimate

To the extent the final directed payments by rate cell vary from the initial estimates presented above, the rate certification will be amended to reflect the final payments made to the providers.

(b) Additional directed payments not addressed in the certification

There are not any additional directed payments in the CSoC managed care program that are not addressed in this certification.

(c) Other requirements regarding reimbursement rates

There are not any additional requirements regarding the reimbursement rates the managed care entity must pay to any providers unless specified in this certification as a directed payment or authorized under applicable law, regulation, or waiver.

5. Projected Non-Benefit Costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR §438.5(e), the non-benefit cost component of the capitation rates includes reasonable, appropriate, and attainable expenses related to managed care entity operation of the CSoC managed care program.

The remainder of Section I, item 5 provides documentation of the data, assumptions, and methodology that we utilized to develop the non-benefit cost component of the capitation rate.

ii. PMPM versus percentage

The non-benefit cost was developed as a percentage of the capitation rates.

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

(a) Description of the data, assumptions, and methodologies

Data

The financial reports submitted by the managed care entity for historical time periods included reported administrative costs by managed care entity. The reported administrative costs and historical non-benefit expense percentages for the CSoC managed care program served as the primary data sources used in the development of the CY 2025 non-benefit costs. Non-benefit costs were established as a percentage of the CSoC effective capitation rate.

Assumptions and methodology

In developing the non-benefit costs, we reviewed historical managed care entity administrative and healthcare quality improvement (HCQI) expenses for the CSoC managed care program along with historical administrative expense percentage included in the CSoC managed care program. We considered the size of CSoC population along with the benefits covered and the demographics of the managed care populations.

Administrative expense ratio and risk margin. The administrative expense ratio and risk margin assumptions have been maintained from the January to December 2024 capitation rates and apply to all benefit expenses included in the capitation rate.

In evaluating the reasonableness of the margin assumptions, we have considered the minimum medical loss ratio requirement for CY 2025, which is 85%. Under CFR 438.8, adjustments are made to the medical loss ratio calculation for quality improvement expenses (numerator) and taxes and regulatory fees (denominator). In addition, a creditability adjustment is applied as appropriate.

Premium tax. The final rate is grossed up for a 5.5% premium tax.

(b) Material changes since last rate certification

There were no material changes since the prior certification.

(c) Other material adjustments

No other material adjustments were made.

ii. Non-benefit costs, by cost category

The CY 2025 non-benefit cost allowance was developed as a percentage effective rate on a statewide basis. The non-benefit expense component (15.0%) is comprised of the administrative load (10.0%), quality improvement (4.0%), and risk margin (1.0%). The 5.5% adjustment for premium tax represents a multiplicative adjustment to the fully loaded rate.

iii. Historical non-benefit cost data

We maintained the historical non-benefit cost allowance assumptions utilized in the CY 2024 rate development following a review of the historical assumptions and managed care entity reported experience.

6. Risk adjustment and acuity adjustments

This section provides information on risk adjustment included in the contract.

A. RATE DEVELOPMENT STANDARDS

i. Overview

The CSoC managed care capitation rates have been developed as full risk rates without an adjustment for risk or acuity. The managed care entity assumes risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract. There is only one managed care entity anticipated to participate in the CSoC managed care program during CY 2025.

ii. Risk adjustment model

Not applicable.

iii. Acuity adjustments

Not applicable.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data

Not applicable.

(b) Risk adjustment model

Not applicable.

(c) Risk adjustment methodology

Not applicable.

(d) Magnitude of the adjustment

Not applicable.

(e) Assessment of predictive value

Not applicable.

(f) Any concerns the actuary has with the risk adjustment process

Not applicable.

ii. Retrospective risk adjustment

Not applicable.

iii. Risk adjustment documentation

Not applicable.

iv. Acuity adjustments

Not applicable.

Section II. Medicaid Managed Care Rates with Long Term Services and Supports

Section II of the CMS Guide is not applicable to the Louisiana Medicaid CSoC managed care program. Managed long-term services and supports (MLTSS) populations are excluded and not covered.

Section III. New Adult Group Capitation Rates

Section III of the CMS Guide is not applicable to the Louisiana Medicaid CSoC managed care program.

Limitations

The information contained in this report has been prepared for the State of Louisiana, Department of Health (LDH) and their consultants and advisors to provide documentation of the development of the calendar year 2025 actuarially sound capitation rates for the populations served under the Louisiana Medicaid Coordinated System of Care managed care program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report will be shared with CMS and the participating managed care entity and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for LDH by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to develop an actuarially sound capitation rate for the calendar year 2025 CSoC managed care program. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models. We have relied upon certain data and information provided by LDH for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes eligibility and FFS claims and encounter data, managed care entity reported financial experience, as well as information related to LDH's eligibility system and assignment of enrollees to rate cells. The models, including all input, calculations, and output may not be appropriate for any other purpose.

Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual managed care entity. Results will differ if actual experience is different from the assumptions contained in the capitation rate setting documentation. LDH and Milliman provide no guarantee, either written or implied, that the data and information is 100% accurate or error free.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

We acknowledge the unique nature of the COVID-19 Public Health Emergency and the resumption of redeterminations that occurred shortly before the rating period. The assumptions documented in this certification report reflect information known to us at the time of this report. We acknowledge that the resumption of redeterminations and enrollment unwinding period could have a material impact on utilization, acuity, Medicaid enrollment, service delivery, and other factors related to the capitation rates illustrated in this rate certification.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

APPENDIX 1: ACTUARIAL CERTIFICATION

State of Louisiana
Department of Health
Louisiana Medicaid CSoC Managed Care Program
Calendar Year 2025 Capitation Rates
Actuarial Certification

I, Anders Larson, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Louisiana, Department of Health to perform an actuarial review and certification regarding the development of capitation rates for the Louisiana Medicaid CSoC managed care program effective January 1, 2025. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- *the capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the MCO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).*

For the purposes of this certification and consistent with the requirements under 42 CFR 438.4(a), "actuarial soundness" is defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Louisiana. The "actuarially sound" capitation rates that are associated with this certification are effective for calendar year 2025.

The "actuarially sound" capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State and managed care entity. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

I acknowledge that LDH may elect to amend the capitation rates in accordance with 42 CFR 438.7(c)(3), which indicates that a capitation rate certification is not required for adjustments that increase or decrease capitation rates by 1.5% or less. The capitation rates developed may not be appropriate for any specific managed care entity. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

Anders Larson, FSA
Member, American Academy of Actuaries

February 17, 2025
Date

APPENDIX 2: ELIGIBILITY REQUIREMENTS

State of Louisiana
Department of Health
Coordinated System of Care (CSoC)
Calendar Year 2025 Capitation Rate Development
Appendix 2: Eligibility Requirements

A child/youth eligible for CSoC will meet the following criteria:

1. Between the ages of 5-20
2. Has a DSM 5 diagnosis or is exhibiting behaviors indicating that a diagnosis may exist (Magellan will refer for a comprehensive assessment in order to make an eligibility determination).
3. Meets clinical eligibility for CSoC as determined by the Child, Adolescent Needs and Strengths (CANS) scale which assesses the following areas:
   - Behavioral/Emotional Diagnosis or Behaviors, e.g. impulsiveness, anxiety, depression, history of trauma, oppositional behavior, etc.
   - Risky Behaviors, e.g. self-harming behaviors, aggression, fire setting, threats of harm to others, etc.
   - Difficulty functioning in various settings including family, home, school or community.
   - Caregiver need for assistance with supervision, understanding behavioral health needs, linking to appropriate supports and services, their own behavioral health needs, etc.
4. Currently in an out of home placement (OOH), or at imminent risk of OOH placement in these settings:
   - Psychiatric Hospitals
   - Psychiatric Residential Treatment Facilities
   - Therapeutic Group Home
   - Non-medical Group Home
   - Addiction Facilities
   - Detention
   - Foster Care
   - Therapeutic Foster Care
   - Developmental Disabilities Facilities
   - Alternative Schools
   - Secure Care Facilities
   - Homeless (As identified by the Department of Education)
5. Generally involved with multiple state agencies.
6. Identified family or adult resource that is or will be responsible for the care of the child/youth that is willing to engage in wraparound.
7. Eligible for Medicaid or deemed eligible for Medicaid based on clinical need. (Certain children/youth not typically eligible for Medicaid may be eligible based on clinical need.)
8. The child is not currently receiving Multi-Systemic Therapy (MST).

The Coordinated System of Care eligibility requirements are provided on LDH's website at https://ldh.la.gov/assets/csoc/Documents/GovernanceBoard/201802February/CSoCGovernanceBoardPackage.pdf.

APPENDIX 3: RETROSPECTIVE COST MODEL

State of Louisiana
Department of Health
Coordinated System of Care (CSoC)
Calendar Year 2025 Capitation Rate Development
Appendix 3: Retrospective Cost Model

Rate Cell: CSoC		MCO Encounter Data Base Year Experience			True-up Adjustments		Completion Adjustments		Retrospective Program Adjustments		Base Year Adjusted Base Experience		
Member Months: 29,279 **Category of Service**	**Utilization Type**	**Utilization per 1,000**	**Cost per Service**	**PMPM**	**Utilization Adjustment**	**Cost Adjustment**	**Utilization Adjustment**	**Cost Adjustment**	**Utilization Adjustment**	**Cost Adjustment**	**Utilization per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital													
Inpatient Psych Facilities	Days	2,619	$ 661.50	$ 144.35	$ 11.92	-	$ 0.92	-	-	-	2,851	$ 661.50	$ 157.18
Subtotal Inpatient Hospital				**$ 144.35**	**$ 11.92**		**$ 0.92**						**$ 157.18**
Outpatient/HCBS Services													
Substance Use Disorder Services - Outpatient	Units	32	$ 53.11	$ 0.14	$ 0.08	-	$ 0.00	-	-	-	51	$ 53.11	$ 0.23
Crisis Intervention	Units	51	96.84	0.41	0.25	-	0.00	-	-	-	82	96.84	0.66
Psychosocial Rehabilitation	15 minutes	26,926	16.82	37.75	22.56	-	0.83	-	-	-	43,616	16.82	61.14
Community Psychiatric Support and Treatment	15 minutes	9,948	33.91	28.11	16.81	-	1.27	-	-	-	16,344	33.91	46.19
Crisis Stabilization	Units	-	-	-	-	-	-	-	-	-	-	0.00	0.00
Assertive Community Treatment	Units	9	185.37	0.14	0.08	-	0.00	-	-	-	14	185.37	0.22
Short Term Respite	15 minutes	114,393	6.80	64.84	38.76	-	0.35	-	-	8.81	183,391	7.38	112.77
Independent Living/Skills Building	15 minutes	19,681	7.79	12.78	7.64	-	0.13	-	-	-	31,639	7.79	20.55
Licensed Professional Counselor	Visits	992	75.49	6.24	3.73	-	0.16	-	-	-	1,611	75.49	10.14
Licensed Clinical Social Worker	Visits	334	76.71	2.14	1.28	-	0.04	-	-	-	540	76.71	3.46
Psychologist	Visits	434	64.96	2.35	1.41	-	0.06	-	-	-	704	64.96	3.81
Licensed Marriage and Family Therapist	Visits	2	86.44	0.02	0.01	-	0.00	-	-	-	3	86.44	0.03
Physicians/Professional (MD, DO, APRN, PA, CNS)	Visits	596	80.51	4.00	2.39	-	0.13	-	-	-	971	80.51	6.52
FQHC/RHC Services	Units	421	74.99	2.63	1.57	-	0.10	-	-	-	688	74.99	4.30
Other Non-defined Psych Services	Units	506	61.46	2.59	1.55	-	0.08	-	-	-	825	61.46	4.23
Subtotal Outpatient Hospital				**$ 164.14**	**$ 98.12**		**$ 3.16**			**$ 8.81**			**$ 274.23**
Total PMPM				**$ 308.49**									**$ 431.41**

* Values are rounded

APPENDIX 4: PROSPECTIVE COST MODEL

State of Louisiana
Department of Health
Coordinated System of Care (CSoC)
Calendar Year 2025 Capitation Rate Development
Appendix 4: Prospective Cost Model

Rate Cell: CSoC		Base Year Adjusted Base Experience			Trend Adjustments		Prospective Program Adjustments		Base Year Adjusted Base Experience		
Member Months: 29,279 **Category of Service**	**Utilization Type**	**Utilization per 1,000**	**Cost per Service**	**PMPM**	**Utilization Adjustment**	**Cost Adjustment**	**Utilization Adjustment**	**Cost Adjustment**	**Utilization per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital											
Inpatient Psych Facilities	Days	2,851	$661.50	$157.18	$33.01	-	-	$ 1.44	3,450	$ 666.51	$ 191.63
Subtotal Inpatient Hospital				**$157.18**	**$33.01**			**$ 1.44**			**$ 191.63**
Outpatient/HCBS Services											
Substance Use Disorder Services - Outpatient	Units	51	$ 53.11	$ 0.23	$ 0.07	-	-	-	67	$ 53.11	$ 0.29
Crisis Intervention	Units	82	96.84	0.66	0.20	-	4.03	-	606	96.84	4.89
Psychosocial Rehabilitation	15 minutes	43,616	16.82	61.14	18.32	-	-	-	56,684	16.82	79.46
Community Psychiatric Support and Treatment	15 minutes	16,344	33.91	46.19	13.84	-	-	-	21,240	33.91	60.02
Crisis Stabilization	Units	-	-	-	-	-	-	-	-	0.00	0.00
Assertive Community Treatment	Units	14	185.37	0.22	0.07	-	-	-	19	185.37	0.29
Short Term Respite	15 minutes	183,391	7.38	112.77	33.79	-	-	-	238,335	7.38	146.55
Independent Living/Skills Building	15 minutes	31,639	7.79	20.55	6.16	-	-	17.12	41,118	12.79	43.82
Licensed Professional Counselor	Visits	1,611	75.49	10.14	3.04	-	-	-	2,094	75.49	13.17
Licensed Clinical Social Worker	Visits	540	76.71	3.46	1.04	-	-	-	702	76.71	4.49
Psychologist	Visits	704	64.96	3.81	1.14	-	-	-	915	64.96	4.96
Licensed Marriage and Family Therapist	Visits	3	86.44	0.03	0.01	-	-	-	4	86.44	0.03
Physicians/Professional (MD, DO, APRN, PA, CNS)	Visits	971	80.51	6.52	1.95	-	-	-	1,262	80.51	8.47
FQHC/RHC Services	Units	688	74.99	4.30	1.29	-	-	0.81	895	85.80	6.40
Other Non-defined Psych Services (describe)	Units	825	61.46	4.23	1.27	-	-	-	1,072	61.46	5.49
Subtotal Outpatient Hospital				**$274.23**	**$ 82.16**		**$ 4.03**	**$ 17.93**			**$ 378.34**
Total PMPM				**$431.41**							**$569.97**

* Values are rounded

APPENDIX 5: FSO PAYMENT DEVELOPMENT

State of Louisiana
Department of Health
Coordinated System of Care (CSoC)
Calendar Year 2025 Capitation Rate Development
Appendix 5: Development of FSO PMPM

Component	Youth Support	Family Support	Composite	Notes
A. Daily FSO Payment Rate	$ 11.00	$ 11.00		Service rate per recipient per day
B. Number of Days in CY 2025	365	365		
C. Average Days per Month	30.4	30.4		C = B / 12
D. Percentage Receiving Payment	19.1%	36.5%		
E. CY 2025 FSO PMPM	$ 64.04	$ 121.98	$ 186.02	E = A * C * D

* Values are rounded

APPENDIX 6: WAA PAYMENT DEVELOPMENT

State of Louisiana
Department of Health
Coordinated System of Care (CSoC)
Calendar Year 2025 Capitation Rate Development
Appendix 6: Development of WAA PMPM

Component	Amount	Notes
A. Base Daily WAA Payment Rate	$ 40.16	Service rate per recipient per day as provided by LDH
B. Performance Based Add-ons	$ 2.00	Two performance based measures with each measure having a maximum add-on of $1.00
C. Expected Performance Based Add-on Received During CY 2025	80.0%	Based upon guidance from LDH
D. Total Daily WAA Payment Rate	$ 41.76	D = A + (B * C)
E. Number of Days in CY 2025	365	
F. Average Wraparound Payments per Month	30.4	F = E / 12
G. Percentage Receiving Payment	90.0%	
H. CY 2025 WAA PMPM	$ 1,143.18	H = D * F * G

* Values are rounded

APPENDIX 7: CSOC RATE BUILD-UP

State of Louisiana
Department of Health
Coordinated System of Care (CSoC)
Calendar Year 2025 Capitation Rate Development
Appendix 7: CSoC Rate Build-Up

	CY 2025 Base Medical Expense	Family Service Organization (FSO)	Wraparound Agency (WAA)	CY 2025 Projected Medical Expense	Non-Benefit Expense Percentage	Premium Tax Percentage	CY 2025 Capitation Rate	Amended CY 2024 Capitation Rate	DBT State Directed Payment	CY 2025 Expected Payment PMPM	Amended CY 2024 Expected Payment PMPM	Expected Payment PMPM Change
	(a)	(b)	(c)	(d) = (a)+(b)+(c)	(e)	(f)	(g) = (d)/[1-(e)]/[1-(f)]	(h)	(i)	(j) = (g)+(i)	(k)	(L) = (j)-(k)
Statewide Rate	$ 569.97	$ 186.02	$ 1,143.18	**$ 1,899.17**	15.0%	5.5%	**$ 2,364.36**	**$ 2,241.75**	$ 6.22	**$ 2,370.58**	**$ 2,363.00**	**$ 7.57**

* Values are rounded

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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Special Provisions for SAMHSA Grant Funded Contracts

Funding Restrictions

Substance Abuse and Mental Health Services Administration (SAMHSA) grant funds must be used for purposes supported by the program and may not be used to:

- Purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 C.F.R. 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase, or distribution of marijuana).
- Pay for promotional items including, but not limited to, clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags (See 45 CFR 75.421(e)(3)).
- Exceed Salary Limitation: The Consolidated Appropriations Act, 2016 (Pub. L.113-76) signed into law on January 10, 2016, limits the salary amount that may be awarded and charged to SAMHSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary can be found in SAMHSA's standard terms and conditions for all awards at https://www.samhsa.gov/grants/grants-management/notice-award-noa/standard-terms-conditions. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub awards/subcontracts under a SAMHSA grant or cooperative agreement.
- Pay for any lease beyond the project period.
- Pay for the purchase or construction of any building or structure to house any part of the program. (Applicants may request up to $75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)
- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible.)
- Provide detoxification services unless it is part of the transition to MAT with extended release naltrexone.
- Make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services (See 42 U.S.C. § 1320a-7b).

  Note: A recipient or treatment or prevention provider may provide up to $30 non-cash incentive to individuals to participate in required data collection follow up. This amount may be paid for participation in each required follow up interview. For programs including contingency management as a component of the treatment program, clients many not receive contingencies totaling more than $75 per budget period. **The contingency amounts are subject to change.**
- Meals are generally unallowable unless they are an integral part of a conference grant or specifically stated as an allowable expense in the Notice of Funding Opportunity.
- General Provisions under Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act Public Law 116-260, Consolidated Appropriations Act, 2021, Division H, Title V, Section 527, notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug. Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with state and local law.

- Support non-evidence-based treatment approaches.
- By any agency which would deny any eligible client, patient or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine.) Specifically, patients must be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder. Similarly, medications available by prescription or office-based implantation must be permitted if it is appropriately authorized through prescription by a licensed prescriber or provider. In all cases, MAT must be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial. Grantees must assure that clients will not be compelled to no longer use MAT as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

Charitable Choice – *Only applies if contractor is a religious/faith-based organization*

SAMHSA's two Charitable Choice provisions [Sections 581-584 and Section 1955 of the public Health Service (PHS) Act, 42 USC 290k, et seq., and 42 USC 300x-65 et seq., respectively] allow religious organizations to provide SAMHSA-funded substance abuse services without impairing their religious character and without diminishing the religious freedom of those who receive their services. These provisions contain important protections both for religious organizations that receive SAMHSA funding and for the individuals who receive their services, and apply to religious organizations and to State and local governments that provide substance abuse prevention and treatment services under SAMHSA grants

If the Contractor is a religious organization, they will comply with the SAMHSA Charitable Choice statutes codified at sections 581-584 and 1955 of the Public Health Service Act (42

U.S.C. §§290kk, et seq., and 300x-65) and their governing regulations at 42 C.F.R. part 54 and 54a respectively.

- Religious organizations must ensure that their inherently religious activities, such as religious worship, instruction, or proselytization, are separate - in time or location - from the government-funded services that they offer and participation by clients must be voluntary.
- SAMHSA funds may not be expended for inherently religious activities, such as worship, religious instruction, or proselytization.
- Religious organizations can maintain their religious character and may use space in their facilities to provide government-funded services, without removing religious art, icons, scriptures, or other symbols.
- A religious organization that is a program participant shall not, in providing program services or engaging in outreach activities under applicable programs, discriminate against a client or prospective client on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.
- If a client or prospective client objects to the religious character of a program participant that is a religious organization, that participating religious organization shall, within a reasonable time after the date of such objection, refer such individual to an alternative provider.

OFFICE OF BEHAVIORAL HEALTH (OBH)
STANDARD PROVISIONS

1. Contractor grants to the Louisiana Department of Health (LDH) and its official designees the right to inspect the facilities in which services are being provided at all times, particularly with respect to its standards of operation, maintenance and compliance with State and Federal regulations and the terms of this contract.

2. Contractor shall establish and maintain an accounting system that contains complete and accurate records that will justify and document all expenditures, reflect all accruals, and provide a clear audit trail to the point of origin. All funds received in the furtherance of this contract, whether fees, state, federal, private or inkind contributions, shall be accounted for in the same manner and according to generally accepted accounting principles.

   Failure to establish and retain adequate documentation will result in disallowance of expenditures and represent a contractual breach.

   Contractor further agrees that in the event that more than one program is operated by Contractor, the funds provided in this contract will be expended only to provide the services described herein to eligible participants. Under no circumstances are monies to be transferred from one program budget to another without contract amendment.

3. In order that costs be considered allowable under this contract, they must satisfy the following general requirements:

   a. They must be calculated using generally acceptable accounting principles, unless some other procedure is specified in federal regulation.

   b. They must be consistent with the contract outcomes established in the Statement of Work.

   c. They must be reasonable and necessary for the proper administration of this contract.

4. Contractor agrees that funds provided under this contract may not be used for:

   a. Costs that are prohibited by federal, state or local laws or regulations or by other provisions within this contract.

5. <u>This provision applies to cost reimbursement contracts only.</u> Contractor agrees to request reimbursement of expenses incurred in performance of this contract only after the Contractor has paid the expense. Further, should LDH determine the Contractor has not paid a reimbursable expense; LDH may withhold an amount equal to the unpaid expense from the reimbursable expenses until such time as LDH determines that payment has been made. In the event that payment has not been made by the end of the fiscal year, the Contractor will forfeit the disputed amount.

6. Contractor shall abide by the Drug Abuse Office and Treatment Act of 1972, as amended; the comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, et. seq., as amended, the Mental Health System Act, Title V: the Protection and Advocacy for Mental Ill Individuals Act of 1986, as amended; all other requirements of the U.S. Department of Health and Human Services; all applicable licensing standards and requirements; and requirements as enumerated in Title XVIII and Title XIX of the Social Security Act as applicable.

   Contractor further agrees to establish and abide by internal policies and procedures that adhere to Federal and State statutory requirements and to applicable regulatory and licensure standards for reporting and investigating allegations of abuse, neglect and exploitation, and where applicable, taking appropriate preventative and correction action.

7. Contractor agrees to develop and implement a drug-free workplace policy that meets the following minimum requirements:

   a. Contractor shall publish a statement notifying the Contractor's employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition;

   b. Contractor shall establish a drug-free awareness program to inform the Contractor's employees about (i) the dangers of drug abuse in the workplace; (ii) the Contractor's policy of maintaining a drug-free workplace; (iii) any available counseling, rehabilitation, and employee assistance programs; and (iv) the penalties that may be imposed upon employees for drug abuse violations;

   c. Contractor shall provide each of its employees with a copy of the written statement required in A., above, and secure a signed statement from each employee indicating that the employee will, as a

condition of employment, (i) abide by the terms of the statement; and (ii) notify the Contractor of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

d. Contractor shall notify OBH of any violations of the drug-free workplace policy.

8. In the preparation of any statements, press releases or printed documents describing the program provided under this contract, Contractor shall clearly acknowledge federal and/or state government funding received, and such credit will be given the same degree of prominence as any other sponsor, supporter or funding agency.

9. Contractor agrees to serve any clients that LDH refers to the Contractor whose needs meet the program's description of services.

10. Contractor agrees to permit the LDH open access to all information and data concerning the program, the program fiscal operations and the program participants. Contractor shall provide the LDH such information and data as the LDH may from time to time require or request, such information to be provided in the form and manner as may be prescribed by the LDH.

11. LDH may terminate this Contract immediately for actions or omissions of the Contractor that endanger client life, health and/or safety.

12. Contractor agrees to provide a monthly and an annual detailed written accounting of all in-kind contributions and all income generated by activities supported through funding from this contract, including payments received from clients or third parties, and to maintain records of the receipt and disposition of grant related income in the same manner as required for Federal funds received in support of the grant.

13. Contractor agrees that the Department of Health and Hospitals is entitled to and may pursue recoupment in the event of an overpayment resulting from an error in billing or as a result of an audit or monitoring reviews.

14. Contractor agrees that no funds, neither federal nor funds obtained through a cost reimbursement mechanism, may be utilized under the terms of this contract for renovation of real property.

15. Contractor agrees to secure and maintain current applicable licenses.

16. Contractor agrees that the Office of Behavioral Health is the payor of last resort.

17. Contractor shall abide by all monthly/quarterly data gathering and record keeping procedures necessary to determine the number of persons utilizing the services of the contract and other service-outcome related information as determined by the OBH designated program office.

18. Failure of the Contractor to specifically perform services required by this agreement will constitute cause for the Office of Behavioral Health to impose fiscal sanctions against the Contractor for such failure. Sanctions of up to $100.00 a day may be imposed against the Contractor by permanently withholding payment when a determination has been made by the Office of Behavioral Health that required services are not being provided.

19. Contractor shall maintain personnel policies and procedures including job descriptions and job qualifications to assure qualified staff are employed.

20. Contractor must comply with legal mandates related to the populations being served (e.g. background checks for staff in contact with children) as provided by the Louisiana Child Protection Act (RS 15:587.1).

21. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal program either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service Contractors whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the contractor certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. Contractor agrees that it will require that the language of this certification be included

in any sub-contracts which contain provisions for children's services and that all sub-contracts shall certify accordingly.

22. The standard provisions specific to cost reimbursement method of payment contracts are as follows:

    In order to be reimbursed for expenses incurred in the delivery of services, the contractor must follow the procedures outlined below:

    a. Submit an invoice to the Office of Behavioral Health contract office, Attention designated contract monitor, as specified on face sheet of contract (item #14)

    b. Maintain documentation of proof of purchase and payment of expenses incurred prior to the billing invoice submitted to OBH. (If pre-payment prior to receipt of services such as registration for conference is necessary, prior approval from OBH contract monitor must be granted.)

    c. Comply with all applicable state and federal laws regarding audit requirements and records retention.

    d. Comply with contractor's published policies on time and attendance.

§ 96.135 Restrictions on the Expenditure of the Grant

1. The contractor does not expend SAPT Block Grant funds to provide inpatient hospital substance abuse services, except in cases when each of the following conditions is met:

    a. The individual cannot be effectively treated in a community-based, non-hospital, residential contractor
    b. The daily rate of payment provided to the hospital for providing the services does not exceed the comparable daily rate provided by a community-based, nonhospital, residential treatment contractor
    c. A physician makes a determination that the following conditions have been met:
        i. The primary diagnosis of the individual is substance abuse and the physician certifies that fact
        ii. The individual cannot be safely treated in a community-based, nonhospital, residential treatment contractor
        iii. The service can reasonably be expected to improve the person's condition or level of functioning
        iv. The hospital-based substance abuse contractor follows national standards of substance abuse professional practice
    d. The service is provided only to the extent that it is medically necessary (e.g., only for those days that the patient cannot be safely treated in a residential, community-based program)

2. The contractor does not expend SAPT Block Grant funds to purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment.

3. The contractor does not expend SAPT Block Grant funds to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

4. The contractor does not expend SAPT Block Grant funds to provide financial assistance to any entity other than a public or nonprofit private entity.

5. The contractor does not expend SAPT Block Grant funds to make payments to intended recipients of health services.

6. The contractor does not expend SAPT Block Grant funds to provide individuals with hypodermic needles or syringes.

7. The contractor does not expend SAPT Block Grant funds to provide treatment services in penal or correctional institutions of the State.

Attachment 5

PO#2000950646

CF-1 ADDENDUM

The following language shall supplement the language contained in the CF-1:

TERMINATION FOR NONAPPROPRIATION OF FUNDS.
When funds are not appropriated or otherwise made available to support continuation of performance in the following fiscal year of a multiyear contract for professional or consulting services, the contract for the remaining term shall be canceled, and the Contractor shall be reimbursed in accordance with the terms of the Contract for the reasonable value of any non-recurring costs incurred but not amortized in the price of the services being delivered pursuant to the Contract. The cost of cancellation may be paid from appropriations made specifically for the payment of such cancellation costs or unobligated funds of the using agency.

With respect to all multiyear contracts for professional services and consulting services pursuant to this Subsection, there shall be no provisions for penalty to the state for cancellation or early payment of the Contract.

PROHIBITION OF COMPANIES THAT DISCRIMINATE AGAINST FIREARM AND AMMUNITION INDUSTRIES.
In accordance with LSA R.S. 39:1602.2, the following applies to any competitive sealed bids, competitive sealed proposals, or contract(s) with a value of $100,000.00 or more involving a for-profit company with at least fifty full-time employees:

Unless otherwise exempted by law, by submitting a response to this solicitation or entering into this Contract, the Bidder, Proposer or Contractor certifies the following:

1. The company does not have a practice, policy guidance or directive that discriminates against a firearm entity or firearm trade association based solely on the entity's or association's status as a firearm entity or firearm trade association.

2. The company will not discriminate against a firearm entity or firearm trade association during the term of the Contract based solely on the entity's or association's status as a firearm entity or firearm trade association.

The State reserves the right to reject the response of the Bidder, Proposer or Contractor if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response or if the certification is no longer true.

MINUTES OF A JOINT MEETING
OF THE BOARDS OF DIRECTORS/MANAGERS
OF

Magellan Life Insurance Company
a Delaware corporation ("MLIC")

Magellan Behavioral Health of New Jersey, LLC
a New Jersey limited liability company ("MBHNJ")

and

Magellan Complete Care of Louisiana, Inc.
a Louisiana corporation ("MCCLA")

Magellan Behavioral Health of Pennsylvania, Inc.
a Pennsylvania corporation ("MBHPA")

Magellan Complete Care of Pennsylvania, Inc.
a Pennsylvania corporation ("MCCPA")

(individually, each is referred to herein as the "Company", as applicable)

April 30, 2024

A joint meeting of the board of directors/managers of each Company (each referred to herein as the "**Board**", as applicable) was held telephonically on April 30, 2024, commencing at 12:30 p.m. Eastern Time. Those who participated could hear and be heard throughout the meeting.

The members of the Board in attendance were:

[redacted]

The following individuals from the Company and/or its affiliates also attended all or a portion of the meeting at the invitation of the Board as indicated in these minutes:

[redacted]

Call to Order

[redacted] declared that a quorum was present for each Company. [redacted] called the meeting to order, and [redacted] acted as secretary and kept the minutes of the meeting.

Statement of Actuarial Opinion

[redacted] invited [redacted] to present the Actuarial Memorandums and Statements of Actuarial Opinion for MLIC and MCCLA and [redacted] to present the Actuarial Memorandum and Statement of Actuarial Opinion for MBHPA. [redacted] and [redacted] reviewed the materials that had been distributed to the Board members in advance of the meeting and summarized the results for the Company.

Adoption of Resolutions

[redacted] then reviewed the resolutions proposed for adoption at the meeting. After discussion, upon motion duly made and seconded, the Board unanimously approved the resolutions attached herein.

Quality Improvement Committee Report

[redacted] and [redacted] presented the MBHPA and MCCLA quality reports, including a review of the materials that had been distributed to the Board members in advance of the meeting. [redacted] provided the PA update of the Q4 2023 achievements and directions and [redacted] presented the LA CSoC update of the Q4 2023 achievements and directions.

Compliance Report – MBHPA AND MCCLA

[redacted] presented the Compliance Update for MBHPA, including a review of the materials distributed to the Board members in advance of the meeting. [redacted] provided an executive summary and summarized the oversight audits. [redacted] then presented the policy and procedures, reviewed privacy/confidentiality, and provided regulatory notes. Questions were asked and discussions ensued.

[redacted] presented the Compliance Update for MCCLA, including a review of the materials distributed to the Board members in advance of the meeting. [redacted] provided an executive summary and summarized the oversight audits. [redacted] then presented the policy and procedures, reviewed privacy/confidentiality, and provided regulatory notes. Questions were asked and discussions ensued.

Operations Update

[redacted] provided a report on the Company's financials, including a review of the materials that had been distributed to the Board members in advance of the meeting. [redacted] reviewed the financial materials relating to the fourth quarter of 2023 and discussed items from the Company's financial statements for the year ended December 31, 2023.

Adjournment

There being no further business to be discussed, upon motion duly made and seconded, the meeting was adjourned.

[redacted]

[redacted] Acting Secretary

Magellan Life Insurance Company,
a Delaware corporation ("MLIC")

Magellan Behavioral Health of New Jersey, LLC,
a New Jersey limited liability company ("MBHNJ"); and

Magellan Complete Care of Louisiana, Inc.,
a Louisiana corporation ("MCCLA")

Magellan Behavioral Health of Pennsylvania, Inc.,
a Pennsylvania corporation ("MBHPA")

Magellan Complete Care of Pennsylvania, Inc.,
a Pennsylvania corporation ("MCCPA")

(each is a "Company" and collectively, the "Companies")

April 30, 2024

Resolutions Proposed for Adoption

1) Approval of Minutes of Prior Meeting

RESOLVED, that, the following minutes of meeting of the Board of Directors of the Company (the **"Board"**) in the form provided and reviewed by the Board and attached hereto as **Exhibit A**, be, and hereby are, approved:

Magellan Life Insurance Company	December 12, 2023
Magellan Complete Care of Louisiana, Inc.	December 12, 2023
Magellan Complete Care of Pennsylvania, Inc.	December 12, 2023
Magellan Behavioral Health of New Jersey, LLC	December 12, 2023
Magellan Behavioral Health of Pennsylvania, Inc.	December 12, 2023

2) Appointment of Officers

RESOLVED, that, the following individuals (each a **"Proper Officer"** and collectively, the **"Proper Officers"**) are appointed or re-appointed, as applicable to the corporate office(s) of the Company indicated opposite their respective name, to serve for the term provided in the Company's bylaws or operating agreement until the earlier of their respective death, resignation, or removal from office.

Magellan Life Insurance Company

Name	Officer Title
[redacted]	President
[redacted]	Vice President
[redacted]	Assistant Treasurer
[redacted]	Secretary
[redacted]	Assistant Secretary
[redacted]	Assistant Secretary

Magellan Complete Care of Louisiana, Inc.

Name	Officer Title
[redacted]	President
[redacted]	Secretary
[redacted]	Assistant Treasurer
[redacted]	Assistant Secretary
[redacted]	Assistant Secretary

Magellan Complete Care of Pennsylvania, Inc.

Name	Officer Title
[redacted]	President
[redacted]	Secretary
[redacted]	Assistant Treasurer
[redacted]	Assistant Secretary
[redacted]	Assistant Secretary

Magellan Behavioral Health of New Jersey, LLC

Name	Officer Title
[redacted]	President
[redacted]	Secretary
[redacted]	Assistant Treasurer
[redacted]	Assistant Secretary
[redacted]	Assistant Secretary

Magellan Behavioral Health of Pennsylvania, Inc.

Name	Officer Title
[redacted]	Chief Executive Officer
[redacted]	President
[redacted]	Assistant Treasurer
[redacted]	Secretary
[redacted]	Assistant Secretary
[redacted]	Assistant Secretary

RESOLVED, FURTHER, that, any individual not named as a Proper Officer who may have been previously appointed as an officer of the Company, is hereby removed as an officer of the Company; and

RESOLVER, FURTHER, that, any individual who in the future is designated as a Proper Officer shall be deemed to be a Proper Officer hereunder.

3) Signature Authority for Certain Tax Matters

WHEREAS, the Board desires and deems it in the best interest of the Company to authorize Tricia Dinkelman, Regional Vice President, Tax of Centene, to execute and deliver any state, local, and federal tax filings, reports, correspondence, audit responses, appeals and any documents and instruments in writing of whatsoever nature related thereto to governmental agencies for and incidental to, the lawful operations of the business of the Company.

NOW, THEREFORE, BE IT RESOLVED, that, [redacted] be and hereby is authorized, directed, and empowered, for and on behalf of the Company, to execute and deliver any state, local, and federal tax filings, reports, correspondence, audit responses, appeals, and any documents and instruments in writing of whatsoever nature related thereto to governmental agencies for and incidental to, the lawful operations of the business of the Company.

4) Signature Authority for Certain Filings

RESOLVED, that, for the purpose of authorizing the Company to do business in any city, municipality, county, state, territory or dependency of the United States or foreign country in which it is necessary or expedient for the Company to transact business, including the Company's state of incorporation and any jurisdiction where the Company may be qualified as a foreign corporation, or licensed as a health maintenance organization, if applicable, the Board hereby delegates and authorizes

signature authority to the following individuals in connection with any licenses, filings, reports related thereto, and the authorization of related expenditures up to the amounts as is listed next to their respective name:

Name	**Expense Limitation**
[redacted]	Up to $2,000
[redacted]	Up to $2,000

RESOLVED, FURTHER, that, any other individual not named above who is or may have been previously authorized with signature authority for certain filings, is hereby removed from having signature authority for certain filings.

5) Approval of Delegation of Investments

WHEREAS, the Board desires and deems it in the best interest of the Company to authorize each of the Chairman, President and Chief Executive Officer and the Executive Vice President, Chief Financial Officer of Centene Corporation (**"Centene"**) to implement the Centene Investment Policy (the **"Investment Policy"**); and

WHEREAS, the Board desires and deems it in the best interest of the Company to authorize each of the Corporate Senior Vice President, Treasurer, Corporate Controller and Chief Accounting Officer, the Corporate Vice President, Assistant Treasurer and the Corporate Director, Treasury of Centene to direct the purchase, sale and safekeeping of securities within the Policy.

NOW, THEREFORE, BE IT RESOLVED, that, in connection with investing the Company's assets, each of the Chairman, President and Chief Executive Officer and Executive Vice President, Chief Financial Officer of Centene are hereby authorized in their sole discretion to implement the Investment Policy; provided, however, that such investments comply with the Insurance Code and/or other regulatory rules, regulations and restrictions; and

RESOLVED, FURTHER, that, each of the Corporate Senior Vice President, Treasurer, Corporate Controller and Chief Accounting Officer, the Corporate Vice President, Assistant Treasurer and the Corporate Director, Treasury of Centene are hereby authorized to direct the purchase, sale and safekeeping of securities within the Investment Policy.

6) Approval of Code of Conduct

WHEREAS, the Board has approved Magellan Health, Inc.'s Code of Conduct (the **"Code of Conduct"**) and deems it to be in the best interest of the Company to adopt the Code of Conduct.

NOW, THEREFORE, BE IT RESOLVED, that, the Code of Conduct, in substantially the form reviewed by the Board and attached hereto as **Exhibit B**, shall be, and hereby is, adopted and approved; and

RESOLVED, FURTHER, that, the Chief Compliance Officer of Magellan Health, Inc. be, and hereby is, authorized and directed to implement, on an ongoing basis, any and all policies and procedures, and to take such other actions, as may be necessary or appropriate to allow the Company to comply with the Code of Conduct, the Company's compliance programs and applicable laws, rules and regulations.

7) Approval of Quarterly Investments

WHEREAS, the Board has approved the Investment Policy and authorized the Chairman, President and Chief Executive Officer and the Executive Vice President, Chief Financial Officer of Centene or their respective designee the authority to make investment decisions for the Company's assets provided such investments comply with the Investment Policy; and

WHEREAS, the Chairman, President and Chief Executive Officer and the Executive Vice President, Chief Financial Officer of Centene have provided the investment transactions for the fourth quarter of 2023 to the Board and have confirmed that the investments comply with Investment Policy.

NOW, THEREFORE, BE IT RESOLVED, that, pursuant to the following Insurance Codes, the Company's investment transactions, completed during the fourth quarter of 2023, in the forms provided to the Board and attached hereto as **Exhibit C**, be, and hereby are, approved;

New Jersey Insurance Code §17B:20-2;
Pennsylvania Insurance Code §653(b);
Louisiana Insurance Code §592;
Delaware Insurance Code §141(f);

and;

RESOLVED, FURTHER, that, the Board has determined that the investments made comply with the Investment Policy.

8) Appointment of Independent Registered Public Accounting Firm

RESOLVED, that, the appointment of KPMG LLP to serve as the Company's independent registered public accounting firm for fiscal year 2024 contingent on approval of Centene management, shall be, and hereby is, authorized, ratified, confirmed and approved in all respects.

9) Designation of Independent Audit Committee

RESOLVED, that, the Audit Committee of the Board of Directors of Centene be, and hereby is, designated to serve as the independent audit committee of each Company for purposes of compliance with the Model Audit Rule of the National Association of Insurance Commissioners.

10) Approval of 2023 Actuarial Statements

WHEREAS, the Actuarial Statements (consisting of the Actuarial Memorandum and Opinion) for MLIC, MCCLA, and MBHPA were submitted for approval by the Board for the year ending December 31, 2023;

WHEREAS, the Board affirmed that the Company's 2023 Actuarial Memorandum conforms to applicable standards, including, without limitation, ASOP No. 41, Actuarial Communications, as further clarified in the NAIC Health Reserve Guidance Manual (the Health Actuarial Memorandum Practice Note); and

WHEREAS, the Company's appointed Actuary is available for discussion if the Board should have any questions.

NOW, THEREFORE, BE IT RESOLVED, that, the Company's 2023 Actuarial Statements, in the form provided to the Board and attached hereto as Exhibit D, be, and hereby are, approved and adopted.

11) General Authorizing Resolutions

RESOLVED, that, any of the Proper Officers or any one or more of them, be and they hereby are authorized, directed, and empowered, for and on behalf of the Company, to do all other acts, take all actions and to execute and deliver all applications, contracts, leases and other deeds and documents or instruments in writing of whatsoever nature that may be required in the ordinary course of the business of the Company and that may be necessary to secure for operation of the corporate affairs, governmental permits and licenses for, and incidental to, the lawful operations of the business of the Company, and to do such acts and things as such Proper Officers deem necessary or advisable to fulfill such legal requirements as are applicable to the Company and its business;

RESOLVED, FURTHER, that, the fiscal year of the Company shall end on December 31 of each year;

RESOLVED, FURTHER, that, the Board does hereby authorize and approve the Proper Officers and the individuals in each of the following offices, or acting in such capacities, of Centene (collectively, the **"Authorized Banking Agents"**), as the authorized signatories on all bank, investment and other financial accounts of the Company and any other such accounts hereinafter opened by the Company:

- [redacted], CEO, Centene Corporation
- [redacted] EVP and CFO, Centene Corporation
- [redacted], EVP, Secretary and General Counsel, Centene Corporation
- [redacted] SVP, Corporate Controller and CAO, Centene Corporation
- [redacted], SVP and Treasurer, Centene Corporation
- [redacted] VP and Assistant Treasurer, Centene Corporation
- [redacted] Director, Treasury, Centene Corporation
- [redacted], Vice President, Controller, Magellan Health, Inc.

a) to designate one or more banks or similar financial institutions as depositories of the funds of the Company;
b) to open, maintain, and close general and special accounts with any such depositories;
c) to cause to be deposited, from time to time, in such accounts with any such depository, such funds of the Company as such officer deems necessary or advisable, and to designate or change the designation of the officer or officers or agent or agents of the Company authorized to make such deposits and to endorse checks, drafts, and other instruments for deposit;
d) to designate, change, or revoke, the designation, from time to time of the officer or officers or agent or agents of the Company authorized to sign or countersign checks, drafts, or other orders for the payment of money issued in the name of the Company against any funds deposited in any of such accounts;
e) to authorize the use of facsimile signatures for the signing or countersigning of checks, drafts, or other orders for the payment of money, and to enter into such agreements as banks and similar financial institutions customarily require as a condition for permitting the use of facsimile signatures;
f) to make such general and special rules and regulations with respect to such accounts as they may deem necessary or advisable and to complete, execute, and certify any customary printed blank signature card forms in order to exercise conveniently the authority granted by this resolution (and any resolutions printed on such cards are deemed adopted as a part of this resolution); and
g) to execute applications for letters of credit and/or amendments thereto, in such amounts and on such terms and conditions as such Authorized Banking Agent, in its sole discretion, may determine to be appropriate, to secure the Company's obligations under such agreements by granting pledges and security interests in
any property belonging to the Company, and to waive discrepancies in any documents required to be presented thereunder.

RESOLVED, FURTHER, that, any other individual not named above who may have been previously approved as an authorized signatory to sign documents relating to the Company's bank accounts, is hereby removed as an authorized signatory;

RESOLVED, FURTHER, that, immediately following the approval of the Authorized Banking Agents as indicated above, the authorized signatories relating to the Company's bank accounts and letters of credit shall consist of Authorized Banking Agents or any one or more of them;

RESOLVED, FURTHER, that, for the purpose of authorizing the Company to do business in any state, territory or dependency of the United States or foreign country in which it is necessary or expedient

for the Company to transact business, including the Company's state of incorporation and any jurisdiction where the Company may be qualified as a foreign corporation, if applicable, the Proper Officers are hereby authorized to appoint and substitute all necessary agents or attorneys for service of process, and to designate and change the location of all necessary certificates, reports, powers of attorney and other instruments as may be required by the law of such state, territory, dependency or country to authorize the Company to transact business therein, and whenever it is expedient for the Company to cease doing business therein, and withdraw therefrom, to revoke any appointment of agent or attorney for service of process, and to file such certificates, reports, revocations of appointment, or surrender of authority of the Company to do business in any such state, territory, dependency or country;

RESOLVED, FURTHER, that, if in connection with the foregoing resolutions, any particular form of resolution shall be required, such form resolution shall be deemed hereby adopted, and that the Secretary of the Company be, and hereby is, authorized to certify such form resolution as having been adopted by the Board at this meeting and that the Secretary be, and hereby is, directed to insert a copy of any such form resolutions in the minute book immediately following these resolutions; and

RESOLVED, FURTHER, that, the Proper Officers and each of them acting singly are hereby authorized, empowered and directed to do all other acts, take all actions and to execute and deliver, in the name and on behalf of the Company, such further agreements, instruments, documents, certificates and filings, with such changes in the terms and provisions thereof as the Proper Officers, executing the same may determine necessary or appropriate, and to do and perform such other acts and deeds as they or any of them determine necessary or appropriate, in order to effectuate the purposes and intent of the foregoing resolutions.

12) <u>General Ratification</u>

RESOLVED, that, the Proper Officers and each of them acting singly are hereby authorized, empowered and directed to do all other acts, take all actions and to execute and deliver, in the name and on behalf of the Company, such further agreements, instruments, documents, certificates and filings, with such changes in the terms and provisions thereof as the Proper Officer executing the same may determine necessary or appropriate, and to do and perform such other acts and deeds as they or any of them determine necessary or appropriate, in order to effectuate the purposes and intent of the foregoing resolutions (such determination to be conclusively, but not exclusively, evidenced by the taking of such actions or the execution, delivery and filing of such agreements, instruments, reports, documents or corporate or other notices by such officer or officers); and

RESOLVED, FURTHER, that, any and all actions previously taken or caused to be taken by the Proper Officers or any one of them, in connection with any of the matters contemplated by any of the foregoing resolutions, are hereby acknowledged to be duly authorized acts and deeds performed on behalf of the Company and are hereby ratified, confirmed and adopted as such.

Exhibit B Job Descrip ions 2000950646--
MAGELLAN COMPLETE CARE OF LA INC

Current Name	Maae lan itle	Business itle	Scope	ob Description	Additional LA CSoC Contract Duties / Details	Additional Responsibilities	Work Experience Experience Level	Work Experience vpe	Education Education	Education Required	Oual fications Oualification
[redacted]	Comp iance Off cer I	Program Integrity Compl ance Officer	Oversees the implementation and ongoing operat on of the Compliance Program. Develops, imp ements and annually updates a formal written comp iance program, and educates the management team and s aff about comp iance and the appropriate deta ls of the comp iance program. Assists in prepara ion of regula ory filings and reports to regulatory agencies. Serves as a l aison or customers on legal and regula ory issues. Ensures corrective ac ions are implemented for all known compliance defic encies. Serves as Company lia son with State regulators. Meets with state regulators as necessary and serves as their point of contact for a l company and its a fil ate s ssues. Main ains exper ise related to authorizat on and non-	Serves as compliance and privacy o ficer. Oversees legal and regulatory compl ance and contract compl ance for all State business, including Medicaid and commercial business. Prov de consultat on as necessary to Compl ance Officers w th regard to S ate compliance issues.	Training and experience in health care or risk management. The PI Compliance Of icer shall be point of contact for the Magel an on ssues related to fraud, waste, abuse, and overpayment issues. The PI Comp iance Off cer will oversee monitoring and en orcement of the Fraud, Waste, and Abuse compliance program to prevent and detect potential fraud, waste, and abuse activities pursuant to state and Federal ru es and regulat ons. The PI Compliance O ficer wi l have the responsibil ty for and carry out the prov sions of the compliance program and p an including fraud, waste, and abuse po icies and procedures, investigate unusual incidents, and implement any corrective act on plans. Th s pos tion, as a management official, shall have the authority to assess records and independently refer suspected member fraud, provider fraud, and member abuse cases to LDH and other duly author zed enforcement agencies. The PI Compliance Officer shall answer directly to the Chief Executive Office of the Mage lan s operations and the Board of Directors. The PI Compliance Of icer s a so responsible for the fol owing: Developing and implemen ing written policies, procedures, and standards to ensure comp iance with the requirements of a l app icable Federal and state requirements; Maintaining compliance with 2 CFR § 38.608; and Collaborating with the LDH Fraud and Abuse program, Medica d Fraud Control Unit (MFCU), and the Louisiana Attorney General s Office.				Mas er's		
[redacted]	Comp iance Manager	Contract Manager	If app icable, oversees the implementation and ongoing operat on of the Compliance Program for the ass gned SBU(s). If app icable, develops and annually updates a formal written comp iance program or the assigned Care Management Center and educates staff about comp iance and the appropriate deta ls of the comp iance program. Directs federal and state regula ory and compliance activities. Custom zes corpora e policies where necessary to address state regulatory s andards and or contractual requirements and, where applicab e and works with corporate comp iance on any customizat ons that are required due to state regula ory standards. Serves as a l aison or customers on legal and regula ory issues.	Serves as the comp iance and privacy manager for assigned areas of the company or an SBU as app icable. Assists with regu atory and contract compl ance for business managed by the Care Center or suppor ed by corporate compl ance. Responsible for the implementation of or support of the SBU and/or Corpora e Compliance Program, Hea th Insurance Portability and Accountabi ity Act (H PAA) compl ance, including audits and the preparation for state and customer audits.	Serve as the primary point-of-contact for all Contract compliance issues, qual fied by know edge, training, and experience in hea th care or risk management. These primary functions may include but are not l imited to coordina ing the tracking and submiss on of a l Contract deliverables; f elding and coordinating responses to LDH inquiries, coordinating the prepara ion and execution of Contract requiremen s, random and per od c audits, and ad hoc visits. The Contract Manager or Contract Compl ance Coordinator shal have access to all persons employed under the Contract. The Contract Manager or Contract Comp iance Coordinator sha l have experience and expert se in operating a managed care compliance program and shall report directly to the CSoC Program Director. The Contract Manager or Contract Comp iance Coordinator is also responsib e for the fo lowing: 2.2.6.6.1.Ensuring that the Magellan's ob iga ions under the erms of the Contract are met; Overseeing, adminis ering, and implementing the Magel an s Compliance Program; Overseeing all audits related to the Contract; Ensuring Magellan comp iance with policies and procedures; and Ensuring tracking and timely c osure of compl ance actions, including corrective action plans (CAPs) arising from the Contract		5 years	Healthcare	Bachelor's	Yes	Knowledge of HIPAA, ederal and state regu atory processes. Med care Advantage and/or Medicaid managed care experience preferred but not required. Strong interpersonal, organizational, and project management sk lls. Ability to research, obtain, coordinate, and integrate eedback and direct ons from diverse operational groups and organizat ons into a written product. Excellent verbal and written communication skil s. 5-8 years compl ance related exper ence. Exper ence and thorough understanding of Microsoft Off ce, flow char ing and other relevant software systems and appl ca ions.
[redacted]	Dir, Call Center Operat ons, Federal	Member Services Administrator	Directs the 2 /7/365 call center operations or service delivery to mil tary and federal government a fil ated el gib e participants. Services avai ab e v a internet, telephone (toll free number and collect ca ls), e ectronic mail (ema l), postal mail, video counse ing, secure real-time messaging (cha), art ficial intell gence (A) chatbox, and face to face counse ing upon request. Ensures appropriate s affing to meet contractual requiremen s and risk m tigation for reducing s affing gaps. Superv ses managers responsible for de ivery of operat ons conducted by a large volume of staff. Provides strategic oversight for training, professional development, quality and opera ional	Direc s the call center staffed by a large volume of emp oyees providing 2 7 information and referral services. Participants many include service members and their families, federal government emp oyees and el gib e benef ciaries. Direc s serv ces of triaging for stated and unstated needs and prov ding support that is appropriate and effective. Serves as a member of the leadership project management team ensuring service delivery and contract de iverab e execution.	coordina e commun cat ons between the Magellan and i s members. There shall be sufficient Member Services Staff o enable members to receive prompt resolution of their problems or inquiries and appropriate education about participa ion in the CSoC program. Th s posi ion shall work closely with the Grievance System and those den ified staff. The Member Service Administrator sha l be responsible for the ca l center operations. The Member Services Admin strator sha l have signif cant exper ence and exper ise in member serv ces and grievance resolut on, in compliance with Federal and state laws and the requirements in this Contract, including all documents incorpora ed by reference.		5 years	Supervisory	Bachelor's - Mental Health Services	Yes	Masters preferred. Licensed behavioral health clinic an at the independent evel preferred.

DIR, CL N CAL CARE SERVICES	Dir, Clinical Care Serv ces	CSoC Clinical Director	Directs, coordinates and evaluates e ficiency and produc iv ty of u ilizat on management func ions. Works closely with SBU and vendors to assure integration, overs ght, and e fic ency of u ilizat on management and appeals processes and for delegated functions. In collabora ion w th the national clinical eam, assures that all uti ization management-re ated activities meet the s andards required for the s ate contract and NCQA. Leads and organizes the ongoing evaluat on of the u ilizat on management program against quality and u ilizat on benchmarks and targets. Ident fies opportunit es or improvement; organ zes and manages cost of care initiatives. Collabora es with local and nat onal leaders including Qual ty Improvement, Analytics, Finance, Network, and	Maintains accountability or medical management functions to ach eve the business and clinical ou comes for the health plan, meeting contract requirements, National Comm ttee of Quality Assurance (NCQA) accred tat on standards, and supporting init atives w th prov ders and members to manage cost of care. Oversees uti ization management and cri eria-based reviews of care, c in cal appeals regarding med cal necessity, and the interac ion w th claims payment policies and processes. Also oversees the health plans 2 /7 Nurse Line program and the clinical management of crisis ca ls. Depending on SBU/product supported, supports goals, contracts, and accred tat on requirements of hea th plan in conducting rev ews of clinical interact ons and	Meet the requirements for a Licensed Mental Health Professional (LMHP) and should have at least seven (7) years of exper ence and exper ise in the special behavioral health needs of chi dren with severe behavioral health cha lenges and their famil es. Prior knowledge and experience working in wraparound and system of care practice, as we l as other child serving sys ems, is required, including OBH approved Introduction to Wraparound and Coaching trainings. The ideal candidate will have at least three (3) years of experience with delivering or managing Evidence-Based Practices (EBPs) and best practices for chi dren and youth, including experience w thin system of care and wraparound environments. The CSoC Clinical Director sha l work closely with the CSoC Governance Board, LDH, and the WAAs to ensure a statewide program that mee s the goals and values of the CSoC in compliance with Federal and state laws and the requirements set forth in the Contract, including a l documents incorpora ed by re erence. The CSoC Clinical Director shall be responsible or resolving clinical care delivery ssues. The CSoC C in cal Direc or shall be responsible for: Monitoring Prior Authorization (PA) funct ons and ensuring that decis ons are made in a consistent manner based on c inical criteria and meet timeliness standards; Mon toring, analyzing and imp ementing appropriate interventions based on uti ization data, including ident fying and correcting over or under uti ization of services; Participa ing in all activit es related o Louisiana Medicaid CSoC eligibil ty in relat on to the Mage lan; Possessing a thorough unders anding of Louisiana Medicaid CSoC Eligibil ty policies; Ho ding responsibi ity for having a team who can research Lou siana Med ca d issues that arise and provide deta ls to support findings; Fully reconciling CSoC eligibil ty data between the Magellan and the Integra ed Med ca d Managed Care Program plans at the direction of LDH; Training and monitoring WAAs to ensure compliance w th Wraparound best prac ices, waiver requirements, and Contract requirements; Participa ing in QI activit es, including data co lection, tracking, and analysis; Prov ding in ormation to members and prov ders regarding mental hea th and substance abuse bene its, community treatment resources, managed care programs, and pol cies and procedures; Ensuring that approp ate concurrent review and discharge p anning of inpa ient stays is conducted; and Overseeing the Care Management Program	7 years	C inical	Mas er's - Behav oral Health	Yes	
[redacted]	Dir, Finance	Finance Direc or	Analyzes current and past trends in key performance indicators including all areas of revenue, cost of care, expenses and cap tal expenditures. Crea es pipe ine - faci itates the pr orit za ion and quali ication of financially-viable opportunit es. Oversees administrative expense management process for assigned SBU. Supports underwr ting e forts and financial aspects of proposals for RFPs. Supports SBU leader in oversight and management of the financial affairs for a l s ate contracts. Prov des market analysis; builds knowledge of various programs/models, state prioritizat on iers, etc. Oversees Mage lan?s management of the annual independent audits, ensuring that the inal independent audit repor s are in compliance with Es abl shes overall direct on and plan and working processes between Network Management and Network Administrat on sta f, including creden ialing, communicat on (prov der services line, etters, website, etc), database integr ty and maintenance, regular reports, and ra e loading. Develops and implements a Network strategy to assure long term mutually successful phys cian, practi ioner and facil ty and organizat on prov der re ationships. Directs all prov der (physic an, prac itioner and organizat ons) recruitment activities. Provides supervis on, deve opment and mentoring of the Field Network Management Department in meeting objectives and functions. Manages financ al goa s (e.g., control care cost	Guides financial decisions by es abl shing, monitoring and en orcing policies and procedures. Prov des status of inancial condition of the company and/or SBU by co lecting, interpre ing and repor ing key financial data. Ensures comp iance w th ederal, state and local legal requirements by researching existing and new egisla ion, consulting w th outside advisers, and filing inanc al reports. Adv ses management of ac ions and poten ial risks. Arranges for audits as required and approp ate. Manages budget and controls expenses effectively. Oversees administrative expense management process for assigned SBU.	Cert fied Pub ic Accountant with exper ence and demonstrated success in managed behavioral hea thcare responsible for e fective implemen ation and oversight of the budget, accounting systems, and all inanc al and inancial reporting operat ons of the Magellan in comp iance with Federal and State laws and the requirements set orth in this Contract, including a l documen s incorporated by reference. The Finance Director shall be a full time pos tion devoted to the CSoC Program, un ess otherwise approved by OBH, to ensure comp iance w th Contract requirements	5 years	Management/Leadership	Bachelor's - Finance	Yes	Minimum of 8 years of hea thcare or comparable profess onal exper ence with at least 5 years of management experience. Customer serv ce ocused with excellent analytical sk lls, interpersonal ski ls and execu ive presence required. Ability to ba ance multiple projects and adapt to new ssues/assignments as business needs change; comfortable with ambiguity. Strateg c mindset. This role may require direct contract negotiations of inanc al terms w th external c ien s. Demonstrated abl ty o influence, negotia e and have a sa es perspective are key requirements for success in this role.
[redacted]	Dir, Network Management	Provider Network Direc or	Responsible for the strateg c and tactical direction of all activ ties for an assigned region(s) related o deve oping and maintaining the physic an, practitioner, facility and organization services de ivery system. Position is responsible for developing and implementing a plan that meets the customer requirements w thin budget. Assures access to a network of serv ces that supports member access and that the Care Management Cen ers (CMCs) are within cost of care plans.	Coordinate communications between the Magel an and ts network providers. The Provider Network Director must have expert se in network development and recruitment and is responsible for ensuring network adequacy, access and appointment availabil ty, development of network resources in response to unmet needs, and adequacy of the prov der network o provide member choice of prov ders, and contracting with qualif ed serv ce prov ders in compliance with Federal and state laws and the requirements in the Contract, including all documents incorporated by reference. To the extent possible, Mage lan shall develop and maintain a provider network inclusive of behav oral hea th providers participating in the Integrated Medicaid Managed Care Program P ans. The Provider Network Director shall have exper ence and exper ise in the development of provider behavioral hea th serv ces for ch ldren and youth involved in mu tip e serv ces systems (ch ld we fare, juven le justice and behavioral health and in or at r sk of out-of-home placement). This posit on sha l oversee all credentialing and contracting funct ons and s aff o ensure imely correspondence, co lection and successful credent aling and re-credentialing of providers. Th s pos tion will also ensure timely and accurate contracting of providers, prompt response to provider questions on credentialing, LDH certi ication and licensing requirements, and Mage lan contracting and correct on of documen ation, f needed, in order to not delay the ava lability of services. The Prov der Network Director staff shall prov de LDH staff w th upda es on individual prov ders' creden ialing status upon request. The Prov der Network Director sha l be responsible for: Educating in-network and out-of-network providers (i e., profess onal and institutiona) regarding approp ate claims subm ss on requirements, coding updates, e ectronic c aims transact ons and electronic fund transfer, System of Care values, and the provider s ro e in the Coordina ed System of Care, as we l as avai able Magellan resources such as provider manuals, webs tes, fee schedules, etc.; Interfacing w th the Magellan's ca l cen er to compi e, analyze, and d sseminate informa ion from prov der cal s; dentifying trends and guiding the development and implementation of stra egies to improve provider satis act on; Frequently communicating (i.e , elephonic and on-s te) with providers to ensure the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate c aims submission practices and fraud, waste and abuse ssues; Ensuring timely in er-provider referra s and assoc ated appointment access, and assisting in resolving provider complaints, d spu es between providers, and the invest gat on of member grievances regarding prov ders; coordinating provider si e vis ts; imp ementing and moni oring CAPs; and ensuring the accuracy of prov der serv ce delivery reports (e.g., encounter information verificat on); and Provider education, in-service training and orientation	2 years	Management/Leadership	Bachelor's	Yes	- 8 years of progressively more responsible health care administrat on experience (inance/contract administration, physician/provider relat ons) with strong preference for managed care experience. - 3 years experience in a eadership ro e.- Broad-scoped financ al expertise, with financial modeling experience.
[redacted]	Dir, Qua ity	Quality & Outcomes Director	Directs and supervises proactively the qua ity department and projects to meet unit goa s or the quality program, including the monitoring cost e fec iveness, pol cies, procedures, activ ties, to meet mul iple contractual requiremen s, external accredita ion, and state and federal regulat ons. Ensures that quality improvement stud es and activities are conducted with appropria e feedback from customer organizat ons, ass gned departments, and member and provider input. In consulta ion w th ass gned business un t leadership, sets priori ies for improving operat ons based on data from performance indicators, delegation audits, and quality improvement processes. Serves as lia son with department managers to ensure that needs are met	Responsible for all aspects of the qua ity program for a business un t within a Strategic Business Un t (SBU) including strategic planning, program development and leadership, and staffing. Serves as a member of the management team in designing, imp ementing, and monitoring qual ty operations with well defined processes and uses performance measurement as the founda ion for qual ty and process improvements. Responsible for performance measurements and analytics, cus omer repor ing, cl ent delegat on ac iv ties, policies and procedures, qua ity of care concerns tracking, accred tat on preparation, coordination of sa is act on surveys, performance guarantee tracking, integrat on of qual ty improvement processes	Licensed Mental Health Professional (LMHP). This position is responsible for the development of the Magel an s QAPI and Uti ization Management (UM) Plan and its effective imp ementa ion in col aboration with the Medical Director and the CSoC Program Director, and comp iance w th Federal and state aws and the requirements in the Contract, including all documents incorporated by reference. The Qua ity and Outcomes Director shall be responsible for implementat on of the Qual ty Program as speci ied in 2 CFR § 38.330 and as required by LDH. The Qua ity and Outcomes Director sha l have signif cant exper ence and expertise in the oversight of ef ective Quality Improvement (QI) for pub ic sector programs and managed behavioral hea thcare delivery systems. The Quality and Outcomes Director shall be responsib e for the fol owing: Ensuring individual and systemic qua ity of care, including grievances; Integra ing qua ity throughout the organ za ion; Implementing process improvement; Resolving, tracking and trending quality of care grievances; Developing and implemen ing a QAPI plan in collabora ion w th the Ch ef Med cal Direc or (CMD); Moni oring, analyzing and imp ementing approp ate interventions based on uti ization data and gr evance investigation outcomes, including ident fying and correcting over or under ut ilization of services; Focusing organ za ional efforts on improving clinical qua ity performance measures; Developing and implemen ing performance improvement projects and CAPs; Util zing data to deve op intervent on stra egies to improve outcomes; Repor ing QI/performance outcomes; Managing and adjud ca ing the Grievance System which includes prov der complaints and member gr evances (including any expressions of dissatisfac ion), appeals, and requests for hearings in comp iance w th Federal and s ate laws and the requirements in the Contract, including all documents incorporated by reference; Tracking, rev ewing, and investigating cri ical incidents and other qual ty of care ssues (e.g., seclusion/restraint, accidents, etc.), including rev ewing performance measures; Measuring treatment outcomes; Ensuring imely access to care; Advocating for member rights within the organization, ensuring grievance and appeal trends are reported to and addressed within the Quality Assessment and Performance Improvement (QAPI) comm ttee; Implementing, measuring, and reporting on performance and reporting requiremen s; and Imp ementing a ide ity mon toring sys em o ensure the core e ements of the wraparound faci itat on are maintained in accordance o the standards of prac ice es abl shed by the Nat onal Wraparound In tiative (NW).	7 years	Healthcare	Mas er's - Hea thcare		

[redacted]	Financial Analyst I	Finance Analyst	Depending on spec fic area suppor ed, duties may vary. Analyzes complex financ al information and reports; provides accurate and timely financial recommendations to management for decis on making purposes. Develops sophist ca ed financial models. Provides recommendations based upon evalua ion of financial trends and forecasts. Evaluates and monitors the e fic ency and performance of programs, ensuring program execu ion is on target. Manages dashboard reporting by tracking monthly, quar erly and annual revenue and expenses. Obtains a thorough understanding of operating infrastructure of Strategic Business Unit(s) (SBUs) operat ons to be able o proactively analyze and ident fy opportun ties for	Primary responsibili ies include analyzing cos s, preparing financ al reports and providing recommendations to leadership or lines of business according to es abl shed policies, gu delines and methodologies. Prepare journal entr es and analyses in conjunct on w th month end c ose process and meet monthly deadlines.	A full- ime position reporting to the Finance Director responsible or per orming financial analys s, developing projection and financial reports and billing in compliance w th Federal and s ate laws and the requirements set forth in this Contract, including a l documents incorporated by reference					Bachelor's - Finance	Yes	1 year Big publ c accounting experience.
[redacted]	Healthplan Care Coordinat on Lia son	Managed Care Organization L aison	Oversees the day to day processes in place for care coordinat on requirements with Managed Care Organ za ions (MCOs) as defined by customer. Moni ors and evalua es data with MCOs on a regular and ongoing basis to drive the h ghest level of performance around referral, triage and coordinat on pract ces. Col aborates with MCOs in order to establ sh processes and procedures in an effort to achieve a seamless system among a l providers and/or vendors providing services to members identi led as having acute care needs. Facil tates meetings in which care coordination issues are presented. Recommends practice adjustments, po icy and procedure revisions, training and support in an e fort to provide continuous improvement to care coordinat on and access to	This posit on s responsible for the coordina ion w th Managed Care Organizat ons (MCO) in order to deve op joint goals around the re erral and care coordination of care to ensure that transit ons in care is coordinated, effective and safe for members. This pos tion w ll be a lia son between Magel an s clin cal teams and MCO primary points of contact and will be responsible for the development, refinement and mainteinance of protoco s and processes between Magellan and the MCOs. This position is responsible for the coordination of services necessary in order to comply with customer and Magel an clinical access standards and, under the superv sion of the Medical Direc or, commun cates Magel an policy to the MCOs. This position partners with ident fied	Have knowledge and experience of Magellan administrative func ions and requiremen s. The MCO L aison w ll be responsible for the interface w th a l Integrated Medicaid Managed Care Program Plans on a day-to-day basis regarding joint in tia ives and projects, shared members, issues related to trans tion in and out of CSoC, and other issues that arise. This position sha l work closely with the care management eam on member specific issues	2 years	Managed Healthcare	Bachelor's	Yes	Excellent organ za ion, time management and verbal and wri ten communication sk lls. Ability to v ew problems and issues from mu tip e perspectives. Strong co laboration and interpersonal skills. Knowledge of organizational policies and system-w de procedures. Strong working knowledge MS Office suite. 3 years' experience working with Managed Care Organ zat ons is required. Exper ence working w th care coordination processes a must. Exper ence establishing, negotia ing and ac ilitating col aborative re ationships.
[redacted]	Medical Director	CSoC Med cal Director	Provides clin cal leadership to the interdisciplinary Medical Management team, which includes c in cal/medical oversight of clinical team members and consultation and training with care managers in order to address cost and qua ity of care. Provides day to day physic an oversight to an ass gned in erdisciplinary UM eam, including regu ar involvement in the case management of at-risk cases and medical necess ty dec sions. Fo lows high risk cases throughout treatment continuum from inpat ent, rehabi lita ion, part al hosp tal za ion, outpat ent and other evels of care. Ensures that persons with severe, comp ex, and/or treatment resistant i lnesses receive med ca ly necessary coordina ed care throughout the episode of treatment. Con inues physician	This posit on supports the clinical vision for the hea th plan(s) for all lines of business (Medicaid, Medicare, and Commercial) and implements programs to support this v sion. May serve multiple health plans managed by the Clin cal Center of Excellence.	A physician with a current, unencumbered Louisiana-l cense as a physic an, board-cert fied in chi d psychiatry w th at east three (3) years of training in a medical specialty. The Medical Director shall devote suff cient time to the Magellan's operations as evidenced by imely med cal decisions, including a ter- hours consu tat on as needed. The Med cal Director must consu t with an Addictionologist as needed. This posit on shall have the responsib lity for effective implementation of the Qual ty Management (QM) program and the UM of serv ces and associated appeals as these funct ons relate o children and youth enrol ed in CSoC. The Medical Director shall share responsib lity for the management of the behavioral health services delivery system, including the 2 -hour behavioral health cr sis ine, with the CSoC Clinical Director, and shall be actively involved in all major clinical and qual ty management components of the behavioral health serv ces of the Magellan. The CSoC Medical Director shall be responsible for the following: Maintairing medical policies and procedures including, but not im ted to, serv ce authorizat on, claims review, discharge p anning, creden ialing, and med cal review included in the Magellan Grievance System; The dec sion making process or approval and denial of provider credentialing; Admin stra ion of all med cal management activi ies of the Magellan; At endance at LDH business reviews, qual ty meetings, des gna ed medical director meetings, including linkage with the Integrated Medicaid Managed Care Program Magellan/Med cal Directors for primary care; Overs ght of a l medical management activ ties including addict on services of the Magellan; Serving as co-chair of the UM comm tee and as chair or co-chair of the Qua ity Assessment and Performance Improvement (QAPI) comm ttee; Ensuring adoption and consis ent app ication of appropriate inpatient and outpatient medical necessity cr teria; and Providing consultation on member treatment plans/p ans of care as requested. However, to maintain consis ency with Wraparound practices, the Medical Director shall not mandate serv ces on the plan			MD	Yes	
[redacted]	Mgr, IT Business Operat ons	Informat on Technology Manager	Plan, ead, or support department stra egic and tactical meetings, including joint meetings with other teams. Assists with department financial planning and management; helps manage the department s budgets and d scretionary expenses. Facil tates, manages, and executes formal continuous improvement efforts. Con inuously evaluates the e fic ency of procedures within the department and recommends or implements improvements consistent with organizat onal objectives. Conduc s structured performance measurements to assess the organizat on delivers ongoing value to ensure a ignment between business por fol o and business need. Meets with leaders and users and analyzes metrics to ensure effective working	This posit on wi l ensure execution of operational ac iv ties to maintain and continuously improve business management capabi ities o support al gnment with department strateg es. Leads business management processes in partnership with respective process owners (strategic and operational planning, repor ing, financial management). Continuously evaluates the eff ciency of procedures w thin the department and recommends or implements improvements that are cons stent with organizational objectives. Responsible for aligning the portfolio of IT investments with the needs of the business, and ensures the consolidated portfolio and overall technology organizat on de ivers ongoing value through structured performance	Be trained and experienced in informat on systems, data processing, and data reporting to oversee all Mage lan information systems func ions including, but not limited to, estabi shing and maintaining connectivity with LDH information systems, sending and receiving encounters to and from the State's Medicaid F scal Intermed ary (FI) and prov ding necessary and timely reports to LDH. The Information Technology Manager shall have s gni icant experience and expertise in managed care data systems and wi l: Support the timely, accurate, and complete submission of encounter data o LDH; and Meet LDH encounter reporting requiremen s			Bachelor's - Computer and Information Sc ence	Yes	

[redacted]	VP, General Manager I	CSoC Program Director	Leads operations for a Care Management Center (CMC), Health P an, Program, or Product to ensure operational success and comp iance in meeting c in cal, quality, customer, business financial, and employee targets and objectives. May partner with account managers to achieve a h gh degree of customer service. Ensures cost effective approach to processes and deliverab es for assigned business unit, program or product.	Manages financial performance, operating budget and variances from plan to ensure cost effective delivery of service. Responsible or development and implementation of annual operating budget. Oversees compl ance to all operations performance standards. Deve ops and ac ivates action plans o bring back in comp iance when standards are not met. Responsible for developing and ful illing service level agreement with Account Management. Creates and manages high-performing cross-functional, matrixed team, ensuring s aff prov de appropria e and e fic ent services. Continually monitors services and programs to ensure that cl ent needs and contract ob igat ons are being met in accordance w th policies and procedures.	be full time (0 hours weekly) and available during LDH working hours to fulfi l the responsibili ies of the pos tion and o oversee all aspects of the CSoC Program. The CSoC Program Director should devote sufficient time to the Magellan's operations to ensure adherence to program requirements and timely responses to LDH. The CSoC Program Director shall have at least en (10) years' exper ence with management of behav oral health services of organ za ions sim lar in s ze and scope to the requiremen s of th s Contract. Th s posi ion is also responsible for: Serves as a primary point-of-contact for all Magellan opera ional ssues that may include but are not limited to coordina ing the tracking and submiss on of a l Contract deliverables; f elding and coordinating responses to LDH inquiries; coordinating the prepara ion and execution of Contract requiremen s, random and per od c audits and ad hoc visits and de iverables. Manages and oversees the Magel an s emergency management p an during disasters and ensures continuity of care benefi s and serv ces for members who may need to be evacuated to other areas of the state or out-of-state. Upon prior approval of LDH, these responsibil ties may be performed through a consultation contract, be part-time (minimum hours per week to be approved by LDH) or be combined w th another key staff pos tion. Provides overs ght and co laboration with Claims Processing Team to ensure c aims processing imelines are met; ensure accuracy and appropriateness of claims payments and encounters; research and resolve ssues related to denied or improperly paid claims.	10 Years	Management/Leadership	Mas er's

Oualification Required
Yes

Yes

Yes

Yes

Exhibit C
PO# 2000950646

Louisiana Professional Counselors Board of Examiners

Proof of Licensure

Name: [redacted]

Profession: Licensed Professional Counselor

Address: [redacted]

License Status: Active

Louisiana State Board of Medical Examiners

Exhibit C
PO# 2000950646

License Verification

Licensee Information

Name	Public Address
[redacted]	Magellan Health, 8550 United Plaza Blvd. Suite 410 Baton Rouge, LA 70809

Credential Information

Credential Number	Practitioner Type	Current Status	Discipline Status	Issue Date	Expiration Date	Reinstatement Date
[redacted]	PHYSICIAN & SURGEON - MD	Active	None	[redacted]	[redacted]	
[redacted]	INTERNSHIP REGISTRATION	Inactive	None	[redacted]	[redacted]	

Specialities

Speciality 1	Speciality 2	Speciality 3	Speciality 4
Psychiatry	Child & Adolescent Psychiatry		

Discipline History

If Discipline Status is Conditional, Limited, Probation, Reprimanded, Revoked, Suspended, Past Disciplinary Action or Voluntary Surrender of License, a Board issued order can be found on our Disciplinary Actions page

Credential Number	Discipline Status	Public Document

Supervisees

First Name	Last Name	License Number	Approved Date	Type

Supervisors

First Name	Last Name	License Number	Approved Date	Type

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