

State of Louisiana
DEPARTMENT OF HEALTH AND HOSPITALS

REQUEST FOR PROPOSALS

DENTAL BENEFIT MANAGEMENT PROGRAM

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

RFP # 305PUR-DHHRFP-DENTAL-PAHP-MVA

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Glossary

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 healthcare. It also includes member practices that result in unnecessary cost to the Medicaid program.

Action - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by DHH), and the failure of the DBPM to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR 438.400(b); and in a rural area with only one DBPM, the denial of a member's right to obtain services outside the provider network, as described in 438.52(b)(2)(ii).

Actuarially Sound PMPM rates - PMPM rates that (1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered, and the services to be furnished under the Contract; and (3) have been certified, as meeting the requirements of this definition, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Adjudicate - To deny or pay a clean claim.

Adjustments to Smooth Data - Adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

Administrative Services - The performance of services or functions, other than the direct delivery of core dental benefits and services, necessary for the management of the delivery of and payment for core dental benefits and services, including but not limited to network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems operation, and reporting.

Advance Directive - A written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of healthcare when the individual is incapacitated.

Adverse Action - Any decision by the DBPM to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested In accordance with 42 CFR 438.214(c).

Adverse Determination An admission, availability of care, continued stay or other healthcare service that has been reviewed by the DBPM and based upon the information provided, does not meet the DBPM's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed or terminated.

Affiliate - Any individual or entity that meets any of the following criteria:

1. owns or holds more than a five percent (five percent) interest in the DBPM (either directly, or through one (1) or more intermediaries); means any individual or entity that meets any of the following criteria:
2. in which the DBPM owns or holds more than a five percent (five percent) interest (either directly, or through one (1) or more intermediaries);

3. any parent entity or subsidiary entity of the DBPM regardless of the organizational structure of the entity;
4. any entity that has a common parent with the DBPM (either directly, or through one (1) or more intermediaries);
5. any entity that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the DBPM; or
6. any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

Agent - An entity that contracts with DHH to perform administrative functions, including but not limited to fiscal intermediary activities, outreach, eligibility, and enrollment activities, systems and technical support, etc.

Allied professional – Allied health professionals are health care practitioners with formal education and clinical training who are credentialed through certification, registration and/or licensure. They collaborate with physicians and other members of the health care team to deliver high quality patient care services for the identification, prevention, and treatment of diseases, disabilities and disorders.

American Dental Association (ADA) – The American Dental Association is the professional association of dentists that works to advance the dental profession on the national, state, and local levels.

Americans with Disabilities Act of 1990 (ADA) – The Americans with Disabilities act 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 action.

Appeal Procedure - A formal process whereby a member has the right to contest an adverse determination/action rendered by the DBPM, which results in the denial, reduction, suspension, termination or delay of healthcare benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Benefits or Covered Services - Those healthcare services to which an eligible Medicaid recipient is entitled under Louisiana Medicaid State Plan.

Bureau of Health Services Financing (BHSE) - The agency within the Louisiana Department of Health & Hospitals, Office of Management & Finance that has been designated as Louisiana's single state Medicaid agency to administer the Medicaid and CHIP programs.

Business Continuity Plan (BCP) - means a plan that provides for a quick and smooth restoration of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

Business Day - Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m. , unless the context clearly indicates otherwise.

CDT® - Current Dental Terminology - A code set with descriptive terms developed and updated by the American Dental Association (ADA) for reporting dental services and procedures to dental benefits plans. DHHS designated the CDT code set as the national terminology for reporting dental services.

CMS 1500 - Universal professional health insurance claim form in the U.S. Previously known as the HCFA-1500 claim form.

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.

Calendar Days - All seven (7) days of the week. Unless otherwise specified, the term “days” in the Contract refers to calendar days.

Can - Denotes a preference but not a mandatory requirement.

Capitation - A contractual agreement through which the DBPM agrees to provide specified core health benefits and services to members for a fixed amount per month.

Capitation Payment - A payment, fixed in advance, that DHH/BHSF makes to the DBPM for each member covered under the Contract for the provision of core health benefits and services and assigned to the DBPM. This payment is made regardless of whether the member receives core dental benefits and services during the period covered by the payment.

Capitation Rate - The fixed monthly amount that the DBPM is prepaid by DHH/BHSF for each member assigned to the DBPM to ensure that core dental benefits and services under this Contract are provided.

Claim – 1) A bill for services; 2) a line item of service; or 3) all services for one recipient within a bill.

Clean Claim – A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state’s claims system. 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.

Community Norms – Services and accessibility to services that members are accustomed to in their geographic area.

Complaint – Anything that is unsatisfactory or unacceptable.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – A standardized survey of members’ experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).

Contract– The written agreement between DHH/BHSF and the DBPM; comprised of the RFP, Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Dispute - A circumstance whereby the DBPM and DHH/BHSF or the DBPM and their subcontractor are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under their contract.

Convicted – A judgment of conviction entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.

Contract Term – The period for which the Contract is written.

Coordination of Benefits (COB) - Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for healthcare services.

Copayment - Any cost sharing payment for which the Medicaid DBPM member is responsible, in accordance with 42 CFR 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.

Core dental benefits and Services - A schedule of healthcare benefits and services required to be provided by the DBPM to Medicaid members as specified under the terms and conditions of this RFP and Contract and the Louisiana Medicaid State Plan.

Corrective Action Plan (CAP) - A plan developed by the DBPM that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframe necessary to address and resolve the deficiency.

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.

Covered Services - Those healthcare services/benefits to which an individual eligible for Medicaid or CHIP is entitled under the Louisiana Medicaid State Plan.

DBP Systems Companion Guide -A supplement to the Contract that outlines the formatting and reporting requirements concerning encounter data, interfaces between the FI and the DBPM and enrollment broker and the DBPM.

Deliverable - A document, manual or report submitted to DHH/BHSF by the DBPM to fulfill requirements of this Contract.

Denied Claim - A claim for which no payment is made to the network provider by the DBPM for any of several reasons, including but not limited to, the claim is for non-covered services, an ineligible provider or recipient, or is a duplicate of another transaction, or has failed to pass a significant requirement in the claims processing system.

Dental Director - The licensed dentist designated by the DBPM to exercise general supervision over the provision of core dental benefits and services by the DBPM.

Department (DHH) - The Louisiana Department of Health and Hospitals, referred to as DHH throughout this RFP.

Disenrollment - The removal of a member from participation in the DBPM's plan, but not necessarily from the Medicaid or LaCHIP Program.

Documented Attempt - A bona fide, or good faith, attempt, in writing, by the DBPM to contract with a provider, made on or after the date the DBPM signs the Contract with DHH/BHSF. Such attempts may include written correspondence that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within 10 calendar days, the potential network provider rejects the request or fails to respond either verbally or in writing, the DBPM may consider the request for inclusion in the DBPM's network denied by the provider. This shall constitute one attempt.

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 the age of 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 (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of “medical assistance”.

Electronic Health Records (EHR) - A computer-based record containing healthcare information. This technology, when fully developed, meets provider needs for real-time data access and evaluation in medical care. Implementation of EMR increases the potential for more efficient care, speedier communication among providers and management of DBPM.

Eligibility Determination - The process by which an individual may be determined eligible for the Medicaid or Medicaid-expansion CHIP program.

Eligible - An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act.

Emergency Dental Condition - A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissue; or unusual swelling of the face or gums.

Emergency Dental Services - Those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

Encounter - A distinct set of healthcare services provided to a Medicaid member enrolled with the DBPM on the dates that the services were delivered.

Encounter Data - Healthcare encounter data include: (i) All data captured during the course of a single healthcare encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter; (ii) The identification of the member receiving and the provider(s) delivering the healthcare services during the single encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single encounter.

Encounter Data Adjustment - Adjustments to encounter data that are allowable under the Medicaid Management Information System (MMIS) for HCFA 1500, UB 92, and NCPDP version 3.2 claim forms as specified in the DBP Systems Companion Guide.

Enrollee - Louisiana Medicaid or CHIP recipient who is currently enrolled in the DBP.

Enrollment - The process conducted by the DBPM by which an eligible Medicaid recipient becomes a member.

Excluded Services - Those services which members may obtain under the Louisiana Medicaid State Plan and for which the DBPM is not financially responsible.

Expanded Services - A covered service provided by the DBPM which is currently a non-covered service(s) in the Medicaid State Plan or is an additional Medicaid covered service furnished by the DBPM to Medicaid DBP members for which the DBPM receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in the RFP.

Experimental Procedure/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 relatively weak or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

Federal Financial Participation (FFP) – This is also known as federal match; 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.

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 and may 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.

FFS Provider - An institution, facility, agency, person, corporation, partnership, or association approved by DHH/BHSF which accepts payment in full for providing benefits, with the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Fiscal Intermediary (FI) - DHH's designee or agent responsible for an array of administrative support services including MMIS system development and maintenance, claims processing, pharmacy support services, provider enrollment and support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.

Fiscal Year (FY) – Budget year - Federal Fiscal Year (FFY): October 1 through September 30; State Fiscal Year (SFY): July 1 through June 30.

Fraud – As relates to Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him 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.

Full time – 40 hours per week.

GEO Coding – Refers to the process in which implicit geographic data is converted into explicit or map-form images.

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 (postal codes). With geographic coordinates the features can be mapped and entered into Geographic Information Systems, or the coordinates can be embedded into media.

Grievance – An expression of enrollee/provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and 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 Process – The process for addressing grievances.

Grievance System – A grievance process, an appeal process, and access to the State Fair Hearing system. Any grievance system requirements apply to all three components of the grievance system not just the grievance process.

HIPAA Privacy Rule (45 CFR Parts 160 & 164) – Federal standards for the privacy of individually identifiable health information.

HIPAA Security Rule (45 CFR Parts 160 & 164) – Section of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must 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.

Healthcare Professional - A physician or other healthcare practitioner licensed, accredited or certified to perform specified health services consistent with state law. “Other healthcare practitioner” includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Healthcare Provider - An individual or an institution that provides preventive, curative, or rehabilitative healthcare services in a systematic way.

Healthcare Effectiveness Data and Information Set (HEDIS) - A set of performance measures developed by the National Committee for Quality Assurance (NCQA) designed to help healthcare purchasers understand the value of healthcare purchases and measure plan (e.g. DBPM) performance.

Historical Provider Relationship - The provider who has been the main source of Medicaid services for the member during the previous year determined through identification of the provider (primary care dentist or dental specialist) in the previous 12 months with whom the member had the most visits).

ICD-9-CM codes – International Classification of Diseases, 9th Revision, Clinical Modification codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria. The DBPM shall move to ICD-10-CM as it becomes effective.

ICD-10-CM codes - International Classification of Diseases, 10th Revision, Clinical Modification codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria.

Immediate – In an instant; instantly or without delay, but not more than 24 hours.

Information Systems (IS) - A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Information Systems Capabilities Assessment (ISCA) – a process to specify the desired capabilities of the DBPM’s information system and to pose standard questions to be used to assess the strength of the DBPM with respect to these capabilities. The process will determine the extent to which the DBPM can

produce valid encounter data, performances measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its enrollees.

Laboratory and X-ray Services – Professional and technical laboratory and radiological services that are ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law or ordered by a physician but provided by referral laboratory; provided in an office or similar facility other than a hospital outpatient or clinic; and furnished by a laboratory that meets the requirements of 42 CFR 493.

Louisiana Department of Health and Hospitals (DHH) – The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.

Louisiana Medicaid State Plan – The binding written agreement between Louisiana’s Department of Health and Hospital through DHH/BHSF and CMS which describes how the Medicaid program is administered and determines the services for which DHH/BHSF will receive federal financial participation.

Major Subcontract - Any contract, subcontract, or agreement between the DBPM and another entity that meets any of the following criteria:

- the other entity is an affiliate of the DBPM;
- the subcontract is considered by DHH to be for a key type of service or function, including:
 - o administrative services (including but not limited to third party administrator, network administration, and claims processing);
 - o delegated networks (including but not limited to vision)
 - o management services (including management agreements with parent)
 - o reinsurance;
 - o call lines (including dental consultation); or
 - o Any other subcontract that is, or is reasonably expected to be, more than \$100,000 per year. Any subcontracts between the DBPM and a single entity that are split into separate agreements (e.g. by time period) will be consolidated for the purpose of this definition.

For the purposes of this RFP, major subcontracts do not include contracts with any non-affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware.

Mass Media - A method of public advertising that can create DBPM name recognition among a large number of Medicaid recipients and can assist in educating them about potential healthcare choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters, and video in doctor's office waiting rooms.

Material Change - Material changes are changes affecting the delivery of care or services provided under this RFP. Material changes include, but are not limited to, changes in composition of the provider network, subcontractor network, the DBPM’s complaint and grievance procedures; healthcare delivery systems, services, changes to expanded services; benefits; geographic service area; enrollment of a new population; procedures for obtaining access to or approval for healthcare services; any and all policies and procedures that required DHH/BHSF approval prior to implementation; and the DBPM’s capacity to meet minimum enrollment levels. DHH/BHSF 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 Amendment. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving covered individuals.

Medicaid Eligible - An individual determined eligible, pursuant to federal and state law, to receive medical care, goods and services for which DHH/BHSF may make payments under the Medicaid or CHIP Programs, who is enrolled in the Medicaid or CHIP Program, and on whose behalf payments may or may not have been made.

Medicaid Management Information System (MMIS) - Mechanized claims processing and information retrieval system which all states Medicaid programs are required to have and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Enrollees.

Medicaid Recipient - An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH/BHSF may make payments under the Medicaid or CHIP Program, who is or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.

Medical Information - Information about an enrollee's medical history or condition obtained directly or indirectly from a licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility.

Medical Record - A single complete record kept at the site of the member's treatment(s), which documents, medical or allied goods and services, including, but not limited to, outpatient and emergency medical healthcare services whether provided by the DBPM, its subcontractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis 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.

Medical Vendor Administration (MVA) - Name for the budget unit specified in the Louisiana state budget that contains the administrative component of the Bureau of Health Services Financing (Louisiana's single state Medicaid agency).

Medically Necessary Services - Those 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; and 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. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Dental Director, may consider authorizing services at his discretion on a case-by-case basis.

Medicare - The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of U.S. citizens 65 years of age and older and some people with disabilities under age 65.

Member – As it relates to the Louisiana Medicaid Program and this RFP, refers to a Medicaid or CHIP eligible who enrolls in the DBPM under the provisions of this RFP and also refers to “enrollee” as defined in 42 CFR 438.10(a).

Member Materials - All written materials produced or authorized by the DBPM and distributed to members or containing information concerning the DBP. Member materials include, but are not limited to, member ID cards, member handbooks, provider directories, and marketing materials.

Member Month – A month of coverage for a Medicaid eligible who is enrolled in the DBPM.

Methodology- The planned process, steps, activities or actions taken by the DBPM to achieve a goal or objective, or to progress toward a positive outcome.

Monetary Penalties – Monetary sanctions that may be assessed whenever the DBPM, its providers, and/or its subcontractors fail to achieve certain performance standards and other items defined in the RFP.

Monitoring - The process of observing, evaluating, analyzing and conducting follow-up activities.

Must – Denotes a mandatory requirement.

National Committee for Quality Assurance (NCQA) - A not-for-profit organization that performs quality-oriented accreditation reviews on health maintenance organizations and similar types of managed care plans. HEDIS and the Quality Compass are registered trademarks of NCQA.

National Response Framework - Part of the Federal Emergency Management Agency (FEMA), the National Response Framework presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies. The framework establishes a comprehensive, national, all-hazards approach to domestic incident response.

Network – As utilized in the RFP, “network” may be defined as a group of participating providers linked through provider agreements or contracts with the DBPM to supply a range of dental services. This is Also called a Provider Network.

Network Adequacy - A network of dental providers for the DBPM that is sufficient in numbers and types of providers and 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 and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations.

Non-Covered Services - Services not covered under the Title XIX Louisiana State Medicaid Plan.

Non-Emergency - a condition not requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

Operational Start Date - The first day on which the DBPM is responsible for providing core dental benefits and services to DBP members and all related Contract functions. The Operational Start Date applicable to this Contract is set forth in the Contract between DHH/BHSF and the DBPM.

Original Signature - denotes that a document must be signed in ink.

Out-of-Network (OON) Provider - An appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the DBPM for the delivery of covered services to the DBPM's members.

Ownership Interest - The possession of stock, equity in the capital, or any interest in the profits of the DBPM, for further definition see 42 CFR 455.101 (2005).

Per Member Per Month (PMPM) - The amount of money paid or received on a monthly basis for each individual enrolled in the DBPM.

Performance Improvement Projects (PIP) - Projects to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effect on health outcomes and member satisfaction.

Performance Measures - Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.

Personal Health Record (PHR) - A health record that is initiated and maintained by an individual.

Plan of Care - Strategies designed to guide healthcare professionals involved with patient care. Such plans are patient specific and are meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care.

PMPM Rate - The per-member, per-month rate paid to the DBPM by DHH/BHSF for the provision of medical services to DBP members.

Potential Enrollee - A Medicaid recipient who is subject to mandatory enrollment, but is not yet an enrollee of the DBPM.

Prepaid Ambulatory Health Plan (PAHP) - an entity contracting with the state that meets the definition contained in 42 CFR 438.2.

Preventive Care - Dental care-related procedures or treatments that are meant to preserve healthy teeth and gums and the prevent dental caries and oral disease.

Primary Dental Provider (PDP) - A provider of primary dental services.

Primary Dental Services - Dental services and laboratory services customarily furnished by or through a primary care dentist for evaluation, diagnosis, prevention, and treatment of diseases, disorders, or conditions of the oral cavity, maxillofacial areas, or the adjacent and associated structures through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.

Prior Authorization - The process of determining medical necessity for specific services before they are rendered.

Professional - A licensed expert and individual whom has specialized knowledge in a field which one is practicing professionally; i.e. dentists, doctors, etc.

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) 45 CFR Part 160 and 164.

Provider – Either (1) for the FFS program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the DBPM, any individual or entity that is engaged in the delivery of dental services and is legally authorized to do so by the state in which it delivers services.

Provider Appeal - The formal mechanism that allows a provider the right of appeal from a DBPM final decision.

Provider Complaint - A verbal or written expression by a provider which indicates dissatisfaction or dispute with DBPM policy, procedure, claims processing and/or payment, or any aspect of DBPM functions.

Provider Directory - A listing of dental service providers under contract with the DBPM that is prepared by the DBPM as a reference tool to assist members in locating providers that are available to provide services.

Provider Subcontract - An agreement between the DBPM and a provider of services to furnish core dental benefits and services to members, or with a marketing organization, or with any other organization or person who agrees to perform any administrative function or service for the DBPM specifically related to fulfilling the DBPM's obligations under the terms of this RFP.

Prudent Layperson – Person who possesses an average knowledge of health and medicine.

Qualified Medicare Beneficiary (QMB)Only - program for Medicaid payment only for Medicare Part A and/or B premiums, Medicare deductibles and Medicare co-insurance for Medicare covered services, not eligible for full Medicaid coverage, including dental benefits.

Quality – As it pertains to external quality review, the degree to which the DBPM increases the likelihood of desired health outcomes of its enrollees 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 (QAPI) Plan – A written plan, required of the DBPM, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve healthcare outcomes for enrollees.

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, medical record audits, performance measures, surveys, and related activities.

Quality Management (QM) – The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.

Readiness Review – Assessment prior to implementation of the DBPM's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of DBPM standards; and review of systems. The review may be done as a desk review, on-site review, or combination and may include interviews with pertinent personnel so that DHH/BHSF can make an informed assessment of the DBPM's ability and readiness to render services.

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.

Referral –dental services provided to the DBPM members when approved by the DBPM, including, but not limited to in-network specialty care and out-of-network services which are covered under the Louisiana Medicaid State Plan.

Reinsurance – Insurance the DBPM purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of members; also referred to as “stop loss” insurance coverage.

Relationship - A director, officer, or partner of the DBPM; a person with beneficial ownership of five percent or more of the DBPM’s equity; or a person with an employment, consulting or other arrangement (e.g., providers) with the DBPM obligations under its contract with the state.

Remittance Advice – An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the DBPM, payments for maternity, and adjustments.

Representative - Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.

Reprocessing (Claims) - Upon determination of the need to correct the outcome of one or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims.

Request for Proposals (RFP) – As relates to DBP, the process by which DHH/BHSF invites proposals from interested parties for the procurement of specified services.

Responsible Party – An individual who, often the head of household and who is authorized to make decisions and act on behalf of the Medicaid recipient. This is the same individual that completes and signs the Medicaid application on behalf of a covered individual, agreeing to the rights and responsibilities associated with Medicaid coverage.

Risk - The chance or possibility of loss. The member is at risk only for pharmacy copayments as allowed in the Medicaid State Plan and the cost of non-covered services.

Routine Dental Care – A well care (non-acute) dental visit for preventive services (e.g. screening, cleaning, check-up, evaluation) or follow up to a previously treated condition and any other routine visit for other than the treatment of a dental illness/condition (e.g. sick care).

Rural Area – Any parish that meets the Office of Management and Budget definition of rural. (See Appendix BB for map of Louisiana Rural Parishes).

Rural Health Clinic (RHC) – A clinic located in an area that has a healthcare provider shortage and is certified to receive special Medicare and Medicaid reimbursement. RHCs provide primary healthcare and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services. RHCs must be reimbursed by the DBPM using prospective payment system (PPS) methodology.

Second Opinion - Subsequent to an initial medical opinion, an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

Secure File Transfer Protocol (SFTP) – Software protocol for transferring data files from one computer to another with added encryption.

Service Area – The 64 parishes within the State of Louisiana.

Service Authorization – A utilization management activity that includes pre-, concurrent, or post review of a service by a qualified health professional to authorize, partially deny, or deny the payment of a service, including a service requested by the DBPM member. Service authorization activities consistently apply review criteria.

Shall - Denotes a mandatory requirement.

Should - Denotes a preference but not a mandatory requirement.

Significant – As utilized in this RFP, except where specifically defined, shall mean important in effect or meaning.

Significant Traditional Provider (STP) - Those Medicaid enrolled providers that provided the top eighty percent (80%) of Medicaid services for the DBP-eligible population in the base year of 2013.

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 the DBPM where assets exceed liabilities and timely payment requirements can be met.

Span of Control – Information systems and telecommunications capabilities that the DBPM itself operates or for which it is otherwise legally responsible according to the terms and conditions with DHH/BHSF. The span of control also includes systems and telecommunications capabilities outsourced by the DBPM.

Specialty Dental Services - A dentist whose practice is limited to a particular branch of dentistry or oral surgery, including one who, by virtue of advanced training is certified by a specialty board as being qualified to so limit his practice.

State - The state of Louisiana.

State Plan –Louisiana Medicaid State Plan as approved by CMS.

Stratification - The process of partitioning data into distinct or non-overlapping groups.

Subcontractor - A person, agency or organization with which the DBPM has subcontracted or delegated some of its management functions or other contractual responsibilities to provide covered services to its members.

Subsidiary - An affiliate controlled by such person or entity directly or indirectly through one or more intermediaries.

System Function Response Time - Based on the specific sub function being performed:

- Record Search Time-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.

- **Record Retrieval Time**-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor.
- **Print Initiation Time**- the elapsed time from the command to print a screen or report until it appears in the appropriate queue.
- **On-line Claims Adjudication Response Time**- the elapsed time from the receipt of the transaction by the DBPM from the provider and/or switch vendor until the DBPM hands-off a response to the provider and/or switch vendor.

System Unavailability – Measured within the DBPM’s information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the “enter” or other function key.

TTY/TTD – Telephone Typewriter and Telecommunication Device for the Deaf, which allows for interpreter capability for deaf callers.

Third Party Liability (TPL) - 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.

Timely – Existing or taking place within the designated period; within the time required by statute or rules and regulations, contract terms, or policy requirements.

Title XIX – Section of the Social Security Act of 1935, as amended, that encompasses and governs the Medicaid Program.

Title XXI - Section of the Social Security Act of 1935, as amended, that encompasses and governs the Children’s Health Insurance Program (CHIP).

Transition Phase - All activities the DBPM is required to perform between the Contract effective date and the implementation date.

Turnover Phase – All activities the DBPM is required to perform in conjunction with the end of the Contract.

Turnover Plan - Written plan developed by the DBPM, approved by DHH, to be employed during the turnover phase.

Urban - Densely developed territory that encompasses residential, commercial, and other non-residential land uses.

Urgent Care - Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

Utilization - The rate patterns of service usage or types of service occurring within a specified time.

Utilization Management (UM) – The process to evaluate the medical necessity, appropriateness, and efficiency of the use of dental services, procedures, and facilities. UM is inclusive of utilization review and service authorization.

Utilization Review (UR) - Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of core dental benefits and services, procedures or settings, and ambulatory review, prospective review, second opinions, care management, discharge planning, or retrospective review.

Validation – The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Virtual Private Network – A network that extends a private network across a public network such as the Internet.

Waiting Time(s) – Time spent both in the lobby and in the examination room prior to being seen by a provider.

Waiver - Medicaid Section 1915(c) Home and Community Based Services (HCBS) programs which in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Adult Day Healthcare (ADHC), Community Choices, Supports Waiver, Residential Options Waiver (ROW), and any other 1915(c) waiver that may be implemented.

Week - The seven-day week, Monday through Sunday.

Will - Denotes a mandatory requirement.

Willful – Conscious or intentional but not necessarily malicious act.

I. GENERAL INFORMATION

A. Background

1. The mission of the Department of Health and Hospitals (DHH) is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. The Department of Health and Hospitals is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner.
2. DHH is comprised of program offices, including the Bureau of Health Services Financing (BHSF) (Medicaid), Office for Citizens with Developmental Disabilities (OCDD), Office of Behavioral Health (OBH), Office of Aging and Adult Services (OAAS), and the Office of Public Health (OPH). Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to DHH.

DHH, in addition to encompassing the program offices, has an administrative office known as the Office of the Secretary, a financial office known as the Office of Management and Finance, and various bureaus and boards. The Office of the Secretary is responsible for establishing policy and administering operations, programs, and affairs.

3. Louisiana intends to transition the provision of state-approved dental services for eligible Medicaid enrollees through a Prepaid Ambulatory Health Plan (PAHP).
4. Federal Authority allows DHH to procure the DBPM as provided in Section 1902(a)(4) and Section 1932(a) (1)(A) of the Social Security Act, as amended (42 U.S.C. 1902(a)(4) and 1932(a)(1)(A)) and Title 42 of the Code of Federal Regulations, (42 CFR Part 438.1). DHH intends to submit a State Plan Amendment to utilize a DBPM.

B. Purpose of RFP

1. Louisiana intends to transition to provision of dental services for Medicaid and CHIP state plan services through procurement of a Prepaid Ambulatory Health Plan (PAHP). The contract will require education/outreach to dentists, dental hygienists, and the state dental association. Proposer's plans for education and outreach will be considered when scoring proposal.
2. The purpose of this RFP is to solicit proposals from qualified proposers to manage the Medicaid Dental Benefit Program for all eligible Medicaid recipients, utilizing the most cost-effective manner and in accordance with the terms and conditions set forth herein.
3. The Contractor who is awarded this contract should be prepared to deliver services to a population of approximately one million full benefit Medicaid enrollees. A contract is necessary to achieve the following goals:
 - A. improved coordination of care;
 - B. better dental health outcomes;
 - C. increased quality of dental care;
 - D. improved access to essential specialty dental services;
 - E. outreach and education to promote dental health;
 - F. increased personal responsibility and self-management;
 - G. a more financially sustainable system; and
 - H. net savings to the state compared to the existing FFS Medicaid delivery system

4. This RFP solicits proposals, details proposal requirements, defines DHH's minimum service requirements, and outlines the state's process for evaluating proposals and selecting the DBPM.
5. Federal Authority for DHH to procure the DBPM is contained in Section 1932(a) (1)(A) of the Social Security Act as Amended and 42 CFR, Part 438; as those requirements apply to PAHPs. DHH intends to submit a State Plan Amendment to utilize a DBPM.

C. Invitation to Propose

The Bureau of Health Services Financing is inviting qualified proposers to submit proposals to manage the Medicaid Dental Benefit Program statewide for eligible Medicaid recipients in return for a monthly capitation payment made in accordance with the specifications and conditions set forth herein.

D. RFP Addenda

In the event it becomes necessary to revise any portion of the RFP for any reason, the Department shall post addenda, supplements, and/or amendments to all potential proposers known to have received the RFP. Additionally, all such supplements shall be posted at the following web address:

<http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm>

May also be posted at:

<http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47>

It is the responsibility of the proposer to check the DOA website for addenda to the RFP, if any.

II. ADMINISTRATIVE INFORMATION

A. RFP Coordinator

1. Requests for copies of the RFP and written questions or inquiries must be directed to the RFP coordinator listed below:

Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
628 N 4th Street, 5th Floor
Baton Rouge, LA 70802
(225)-342-5266
Mary.Fuentes@la.gov

2. All communications relating to this RFP must be directed to the DHH RFP Coordinator person named above. All communications between Proposers and other DHH staff members concerning this RFP shall be strictly prohibited. Failure to comply with these requirements shall result in proposal disqualification.
3. This RFP is available in a PDF format at the following web links:
<http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm>
<http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47>

B. Proposer Inquiries

1. The Department will consider written inquiries regarding the requirements of the RFP or Scope of Services to be provided before the date specified in the Schedule of Events. To be considered, written inquiries and requests for clarification of the content of this RFP must be received at the above address or via the above fax number or email address by the date specified in the Schedule of Events. Any and all questions directed to the RFP coordinator will be deemed to require an official response and a copy of all questions and answers will be posted by the date specified in the Schedule of Events to the following web link:
<http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm>

May also be posted at: <http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47>

2. Action taken as a result of verbal discussion shall not be binding on the Department. Only written communication and clarification from the RFP Coordinator shall be considered binding.

C. Schedule of Events

DHH reserves the right to deviate from this Schedule of Events

Schedule of Events	
Public Notice of RFP	1/08/2014
Deadline for Receipt of Written Questions	11:59 p.m. CST on 1/22/2014
Response to Written Questions	2/01/2014
Deadline for Receipt of Written Proposals	4:00 p.m. CST 3/07/2014
Proposal Evaluation Begins	3/08/2014
Contract Award Announced	3/21/2014
Contract Negotiations Begin	3/21/2014
Contract Begins	5/01/2014

III. SCOPE OF WORK

A. Project Overview

The Dental Benefit Program Manager (DBPM) is a risk-bearing, Prepaid Ambulatory Health Plan (PAHP) healthcare delivery system responsible for providing specified Medicaid dental benefits and services for eligible Louisiana Medicaid enrollees as described in Section B.2.D of this RFP.

In order to participate as a network for dental services, the DBPM must meet the following mandatory requirements:

1. meet the federal definition of a PAHP, as defined in 42 C.F.R. §438.2;
2. have a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as a Medicaid risk bearing "prepaid entity" pursuant to LSA-R.S. Title 22:1016 and submit with the proposal response;
3. have a certificate from the Louisiana Secretary of State, pursuant to LSA-R.S. 12:24, to conduct business in the state, which is submitted to DHH at the time the DBPM signs the Contract with DHH;

4. meet solvency standards as specified in 42 C.F.R. § 438.116 and Title 22 of the Louisiana Revised Statutes;
5. have a network capacity to enroll a minimum of 1,288,625 Medicaid members into the network;
6. is without an actual or perceived conflict of interest that would interfere or give the appearance of impropriety or of interfering with the contractual duties and obligations under this Contract or any other contract with DHH, and any and all applicable DHH written policies. Conflict of interest shall include, but is not limited to, the Contractor serving, as the Medicaid fiscal intermediary contractor for DHH;
7. is awarded a contract with DHH, and successfully completed the Readiness Review prior to the start date of operations; and
8. have the ability to provide core dental benefits and services to all assigned members on the day the Dental Benefit Manager Program is implemented.

B. Deliverables

1. General Requirements

- A. The DBPM shall be responsible for the administration and management of its requirements and responsibilities under the contract with DHH and any and all DHH issued policy manuals and guides. This is also applicable to all subcontractors, employees, agents and anyone acting for or on behalf of the DBPM.
- B. The DBPM's administrative office shall maintain normal business hours of 8:00 a.m. to 5:00 p.m. CT Monday through Friday.
- C. The DBPM shall comply with all current state and federal statutes, regulations, and administrative procedures that are or become effective during the term of this Contract. Federal regulations governing contracts with PAHPs are specified in 42 CFR Part §438 and will govern this Contract. DHH is not precluded from implementing any changes in state or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes.
- D. The Louisiana Department of Insurance (DOI) regulates the solvency of risk-bearing entities providing Louisiana Medicaid services; therefore, the DBPM must comply with all DOI applicable standards. Information pertaining to DOI can be found at DOI's website (www.lds.louisiana.gov).
- E. 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 shall be considered null and void.

2. Programmatic Requirements

A. Mandatory Population

The DBPM will serve eligible Louisiana Medicaid enrollees in the following categories except those excluded in section B.2.B below:

1. Group A - as specified in LAC 50:XV.6901, Medicaid recipients who are under 21 years of age; and
2. Group B - as specified in LAC 50:XXV.303, Medicaid recipients who are 21 years of age and older and whose Medicaid coverage includes the full range of Medicaid services

B. Excluded Populations

1. Individuals residing in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD); and
2. Individuals who are 21 years of age and older that are certified as Qualified Medicare Beneficiary Only.

C. Primary Dental Provider

1. The DBPM shall offer each enrollee a choice of primary dental providers (PDPs). After making a choice, each enrollee shall have a single or group PDP.
2. When making PDP assignments, the DBPM shall take into consideration the enrollee's last PDP (if the PDP is known and available in the DBPM's network), closest PDP to the enrollee's ZIP code location, keeping children/adolescents within the same family together, and age.
3. The DBPM shall permit enrollees to request to change PDPs at any time. If the enrollee request is not received by the DBPM's established monthly cut-off date for system processing, the PDP change will be effective the first (1st) day of the next month.
4. The DPBM shall assign all enrollees who are reinstated after a temporary loss of eligibility to the PDP who was treating them prior to loss of eligibility, unless the enrollee specifically requests another PDP, the PDP no longer participates in the DBPM or is at capacity, or the enrollee has changed geographic areas.

D. Core Dental Benefits And Services

General Provisions

1. The DBPM shall provide members, at a minimum, with those core dental benefits and services specified in the Contract and as defined in the Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals. The DBPM shall possess the expertise and resources to ensure the delivery of quality healthcare services to DBPM members in accordance with Louisiana Medicaid program standards and the prevailing dental community standards.
2. The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services shall be furnished in an amount, duration, and scope that is not less than the amount, duration, and scope for the same services furnished to those that are eligible under Fee For Service (FFS) Medicaid, as specified in 42 CFR §§438.210(a)(1) and (2). Upward variances of amount, duration and scope of these services are allowed.
3. Although the DBPM shall provide the full range of required core dental benefits and services listed below, it may choose to provide services over and above those specified when it is cost effective to do so. The DBPM may offer additional benefits that are outside the scope of core dental benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or member's family, the potential for improved health status of the member, and functional necessity.
4. If new dental services are added to the Louisiana Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contract shall be amended and the Department will make every effort to give the DBPM sixty (60) days advance notice of the change. However, the DBPM shall add, delete, or change any service as may be deemed necessary by DHH within the timeframe required by DHH if mandated by federal or state legislation or court order.

5. Louisiana Medicaid State Plan Services (Appendix D) provides a general overview of Louisiana Medicaid services, which are identified as either federally mandated or state legislatively approved optional services.
6. The DBPM shall provide core dental benefits and services to Medicaid members based on their eligibility group:

Group A (Children Under Age 21)

This DBPM shall provide Group A the services listed in LAC 50:XV.6903 and as specified in Section 16.5 of the Dental Services Manual which include but are not limited to the following services:

- **Diagnostic Services** which include oral examinations, radiographs and oral/facial images, diagnostic casts and accession of tissue – gross and microscopic examinations;
- **Preventive Services** which include prophylaxis, topical fluoride treatments, sealants, fixed space maintainers and re-cementation of space maintainers;
- **Restorative Services** which include amalgam restorations, composite restorations, stainless steel and polycarbonate crowns, stainless steel crowns with resin window; pins, core build-ups, pre-fabricated posts and cores, resin-based composite restorations, appliance removal, and unspecified restorative procedures;
- **Endodontic Services** which include pulp capping, pulpotomy, endodontic therapy on primary and permanent teeth (including treatment plan, clinical procedures and follow-up care), apexification/recalcification, apicoectomy/periradicular services and unspecified endodontic procedures;
- **Periodontal Services** which include gingivectomy, periodontal scaling and root planning, full mouth debridement, and unspecified periodontal procedures;
- **Removable Prosthodontics** services which include complete dentures, partial dentures, denture repairs, denture relines and unspecified prosthodontics procedures;
- **Maxillofacial Prosthetics** service;
- **Fixed Prosthodontics** services which include fixed partial denture pontic, fixed partial denture retainer and other unspecified fixed partial denture services;
- **Oral and Maxillofacial Surgery** services which include non-surgical extractions, surgical extractions, coronal remnants extractions, other surgical procedures, alveoloplasty, surgical incision, temporomandibular joint (TMJ) procedure and other unspecified repair procedures;
- **Orthodontic Services** which include interceptive and comprehensive orthodontic treatments, minor treatment to control harmful habits and other orthodontic services; and **Adjunctive General Services** which include palliative (emergency) treatment, anesthesia, professional visits, miscellaneous services, and unspecified adjunctive procedures.

EPSDT Services

1. In accordance with 42 CFR §441.56(b)(1)(vi) and periodicity charts posted on Louisiana Medicaid's website at www.lamedicaid.com, the DBPM shall provide dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.
2. In accordance with 42 CFR §441.56(c)(2), the Contractor shall provide dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.
3. The DBPM shall accurately report, via encounter data submissions all dental screenings and access to preventive services as required for DHH to comply with federally mandated CMS 416 reporting requirements (Appendix X – EPSDT Reporting). Instructions on how to complete the CMS 416 report may be found on CMS's website at:
http://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage

See the DBPM Systems Companion Guide for format and timetable for reporting of EPSDT data at:

<http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47>

Group B (Adult Denture Program Age 21 and Above)

This Health Plan shall provide Group B the services listed in LAC 50:XXV.501 and as specified in Section 16.9 of the Dental Services Manual which include but is not limited to the following services:

- Comprehensive oral examination;
- Intraoral radiographs, complete series;
- Complete denture, maxillary;
- Complete denture, mandibular;
- Immediate denture, maxillary;
- Immediate denture, mandibular;
- Maxillary partial denture, resin base (including clasps);
- Mandibular partial denture, resin base (including clasps);
- Repair broken complete denture base;
- Replace missing or broken tooth, complete denture, per tooth;
- Repair resin denture base, partial denture;
- Repair or replace broken clasp, partial denture;
- Replace broken teeth, partial denture, per tooth;
- Add tooth to existing partial denture;
- Add clasp to existing partial denture;
- Reline complete maxillary denture (laboratory);
- Reline complete mandibular denture (laboratory);
- Reline maxillary partial denture (laboratory);
- Reline mandibular partial denture (laboratory); and
- Unspecified removable prosthodontic procedure.

4. The DBPM 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.
5. The DBPM 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.
6. The DBPM may place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity; or (b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.
7. The DBPM may exceed the service limits as specified in the Louisiana Medicaid State Plan to the extent that those service limits can be exceeded with authorization in FFS. No dental service limitation can be more restrictive than those that currently exist under the Louisiana Medicaid State Plan.
8. The DBPM may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care.
9. The DBPM shall not portray core dental benefits or services as an expanded health benefit.

Emergency Dental Services

The DBPM shall make provisions for and advise all members, described in Group A, of the provisions governing emergency use pursuant to 42 CFR §438.114. Emergency-related definitions are in the Glossary of this RFP. Requirements for the DBPM to provide emergency dental services are as follows:

1. The DBPM shall cover services as described in Section c(1)(f)(i). Provision of these services in an emergency context broadens the DBPM's responsibilities to include payment for these services to out-of-net providers as described in this section.
2. The DBPM shall be responsible for dental related services provided in an emergency context other than those described in Section c(1)(f)(i).
3. In providing for emergency dental services and care as a covered service, the DBPM **shall not**:
 - a) Require prior authorization for emergency dental services and care.
 - b) Indicate that emergencies are covered only if care is secured within a certain period of time.
 - c) Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.
 - d) Deny payment based on the member's failure to notify the DBPM in advance or within a certain period of time after the care is given.
4. The DBPM shall not deny payment for emergency dental care.
5. The DBPM shall not deny payment for treatment obtained when a member had an emergency dental condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an emergency dental condition.
6. The hospital-based provider and the primary care dentist may discuss the appropriate care and treatment of the member. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient in accordance with federal law to determine if the patient is a member of the DBPM, if emergency dental services and care are not delayed.
7. The DBPM shall not deny emergency dental services claims submitted by a non-contracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds 365 days.

8. If third party liability exists, payment of claims shall be determined in accordance with this RFP.
9. The DBPM must review and approve or disapprove emergency service claims based on the definition of emergency dental services and care specified in the Glossary.

Prohibited Services

The DBPM is prohibited from providing:

1. Experimental/investigational drugs, procedures or equipment, unless approved by the secretary of DHH; or
2. Elective cosmetic surgery.

Expanded Services/Benefits

The DBPM shall provide DHH a description of the expanded services/benefits to be offered by the DBPM for approval. Additions or modifications to expanded services/benefits made during the contract period must be submitted to DHH, for approval.

1. As permitted under 42 CFR §438.6(e), the DBPM may offer expanded services and benefits to enrolled Medicaid DBPM members in addition to those core dental benefits and services specified in this RFP.
2. These expanded services may include dental care services which are currently non-covered services by the Louisiana Medicaid State Plan and/or which are in excess of the amount, duration, and scope in the Louisiana Medicaid State Plan.
3. These services/benefits shall be specifically defined by the DBPM in regard to amount, duration and scope. DHH will not provide any additional reimbursement for these services/benefits. The DBPM may not seek reimbursement for these services from the enrollees.

3. Operations Requirements

A. The DBPM shall be responsible for any additional costs associated with on-site audits or other oversight activities that result when required systems are located outside of the state of Louisiana.

B. DBPM Reimbursement

1. DHH shall make monthly capitated payments for each member enrolled into the DBPM. The capitation rate will be developed in accordance with 42 CFR 438.6 and will include claims for retroactive coverage. The capitated payment rates are contained in Appendix E and are subject to change based upon the implementation date of the program.
2. DBPM agrees to accept payment in full and shall not seek additional payment from a member for any unpaid costs, including costs incurred during the retroactive period of eligibility.
3. DHH reserves the right to defer remittance of the PMPM payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.
4. DBPM Payment Schedule

- a) The monthly capitated payment shall be based on Medicaid recipients eligible for DBPM participation during the month and paid in the weekly payment cycle nearest the 15th calendar day of the month (see Appendix L – Fiscal Intermediary (FI) Payment Schedule).
- b) The DBPM shall make payments to its providers as stipulated in the contract.
- c) The DBPM shall not assign its right to receive payment to any other entity.
- d) Payment for items or services provided under this contract shall 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 Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.
- e) The DBPM shall agree to accept payments as specified in this section and have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions shall be borne by the DBPM.

5. Payment Adjustments

- a) In the event that an erroneous payment is made to the DBPM, DHH shall reconcile the error by adjusting the DBPM’s future monthly capitation payment.
- b) Retrospective adjustments to prior payments may occur when it is determined that a member’s aid category was changed. Payment adjustments may only be made when identified within twelve (12) months from the date of the member’s aid category change for all services delivered within the twelve (12) month time period. If the member switched from a DBPM eligible aid category to a DBPM excluded aid category, previous capitation payments will be recouped from the DBPM.
- c) The DBPM shall refund payments received from DHH for a deceased member effective the month of service after the month of death. DHH will recoup the payment as specified in the Systems Companion Guide.
- d) The entire monthly capitation payment shall be paid during the month of birth and month of death. Payments shall not be pro-rated to adjust for partial month eligibility as this has been factored into the actuarial rate setting.

6. Rate Adjustments

- a) DHH reserves the right to re-negotiate the PMPM rates:
 - If the rate floor is removed;
 - If a result of federal or state budget reductions or increases;
 - If due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated in the monthly capitation rates; or
 - In order to comply with federal requirements.
- b) The rates may also be adjusted due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated in the monthly capitation rate; and/or based on legislative appropriations and budgetary constraints. Any adjusted rates must continue to be actuarially sound as determined by DHH’s actuarial contractor and will require an amendment to the Contract that is mutually agreed upon by both parties. 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 contract exceeds \$20,000, approved by the Director of the Office of Contractual Review, Division of Administration. 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.

7. Copayments

Any cost sharing imposed on Medicaid members must be in accordance with 42 CFR §§447.50 through 447.58 and cannot exceed cost sharing amounts in the Louisiana Medicaid State Plan. Louisiana currently has no cost sharing requirements for any of the DBPM core dental benefits and services. DHH reserves the right to amend cost sharing requirements.

8. Return of Funds

- a) All amounts owed by the DBPM to DHH, as identified through routine or investigative reviews of records or audits conducted by DHH or other state or federal agency, shall be due no later than thirty (30) calendar days following notification to the DBPM by DHH unless otherwise authorized in writing by DHH. DHH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to DHH to future payments. DHH 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 §30.13. This rate may be revised quarterly by the Secretary of the Treasury and is published by HHS in the Federal Register.
- b) The DBPM shall reimburse all payments as a result of any federal disallowances or sanctions imposed on DHH as a result of the DBPM's failure to abide by the terms of the Contract. The DBPM shall be subject to any additional conditions or restrictions placed on DHH by the United States Department of Health and Human Services (HHS) as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.

9. Third Party Liability (TPL)

- a) General TPL Information
 - i. 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 Third Party Liability resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid, unless otherwise noted.
 - ii. The DBPM shall take reasonable measures to determine Third Party Liability.
 - iii. The DBPM shall coordinate benefits in accordance with 42 CFR §433.135 et seq. and Louisiana Revised Statutes, Title 46, so that costs for services otherwise payable by the DBPM are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery. The DBPM shall use these methods as described in federal and state law.
 - iv. If the probable existence of Third Party Liability cannot be established the DBPM must adjudicate the claim. The DBPM must then utilize post-payment recovery which is described in further detail below.

- v. The term “state” shall be interpreted to mean “DBPM” for purposes of complying with the federal regulations referenced above. The DBPM may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

b) Cost Avoidance

- i. Unless prohibited by applicable federal or state law or; regulations, The DBPM shall cost-avoid a claim if it establishes the probable existence of Third Party Liability at the time the claim is filed.
- ii. The DBPM shall bill the private insurance within sixty (60) days from date of discovery of liability.
- iii. The DBPM shall adjudicate claims for dental treatment associated with EPSDT in accordance with federal and state law.

c) Post-payment Recoveries

Post-payment recovery shall be necessary in cases where the DBPM has not established the probable existence of Third Party Liability at the time services were rendered or paid for, or was unable to cost avoid. The following sets forth requirements for DBPM recovery:

- i. The DBPM must have established procedures for recouping post-payments for DHH’s review during the Readiness Review process. The DBPM must void encounters for claims that are recouped in full. For recoupments that result in an adjusted claim value, the DBPM must submit replacement encounters.
- ii. The DBPM shall identify the existence of potential Third Party Liability to pay for core dental benefits and services in accordance with 42 CFR 433.138.
- iii. The DBPM must report the existence of Third Party Liability in a weekly file to the department fiscal intermediary in the specified format.
- iv. The DBPM shall be required to seek reimbursement in accident/trauma related cases when claims in the aggregate equal or exceed \$500 as required by the Louisiana Medicaid State Plan and federal Medicaid guidelines and may seek reimbursement when claims in the aggregate or less than \$500.
- v. The amount of any recoveries collected by the DBPM outside of the claims processing system shall be treated by the DBPM as offsets to dental expenses for the purposes of reporting.
- vi. Prior to accepting a Third Party Liability settlement on claims equal to or greater than \$25,000, the DBPM shall obtain approval from DHH. The DBPM may retain up to 100% of its Third Party Liability collections if all of the following conditions exist:
 - Total collections received do not exceed the total amount of the DBPM financial liability for the member;
 - There are no payments made by DHH related to FFS, reinsurance or administrative costs (i.e., lien filing, etc.); and
 - Such recovery is not prohibited by state or federal law.
- vii. DHH will utilize the data in calculating future capitation rates.

d) TPL Reporting Requirements

- i. The DBPM shall provide DHH Third Party Liability information in a format and medium described by DHH and shall cooperate in any manner necessary, as requested by DHH, with DHH and/or a cost recovery vendor of DHH.
 - ii. The DBPM shall be required to include the collections and claims information in the encounter data submitted to DHH, including any retrospective findings via encounter adjustments.
 - iii. Upon the request of DHH, the DBPM must provide information not included in encounter data submissions that may be necessary for the administration of Third Party Liability activity. The information must be provided within thirty (30) calendar days of DHH's request. Such information may include, but is not limited to, individual dental records for the express purpose of a Third Party Liability resource to determine liability for the services rendered.
 - iv. Upon the request of DHH, the DBPM shall demonstrate that reasonable effort has been made to seek, collect and/or report Third Party Liability and recoveries. DHH shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.
 - v. The DBPM must submit an annual report of all health insurance collections for its members plus copies of any Form 1099's received from insurance companies for that period of time.
- e) DHH Right to Conduct Identification and Pursuit of TPL
- i. When the DBPM fails to collect payment from the Third Party Liability within three hundred sixty-five (365) days from date of service, DHH may invoke its right to pursue recovery.
 - ii. If DHH determines the DBPM is not actively engaged in cost avoidance the DBPM will be responsible for all administrative costs associated with this DHH's collection activities.
- f) Coordination of Benefits
- i. Other Coverage Information
 - ii. The DBPM shall maintain other coverage information for each member. The DBPM shall verify the other coverage information provided by DHH and develop a system to include additional other coverage information when it becomes available. The DBPM shall provide a periodic file of updates to other coverage back to the state.
 - iii. Cost Avoidance
The DBPM shall attempt to avoid payment in all cases where there is other insurance (Medicaid is payer of last resort).
 - iv. Post-Payment Recoupment
DBPM shall initiate a post payment recovery process when it is determined after the fact that the member had other coverage at the time of service.
 - v. Reporting and Tracking
The DBPM's system shall identify and track potential collections. The System should produce reports indicating open receivables, closed receivables, amounts collected, amounts written off and amounts avoided.

10. Provider Network Requirements

a) General Provider Network Requirements

- i. The DBPM must maintain a network of qualified dental providers in sufficient numbers and locations to provide required access to covered services. The DBPM is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the DBPM's member population. The DBPM shall design its dental provider network to maximize the availability of primary dental services and specialty dental services.
- ii. The DBPM must provide a comprehensive network to ensure its membership has access at least equal to, or better than, community norms. Services shall be accessible to DBPM members in terms of timeliness, amount, duration and scope equal to services provided by fee for service (FFS) Medicaid at the time the DBPM is implemented [42 CFR §438.210(a)(2)]. If the network is unable to provide necessary services required under contract, the DBPM shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The DBPM shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206(b)(4) and (5)].
- iii. All providers shall be in compliance with Americans with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.
- iv. Request from Medicaid Providers, including significant traditional providers (STP) to participants in DBPM services are received, the DBPM should make a good faith effort to enter into a contract with such providers. The DBPM shall document efforts made and maintain records for all successful and non-successful agreements.
- v. The DBPM shall not discriminate with respect to participation in the Dental Benefit Program, reimbursement or indemnification against any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the provider's type of licensure or certification [42 CFR §§438.12(a)(1) and (2)]. In addition, the DBPM must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR §438.214(c)].
- vi. The provisions of this RFP do not prohibit the DBPM from limiting provider participation to the extent necessary to meet the needs of the DBPM's members. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using reimbursement amounts that are less or greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].

- vii. The DBPM may decline requests from providers to participate in the DBPM network. Pursuant to [42 CFR §438.12(a)(1)], the DBPM shall give the Provider in written notice for reasons of its decision to decline the request. Response shall be within fourteen (14) calendar days from when the decision was made.
- viii. The DBPM may terminate a contract with a provider for cause. The DBPM shall within 14 days written notice of termination to the provider. The DBPM shall notify DHH of the termination as soon as the written notification of cancelation is sent to the provider, but no later than seven (7) calendar days
- ix. The DBPM shall notify the DBPM members that their primary dental care provider's contract has been terminated. Notice shall be sent , within fifteen (15) calendar days after receipt of issuance of the termination notice, as specified in 42 CFR §438.10(f)(5). This notice shall include a list of recommended network providers available to the member in their surrounding area.
- x. The DBPM shall also meet the following requirements:
 - Ensure the provision of all core dental benefits and services specified in the Contract. Accessibility of benefits/services, including geographic access, appointments, and wait times shall be in accordance with the requirements in this RFP. These minimum requirements do not release the DBPM from ensuring that all necessary covered dental benefits and services required by its members are provided pursuant to this RFP.
 - Provide core dental services directly or enter into written agreements with providers or organizations that shall provide core dental services to the members in exchange for payment by the DBPM for services rendered.
 - Not execute contracts with individuals or groups of providers who have been excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded healthcare programs. The list of providers excluded from federally funded healthcare programs can be found at <http://exclusions.oig.hhs.gov/search.aspx> and www.EPLS.gov and Health Integrity and Protection Data Bank at <http://www.npdb-hipdb.hrsa.gov/index.jsp>.
 - 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 for the following:
 - o Member's health status, medical or behavioral healthcare, or treatment options, including any alternative treatment that may be self-administered;
 - o Information the member needs in order to decide among all relevant treatment options;
 - o The risk, benefits, and consequences of treatment and non-treatment; or
 - o 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.
 - Monitor provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply. The DBPM shall conduct

appointment availability surveys annually. The surveys shall be submitted within 30 days after the conclusion of each contract year. The survey results must be kept on file and be readily available for review by DHH upon request. The DBPM may be subject to sanctions for noncompliance of providers with applicable appointment and wait time requirements set forth in this RFP.

- If a member requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the DBPM who accepts new patients, it shall not be considered a violation of the access requirements for the DBPM to grant the member's request.
- The DBPM shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR §438.206.
- The DBPM shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers. Failure to do so may result in monetary penalties up to \$5,000 per day against the DBPM; whether the data is clean, current or accurate shall be at the discretion of DHH.

b) General Provider Network Requirements

The DBPM shall ensure access to dental services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care) in accordance with the provision of services under this RFP. DHH will monitor the DBPM's service accessibility and may require that the DBPM obtain services from out-of-network providers as necessary for the provision of core dental benefits and services. The DBPM shall provide available, accessible, and adequate numbers of service locations, service sites, and dental professionals for the provision of core dental benefits and services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:

i. Distance

The DBPM shall comply with the following maximum distance requirements, as determined by mapping software (e.g. MapQuest, Google Maps, ArcGIS). Requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval.

ii. Distance to Primary Dental Services

Travel distance from member's place of residence shall not exceed forty (40) miles for rural areas and twenty (20) miles for urban areas.

iii. Distance to Specialty Dental Services

Travel distance shall not exceed sixty (60) miles from the member's place of residence for at least 7five percent of members and shall not exceed ninety (90) miles from the member's place of residence for all members.

c) Waiting Times and Timely Access

- i. The DBPM shall ensure that its network providers have an appointment system for core dental benefits and services and/or expanded services

which are in accordance with prevailing dental community standards as specified below.

- ii. Formal policies and procedures establishing appointment standards must be submitted for initial review and approval during the readiness review process. Revised versions of these policies and procedures should be submitted to DHH for record keeping purposes as they become relevant. If changes to policies and procedures are expected to have a significant impact on the provider network or member services, DHH staff must be notified in writing 30 days prior to implementation. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The DBPM shall disseminate these appointment standard policies and procedures to its in-network providers and to its members. The DBPM shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.
- iii. Urgent Care must be provided within twenty-four (24) hours [42 CFR §438.206(c)(1)(i)]; Urgent care may be provided directly by the primary care dentist or directed by the DBPM through other arrangements.
- iv. Routine or preventative dental services within six (6) weeks;
- v. The DBPM shall establish processes to monitor and reduce the appointment “no-show” rate for primary care dentists. As best practices are identified, DHH may require implementation by the DBPM. This information shall be provided to DHH during the readiness review process.
- vi. The DBPM shall have written policies and procedures about educating its provider network about appointment time requirements and provide these to DHH for approval during the readiness review process. The DBPM must develop a corrective action plan when appointment standards are not met; if appropriate, the corrective action plan should be developed in conjunction with the provider [42 CFR §438.206(c)(1)(iv), (v) and (vi)]. Appointment standards shall be included in the Provider Manual. The DBPM is encouraged to include the standards in the provider subcontracts.

d) Assurance of Adequate Primary Care Dentist Access and Capacity

- i. The primary care dentist may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or outpatient clinic. The DBPM shall provide at least one (1) full time equivalent (FTE) primary care dentist per three thousand (3,000) DBP members. DHH defines a full time primary care dentist as a provider that provides dental care services for a minimum of thirty-two (32) hours per week of practice time. The DBPM shall require that each individual primary care dentist shall not exceed a total of three thousand (3,000) Medicaid linkages in all DBPM’s in which the primary care dentist may be a network provider.
- ii. The DBPM shall provide access to dentists that offer extended office hours (minimum of 2 hours) at least one day per week (before 8:00 am and after 4:30 pm) and on Saturdays, within sixty (60) miles of a member’s residence for urgent care.
- iii. Network providers must offer office hours at least equal to those offered by fee for service (FFS) Medicaid at the time the DBP is implemented
- iv. Within thirty (30) calendar days after implementation of the DBPM and monthly thereafter, the DBPM shall provide on or before the first of each

month the primary care dentist with a report (electronic or hard copy) of all members linked to their practice.

e) Access to Specialty Providers

- i. The DBPM shall assure the availability of access to specialty providers for all Group A members. The DBPM shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.
- ii. The DBPM shall establish and maintain a provider network of dentist specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the dental needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:
 - The DBPM has signed a contract with providers of the specialty types listed below who accept new members and are available on at least a referral basis; and
 - The DBPM is in compliance with access and availability requirements.
- iii. The DBPM shall assure, at a minimum, the availability of the following providers, as appropriate for members under the age of 21:
 - Endodontists
 - Maxillofacial Surgeons
 - Oral Surgeons
 - Orthodontists
 - Pedodontists
 - Periodontists
 - Prosthodontists
 - Special Needs Pedodontists
- iv. The DBPM must use specialists with pediatric expertise when the need for pediatric specialty care is significantly different from the need for a general dentist.
- v. The DBPM shall meet standards for timely access to all specialists. In accordance with 42 CFR §438.208(c)(4) for members determined to need a course of treatment or regular care monitoring, the DBPM must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.

f) FQHC/RHC Clinic Services

- i. The DBPM must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) and include them in its provider network.
- ii. If the DBPM does not enter into a contract with the FQHCs and/or RHCs within the geographic services area and within the time and distance travel standards of the primary dental care provider, the DBPM is not required to reimburse for out-of-network services. Exception is given when it is determined that the services provided were considered emergency services and in compliance with 42 CFR §438.114 emergency.
- iii. The DBPM shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from DHH.

- g) Significant Traditional Providers
The DBPM should make a good faith effort to include in its network, primary care dentists and specialists who are significant traditional providers (STPs) provided that the STP agrees to participate as an in-network provider and abide by the provisions of the provider contract and meets the credentialing requirements. The list of STPs will be available on the DHH web site.
- h) Provider Network Development Management Plan
- i. The DBPM shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of core dental benefits and services will occur [42 CFR §438.207(b)]. The Network Development and Management Plan shall be submitted to DHH within thirty (30) days from the date the DBPM signs to contract with DHH for evaluation and approval, as well as when significant changes occur and annually thereafter within thirty (30) days of the start of each contract year. The Network Development and Management Plan shall include the DBPM's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the DBPM shall consider the following (42 CFR §438.206):
- Anticipated maximum number of Medicaid members;
 - Expected utilization of services, taking into consideration the characteristics and healthcare needs of the members in the DBPM;
 - The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core dental benefits and services;
 - The numbers of DBPM providers who are not accepting new DBPM members; and
 - The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.
- ii. The Network Provider Development and Management Plan shall demonstrate the ability to provide access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:
- Assurance of Adequate Capacity and Services
 - Access to Primary Care Dentists
 - Access to Specialists
 - Timely Access
 - Service Area
 - Second Opinion
 - Out-of-Network Providers
- iii. The Network Provider Development and Management Plan shall identify gaps in the DBPM's provider network and describe the process by which DBPM shall assure all covered services are delivered to DBPM members.

Planned interventions to be taken to resolve such gaps shall also be included.

- iv. The DBPM shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The DBPM shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.
 - v. The DBPM shall develop and implement Network Development and Management policies and procedure that comply with 42 CFR §438.214(a) and (b).
 - vi. The DBPM shall communicate and negotiate with the network regarding contractual and/or program changes and requirements.
 - vii. The DBPM shall monitor network compliance with policies and rules of DHH and the DBPM, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes.
 - viii. The DBPM shall evaluate the quality of services delivered by the network;
 - ix. The DBPM shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.
 - x. The DBPM shall monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.
 - xi. The DBPM shall process expedited and temporary credentials. During the transition period, DHH has allowed a sixty (60) days grace period from the date the contract has been signed to have all providers credentialed. Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management, utilization, office audits and provider profiling.
 - xii. The DBPM shall provide training for its providers and maintain records of such training.
 - xiii. The DBPM shall track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.
 - xiv. The DBPM shall ensure that provider calls are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 calendar days of receipt (this does not include inquiries from DHH). If not resolved in 30 days the DBPM must document why the issue goes unresolved; however, the issue must be resolved within 90 calendar days.
 - xv. Inquiries from DHH must be acknowledged by the next business day and the resolution, or process for resolution, communicated to DHH within twenty-four (24) hours.
- i) Material Change to Provider Network
- i. The DBPM shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the DBPM's provider network, whether terminated by the DBPM or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the DBPM's ability to meet the performance and

network standards as described in the Contract, including but not limited to the following:

- Any change that would cause more than five percent (five percent) of members to change the location where services are received or rendered.
 - A decrease in the total of individual primary care dentists by more than five percent (five percent);
 - A loss of any participating specialist which may impair or deny the members' adequate access to providers; or
 - Other adverse changes to the composition of which impair or deny the members' adequate access to providers.
- ii. The DBPM shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.
- iii. When the DBPM has advance knowledge that a material change will occur, the Heath Plan must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.
- iv. 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.
- v. DHH will respond within thirty (30) calendar days to the material change request and the notice received by DBPM. If DHH fails to respond within such time, the request and notice will be considered approved. Changes and alternative measures must be within the contractually agreed requirements. The DBPM shall within thirty (30) calendar days give advance written notice of provider network material changes to affected members. The DBPM shall notify DHH of emergency situation and submit request to approve material changes. DHH will act to expedite the approval process .
- vi. The DBPM shall notify DHH within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, 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:
- Information about how the provider network change will affect the delivery of covered services, and
 - The DBPM's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services
- j) Coordination with Other Service Providers

The DBPM shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members

in the coordination and delivery of health care services. Such other service providers may include: Bayou Health Prepaid Health Plans; Bayou Health Shared Savings Plans; Magellan; Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; FQHCs and RHCs; dental schools; dental hygiene programs; and parish school systems. Such cooperation may involve sharing of information (with the consent of the member).

k) Subcontract Requirements

- i. The DBPM shall provide or assure the provision of all core dental benefits and services specified in the RFP. The DBPM may provide these services directly or may enter into subcontracts with providers who will provide services to the members in exchange for payment by the DBPM for services rendered. Provider contracts are required with all providers of services unless otherwise approved by DHH. Any plan to delegate responsibilities of the DBPM to a subcontractor that meets the definition of "Major Subcontract" in the Glossary shall be submitted to DHH for approval.
- ii. The DBPM shall have written policies and procedures for selection and retention of providers in accordance with 42 CFR §438.214.
- iii. The subcontractor shall follow the State's credentialing and re-credentialing policy.
- iv. The DBPM provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- v. As required by 42 CFR §438.230, the DBPM shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:
 - All provider subcontracts must fulfill the requirements of 42 CFR Part §438 that are appropriate to the service or activity delegated under the subcontract;
 - DHH shall have the right to review and approve or disapprove any and all major subcontracts entered into for the provision of any services under this RFP;
 - The DBPM must evaluate the prospective subcontractor's ability to perform the activities to be delegated;
 - The DBPM must have a written agreement between the DBPM and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
 - The DBPM shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards; and
 - The DBPM shall identify deficiencies or areas for improvement, and take corrective action.
- vi. The DBPM shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this RFP to DHH for

prior review and approval. DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.

- vii. The DBPM shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The DBPM 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.
 - viii. The DBPM shall provide written notification to DHH of its intent to terminate any provider subcontract that may materially impact the DBPM's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the DBPM shall provide immediate written notice to the provider.
 - ix. If termination is related to network access, the DBPM shall include in the notification to DHH their plans to notify DBPM members of such change and strategy to ensure timely access to DBPM members through out-of-network providers. If termination is related to the DBPM's operations, the notification shall include the DBPM's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers.
 - x. The DBPM shall give written notice of termination of a subcontract provider, within fifteen (15) calendar days after receipt of issuance of the termination notice, to each DBPM member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).
 - xi. All subcontracts executed by the DBPM pursuant to this section shall, at a minimum, include the terms and conditions listed in Section III.F ("Subcontracts"). No other terms or conditions agreed to by the DBPM and its subcontractor shall negate or supersede the requirements in Section III.F.
- l) Provider-Member Communication Anti-Gag Clause.
- i. In accordance with 42 CFR §438.102, the DBPM 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 the Contract, for the following:
 - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
 - Any information the member needs in order to decide among relevant treatment options;
 - The risks, benefits and consequences of treatment or non-treatment; and

- The member's right to participate in decisions regarding their healthcare, including, the right to refuse treatment, and to express preferences about future treatment decisions.
- ii. Any DBPM that violates the anti-gag provisions set forth in 42 CFR §438.102 shall be subject to intermediate sanctions.
- iii. The DBPM 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 Provider Incentive Plans.

11. Utilization Requirements

a) General Requirements

- i. The DBPM shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The DBPM shall submit an electronic copy of the UM policies and procedures to DHH for written approval within thirty (30) calendar days from the date the Contract is signed by the DBPM, but no later than prior to the Readiness Review, annually thereafter, and prior to any revisions.
- ii. The UM Program policies and procedures shall meet all Utilization Review Accreditation Commission (URAC) standards or equivalent and include medical management criteria and practice guidelines that:
 - Are adopted in consultation with a contracting dental care professionals;
 - Are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field;
 - Are considering the needs of the members; and
 - Are reviewed annually and updated periodically as appropriate
- iii. The policies and procedures shall include, but not be limited to:
 - The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services;
 - The data sources and clinical review criteria used in decision making;
 - The appropriateness of clinical review shall be fully documented;
 - The process for conducting informal reconsiderations for adverse determinations;
 - Mechanisms to ensure consistent application of review criteria and compatible decisions;
 - Data collection processes and analytical methods used in assessing utilization of dental care services; and
 - Provisions for assuring confidentiality of clinical and proprietary information.

- iv. The DBPM shall disseminate the practice guidelines to all affected providers and, upon request, to members. The DBPM shall take steps to encourage adoption of the guidelines.
- v. The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:
 - The vendor must be identified if the criteria were purchased;
 - The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society;
 - The guideline source must be identified if the criteria are based on national best practice guidelines; and
 - The individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the DBPM Dental Director or other qualified and trained professionals.
- vi. UM Program dental management criteria and practice guidelines shall be disseminated to all affected providers, and members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.
- vii. The DBPM shall have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or healthcare provider when requested. The procedures shall outline the process to be followed in the event the DBPM determines the need for additional information not initially requested.
- viii. The DBPM shall have written procedures to address 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 DBPM may deny authorization of the requested service(s).
- ix. The DBPM shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines
- x. The DBPM shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The DBPM shall make medical necessity determinations that are consistent with the State's definition.
- xi. The DBPM shall submit written policies and processes for DHH approval, within thirty (30) calendar days, but no later than prior to the Readiness Review, of the contract signed by the DBPM, on how the core dental benefits and services the DBPM provides ensure:
 - The prevention, diagnosis, and treatment of health impairments;
 - The ability to achieve age-appropriate growth and development; and
 - The ability to attain, maintain, or regain functional capacity.

- xii. The DBPM must identify the qualification of staff who will determine medical necessity.
- xiii. Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.
- xiv. The DBPM shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.
- xv. 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 clinical peer reviewer's physical, mental, or professional or moral character.
- xvi. The individual making these determinations is required to attest that no adverse determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.
- xvii. The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of 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 and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The DBPM 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. The DBPM may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR 438.210.
- xviii. The DBPM shall ensure that 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 covered services to any member in accordance with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210.
- xix. The DBPM shall report fraud and abuse information identified through the UM program to DHH's Program Integrity Unit in accordance with 42 CFR 455.1(a)(1).
- xx. In accordance with 42 CFR §456.111 and 456.211, the DBPM Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:
 - Identification of the enrollee;
 - The name of the enrollee's dentist;

- Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;
- The plan of care required under 42 CFR 456.80 and 456.180;
- Initial and subsequent continued stay review dates described under 42 CFR 456.128, 456.133; 456.233 and 456.234;
- Date of operating room reservation, if applicable; and
- Justification of emergency admission, if applicable.

b) Utilization Management Committee

- i. The UM program shall include a Utilization Management (UM) Committee that integrates with other functional units of the DBPM as appropriate and supports the QAPI Program (refer to the Quality Management subsection for details regarding the QAPI Program).
- ii. The UM Committee shall provide utilization review and monitoring of UM activities of both the DBPM and its providers and is directed by the DBPM Dental Director. The UM Committee shall convene no less than quarterly and shall submit a summary of the meeting minutes to DHH with other quarterly reports. UM Committee responsibilities include:
 - Monitoring providers' requests for rendering healthcare services to its members;
 - Monitoring the dental appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;
 - Reviewing the effectiveness of the utilization review process and making changes to the process as needed;
 - Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;
 - Monitoring consistent application of "medical necessity" criteria;
 - Application of clinical practice guidelines;
 - Monitoring over- and under-utilization;
 - Review of outliers, and
 - Dental Record Reviews.
- iii. Dental Record Reviews shall be conducted to ensure that primary care dentists provide high quality healthcare that is documented according to established standards. The DBPM shall establish and distribute to providers standards for Record Reviews that include all dental record documentation requirements addressed in the Contract.
- iv. The DBPM shall maintain a written strategy for conducting dental record reviews, reporting results, and the corrective action process. The strategy shall be provided within thirty (30) calendar days from the date the Contract is signed by the DBPM, but no later than prior to the Readiness Review, and annually thereafter. The strategy shall include, at a minimum, the following:
 - Designated staff to perform this duty;
 - The method of case selection;

- The anticipated number of reviews by practice site;
 - The tool the DBPM shall use to review each site; and
 - How the DBPM shall link the information compiled during the review to other DBPM functions (e.g. QI, credentialing, peer review, etc.)
- v. The DBPM shall conduct reviews at all primary dental services providers that have treated more than 100 unduplicated members in a calendar year, including individual offices and large group facilities. The DBPM shall review each site at least one (1) time during each five (5) year period.
 - vi. The DBPM shall review a reasonable number of records, in a random process, at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target, though additional reviews shall be completed for large group practices or when additional data is necessary in specific instances
 - vii. The DBPM shall report the results of all record reviews to DHH quarterly with an annual summary.

c) Utilization Management Reports

The DBPM shall submit reports as specified by DHH. DHH reserves the right to request additional reports as deemed by DHH. DHH will make every effort the DBPM of additional required reports no less than 30 calendar days prior to due date of those reports. However, there may be occasions the DBPM will ports in a shorter time frame.

d) Service Authorization

- i. Service authorization includes, but is not limited to, prior authorization.
- ii. The DBPM UM Program policies and procedures shall include service authorization policies and procedures consistent with 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:
 - Written policies and procedures for processing requests for initial and continuing authorizations of services, where a provider does not request a service in a timely manner or refuses a service;
 - Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;
 - 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 enrollee's condition or disease;
 - 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;
 - The DBPM's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and
 - The DBPM's service authorization system shall have capacity to electronically store and report all service authorization requests, decisions

made by the DBPM regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

- iii. The DBPM shall not deny continuation of higher level services for failure to meet medical necessity unless the DBPM can provide the service through an in-network or out-of-network provider for a lower level care.

e) Timing of Service Authorization Decisions

i. Standard Service Authorization

- The DBPM shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. The DBPM shall maintain documentation system to report to DHH on a monthly basis all service authorizations provided in the format specified by DHH.
- An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the DBPM justifies to DHH a need for additional information and the extension is in the member's best interest. In no instance shall any determination of standard service authorization be made later than (25) calendar days from receipt of the request.

ii. Expedited Service Authorization

- In the event a provider indicates, or the DBPM 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 DBPM 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.

iii. Post Authorization

- The DBPM may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the DBPM justifies to DHH a need for additional information and how the extension is in the member's best interest.
- The DBPM shall make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate dental or medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.
- The DBPM 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

misrepresentation about the member's health condition made by the provider.

iv. Timing of Notice

- Approval
 - For service authorization approval for a non-emergency admission, procedure or service, the DBPM shall notify the provider of 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 documented confirmation of such notification to the provider within two (2) business days of making the initial certification.
 - For service authorization approval for extended stay or additional services, the DBPM shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.
- Adverse Action
 - The DBPM shall notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d) and in this RFP for member written materials.
 - The DBPM shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.
- Informal Reconsideration
 - As part of the DBPM appeal procedures, the DBPM shall include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
 - In a case involving an initial determination, the DBPM shall provide the member or a provider acting 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 dentist or clinical peer making the adverse determination.
 - The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the DBPM's dentist authorized to make adverse determinations or a clinical

peer designated by the Dental Director if the dentist who made the adverse determination cannot be available within one (1) business day. The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.

- Exceptions to Requirements
 - o The DBPM shall not require service authorization for emergency dental services as described in this Section whether provided by an in-network or out-of-network provider.
 - o The DBPM shall not require service authorization or referral for EPSDT dental screening services.
 - o The DBPM shall not require service authorization for the continuation of covered services of a new member transitioning into the DBPM, regardless of whether such services are provided by an in-network or out-of-network provider, however, the DBPM may require prior authorization of services beyond thirty (30) calendar days.

f) Primary Care Dentist Utilization and Quality Profiling

- i. The DBPM shall profile its primary care dentists and analyze utilization data to identify primary care dentist utilization and/or quality of care issues.
- ii. The DBPM shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.
- iii. DHH reserves the right to request additional reports as deemed necessary. DHH will make every effort to notify the DBPM of additional required reports whether profile report or other reports, no less than sixty (60) calendar days prior to due date of those reports. However, there may be occasions the DBPM will be required to produce reports in a shorter timeframe.

g) Provider Payments

- i. The DBPM shall profile its primary care dentists and analyze utilization data to identify primary care dentist utilization and/or quality of care issues.
- ii. Minimum Reimbursement to In-Network Providers
 - The DBPM shall provide reimbursement for defined core dental benefits and services provided by an in-network provider. The DBPM rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on July 1, 2013, unless DHH has granted an exception for a provider- initiated alternative payment arrangement.
 - The network provider may enter into alternative reimbursement arrangements with the DBPM if the network provider initiates the request and it is approved in advance by DHH. The provider shall submit the Request for Alternative DBPM Reimbursement Arrangement Form to the following address:

iii. FQHC/RHC Contracting and Reimbursement

- The DBPM must offer to contract for dental services, if applicable, with all FQHCs and RHCs in its service area. If an agreement cannot be reached between the DBPM and FQHC/RHC, the DBPM shall inform DHH.
- The DBPM may stipulate that reimbursement will be contingent upon receiving a clean claim.
- The DBPM shall reimburse an FQHC/RHC the Prospective Payment System (PPS) rate or Alternative Payment Date in effect on the date of service for each encounter.

iv. Reimbursement to Out-of-Network Providers

The DBPM shall make prompt payment for covered emergency dental services that are furnished by providers that have no arrangements with the DBPM for the provision of such services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the DBPM to out-of-network providers for the provision of emergency dental services shall be no more than what would be paid under Medicaid FFS by DHH.

v. Claims Processing Requirements

- All provider claims that are clean and payable must be paid according to the following schedule.
 - Ninety percent (90%) of all cleans claims must be paid within fifteen (15) business days of the date of receipt (the date the DBPM receives the claim as indicated by the date stamp on the claim).
 - Ninety-nine percent (99%) of all clean claims must be paid within thirty (30) calendar days of the date of receipt.
 - The date of payment is the date of the check or other form of payment.
- At a minimum, the DBPM shall run one (1) provider payment cycle per week, on the same day each week, as determined by the DBPM. The DBPM and its subcontractors may, but mutual agreement, establish an alternative payment schedule.
- The DBPM shall support an Automated Clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.
- The DBPM shall encourage that its providers, as an alternative to the filing of paper-based claims, submit and receive claims information through electronic data interchange (EDI 837), i.e. electronic claims. Electronic claims must be processed in adherence to information exchange 16.1 of this RFP. As part of this Electronic Claims Management (ECM) function, the DBPM shall also provide on-line and phone-based capabilities to obtain claims processing status information.
- The DBPM shall generate Explanation of Benefits (EOBs) and Remittance Advices (RAs) in accordance with DHH standards for formatting, content and timeliness.

- The DBPM shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The DBPM shall not pay any claim submitted by a provider that is on payment hold under the authority of DHH or its authorized agent(s).
- Not later than the fifteenth (15th) business day after the receipt of a provider claim that does not meet clean claim requirements, the DBPM shall pend the claim and request in writing (notification via email, the DBPM Website/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the claim can be deemed clean. After receipt of the requested information from the provider, the DBPM must process the claim within fifteen (15) business days of the date of receipt (the date the DBPM receives the claim as indicated by the date stamp on the claim).
- Claims denied for additional information must be closed (paid or denied) by the thirtieth (30th) calendar day following the date the claim is denied if all requested information is not received prior to the expiration of the 30-day period. The DBPM shall send providers written notice (notification via email, the DBPM Website/Provider Portal or an Explanation of Benefits satisfies this requirement) for each claim that is denied, including the reason(s) for the denial and the date the DBPM received the provider to adjudicate the claim.
- The DBPM shall pay providers interest at 12% per annum, calculated daily for the full period in which the clean claim remains adjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid the same date that the claim is adjudicated.
- The DBPM shall process all appealed claims to a paid or denied status within (30) business days of receipt of the appealed claim.
- The DBPM shall finalize all claims, including appealed claims, within twenty-four (24) months of the date of service.
- The DBPM must deny any claim not initially submitted to the DBPM by the three hundred and sixty-fifth (365) calendar day from the date of service, unless the DBPM or its vendors created the error. If a provider files erroneously with DHHs FI, but produces documentation verifying that the initial filing of the claim occurred within the three hundred and sixty-five (365) calendar day period, the DBPM shall process the provider's claim without denying for failure to timely file.
- The DBPM shall inform all network providers about the information required to submit a clean claim at least thirty (30) calendar days prior to the Operational Start Date. The DBPM shall make available to network providers claims coding and processing guidelines for the applicable provider type. The DBPM shall notify providers ninety (90) calendar days before implementing changes to claims coding and processing guidelines.
- In addition to the specific Website requirements outlined above, the DBPM's Website shall be functionally equivalent to the Website maintained by DHHs FI.
- For the purposes of DBPM reporting on payments 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.

vi. Inappropriate Payment Denials

If the DBPM has a pattern of inappropriately denying or delaying provider payments for services, the DBPM may be subject to suspension of new enrollments, sanctions, contract cancellation, or refusal to contract in a future time period. This applies not only to situations where DHH has ordered payment after appeal but to situations where no appeal has been made (i.e. DHH is knowledgeable about the documented abuse from other sources).

vii. Payment for Emergency Dental Services

- The DBPM shall reimburse providers for emergency dental services rendered without a requirement for service authorization of any kind.
- The DBPM's protocol for provision of emergency dental services must specify that emergency dental services will be covered when furnished by a provider with which the DBPM does not have a subcontract or referral arrangement.
- The DBPM may not limit what constitutes an emergency dental condition on the basis of diagnoses or symptoms or refuse to cover emergency dental services based on the provider notifying the member's primary dentist of the member's screening and treatment within ten (10) calendar days of presentation for emergency dental services.
- The DBPM shall not deny payment for treatment when a representative of the DBPM instructs the member to seek emergency dental services.
- The DBPM shall not deny payment for treatment obtained when a member had an emergency dental condition and the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency dental condition.
- The DBPM shall be financially responsible for emergency dental services and shall not retroactively deny a claim for emergency dental services to a provider because the condition, which appeared to be an Emergency Dental Condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.
- Expenditures for emergency dental services as previously described must be factored into the capitation rate described in this RFP and the DBPM will not be entitled to receive any additional payments.

viii. Provider Incentive Plans

- Provider Incentive Plans (PIPs) must comply with requirements for physician incentive plans in 42 CFR 417.479, 422.208, 422.210, and 438.6(h). Specific payment cannot be made directly or indirectly under a Provider Incentive Plan to a dentist or dentist group as an inducement to reduce or limit medically necessary services furnished to an individual.
- The DBPM shall submit any information regarding incentives as may be required by DHH). The DBPM shall receive approval from DHH prior to implementation of the PIP.
 - o The DBPM shall receive prior DHH approval of the Provider Incentive Plan and shall submit to DHH any contract templates that involve a PIP for review as a material modification. The DBPM shall disclose the following:

- Services that are furnished by a dentist/group that are covered by any incentive plan;
 - Type of incentive arrangement, e.g. withhold, bonus, capitation;
 - Percent of withhold or bonus (if applicable);
 - Panel size, and if patients are pooled, the approved method used; and
 - If the dentist/group is at substantial financial risk, the entity must report proof the dentist/group has adequate stop loss coverage, including amount and type of stop-loss.
- o The DBPM shall conduct periodic surveys of current and former enrollees where substantial financial risk exists (as specified in 42 CFR 422.208(h). A summary of the results must be provided to any beneficiary who requests it (as specified in 42 CFR 422.210(b)).
 - o The DBPM shall provide information on its incentive plans to any Medicaid member upon request (this includes the right to adequate and timely information on the plan).

h) Provider Services

i. Provider Relations

- The DBPM shall, at a minimum, provide a Provider Relations function to provide support and assistance to all providers in their DBPM network. This function shall:
 - o Be available Monday through Friday from 7 am to 5 pm Central Time to address non-emergency provider issues or requests;
 - o Ensure each DBPM provider is provided all rights outlined in the Provider's Bill of Rights (see Appendix J);
 - o Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and
 - o Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate.

ii. Provider Toll-free Telephone Line

- The DBPM must operate a toll-free telephone line to respond to provider questions, comments and inquiries.
- The provider access component of the toll-free telephone line must be staffed between the hours of 7am-7pm Central Time Monday through Friday to respond to provider questions in all areas, including but not limited to prior authorization requests, provider appeals, provider processes, provider complaints, and regarding provider responsibilities.
- The DBPM's call center system must have the capability to track provider call management metrics.
- 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 for any DBPM member with an emergency or urgent dental condition.

This shall not be construed to mean that the provider must obtain verification before providing emergency/urgent care.

iii. Provider Website

- The DBPM shall have a provider website. The provider website may be developed on a page within the DBPM's existing website (such as a portal) to meet these requirements.
- The DBPM provider website shall include general and up-to-date information about the DBPM as it relates to the Louisiana Medicaid FFS, Bayou DBPMs. This shall include, but is not limited to:
 - o DBPM provider manual;
 - o DBPM-relevant DHH bulletins;
 - o Information on upcoming provider trainings;
 - o A copy of the provider training manual;
 - o Information on the provider grievance system;
 - o Information on obtaining prior authorization and referrals; and
 - o Information on how to contact the DBPM Provider Relations.
- The DBPM provider website is considered marketing material and, as such, must be reviewed and approved by DHH in writing within thirty (30) calendar days of the date the DBPM signs the Contract.
- The DBPM must notify DHH when the provider website is in place and when any approved changes are made.
- The DBPM must remain compliant with HIPAA privacy and security requirements when providing any member eligibility or member identification information on the website.
- The DBPM 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.

iv. Provider Handbook

- The DBPM shall develop and issue a provider handbook within thirty (30) calendar days of the date the DBPM signs the Contract with DHH.
- The DBPM may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the DBPM's website. This notification shall also detail how the provider can request a hard copy from the DBPM 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 DBPM covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all DBPM requirements are met.
- At a minimum, the provider handbook shall include the following information:
 - o Description of the DBPM;
 - o Core dental benefits and services the DBPM must provide;
 - o Emergency dental service responsibilities;
 - o Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions

- o regarding how to contact the DBPM to file a provider complaint and which individual(s) has the authority to review a provider complaint;
 - o Information about the DBPM's Grievance System, that the provider may file a grievance or appeal on behalf of the member with the member's written consent, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;
 - o Medical necessity standards as defined by DHH and practice guidelines;
 - o Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;
 - o Primary care dentist responsibilities;
 - o Other provider responsibilities under the subcontract with the DBPM;
 - o Prior authorization and referral procedures;
 - o Dental records standards;
 - o Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;
 - o DBPM prompt pay requirements;
 - o Notice that provider complaints regarding claims payment shall be sent to the DBPM;
 - o Quality performance requirements; and
 - o Provider rights and responsibilities.
 - The DBPM shall disseminate bulletins as needed to incorporate any changes to the provider handbook.
 - The DBPM shall make available to DHH for approval a provider handbook specific to the Louisiana DBP, no later than thirty (30) calendar days from the date the DBPM signs the Contract with DHH, but no later than prior to the Readiness Review.
- v. Provider Education and Training
- The DBPM shall provide training to all providers and their staff regarding the requirements of the Contract. The DBPM shall conduct initial training within thirty (30) calendar days of placing a newly contracted provider, or provider group, on active status. The DBPM shall also conduct ongoing training, as deemed necessary by the DBPM or DHH, in order to ensure compliance with program standards and the Contract.
 - The DBPM shall submit a copy of the Provider Training Manual and training schedule to DHH for approval within thirty (30) calendar days of the date the DBPM signs the Contract with DHH. Any changes to the manual shall be submitted to DHH at least thirty (30) calendar days prior to the scheduled change and dissemination of such change.
- vi. Provider Complaint System
- The DBPM shall establish a Provider Complaint System for in-network and out-of-network providers to dispute the DBPM's policies, procedures, or any aspect of the DBPM's administrative functions. As part of the Provider Complaint system, the DBPM shall:
 - o 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;

- o Identify a staff person specifically designated to receive and process provider complaints;
 - o Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the DBPM's written policies and procedures; and
 - o Ensure that DBPM executives with the authority to require corrective action are involved in the provider complaint process as necessary.
- The DBPM shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The DBPM shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is signed, or not later than prior to the Readiness Review. The policies and procedures shall include, at a minimum:
 - o Allowing providers thirty (30) calendar days to file a written complaint and a description of how providers file complaint with the DBPM and the resolution time;
 - o A description of how and under what circumstances providers are advised that they may file a complaint with the DBPM for issues that are DBPM Provider Complaints and under what circumstances a provider may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the DBPM;
 - o A description of how provider relations staff are trained to distinguish between a provider complaint and an member grievance or appeal in which the provider is acting on the member's behalf with the member's written consent;
 - o 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;
 - o A process for thoroughly investigating each complaint using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation;
 - o A description of the methods used to ensure that DBPM executive staff with the authority to require corrective action are involved in the complaint process, as necessary;
 - o A process for giving providers (or their representatives) the opportunity to present their cases in person;
 - o Identification of specific individuals who have authority to administer the provider complaint process;
 - o 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
 - o A provision requiring the DBPM to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.
- The DBPM shall include a description of the Provider Complaint System in the Provider Handbook and include specific instructions regarding how to contact the DBPM's Provider Relations staff; and contact

information for the person from the DBPM who receives and processes provider complaints.

- The DBPM shall distribute the DBPM's policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice. The DBPM 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 DBPM's website. This summary shall also detail how the in-network provider can request a hard copy from the DBPM at no charge to the provider.

i) Enrollment and Disenrollment

i. Enrollment

- The Medicaid Fiscal Intermediary (FI) shall provide Louisiana Medicaid recipient information to the DBPM via an electronic file transfer, hereafter referred to as the "Member File". The DBPM will utilize the Member File to identify all individuals eligible for enrollment, based on predetermined eligibility criteria as outlined in this RFP. The DBPM's responsibilities subsequent to eligibility determination will include, but will not necessarily be limited to, the following:
 - o DBPM staff shall be available by telephone as appropriate to provide assistance to DBP potential members, and educating the Medicaid eligible about the DBP in general, including the manner in which services typically are accessed under the DBPM, the role of the primary care dentist, the responsibilities of the DBPM member, his/her right to file grievances and appeals, and the rights of the member to choose any primary care dentist within the DBPM, subject to the capacity of the provider;
 - o Educating the member, or in the case of a minor, the member's parent or guardian, about benefits and services available through the DBP.; and
 - o Identifying any barriers to access to care for the DBP members such as the necessity for multi-lingual interpreter services and special assistance needed for members with visual and hearing impairment and members with physical or mental disabilities.

ii. Enrollment Procedures

- **Effective Date of Enrollment**
DBPM enrollment for members in a given month will be effective at 12:01AM on the first (1st) calendar day of the month of Medicaid eligibility.
- **Change in Status**
The DBPM agrees to report in writing to DHH'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, email address, telephone number and insurance coverage.

- Assignment of Primary Care Dentists
 - o The DBPM shall encourage the continuation of any existing satisfactory provider/patient relationship with current primary care dentists participating in the DBPM.
 - o The DBPM shall contact the member, as part of the welcome process, within ten (10) business days of receiving the Member File from the FI to assist the member in making a selection of a primary care dentist. The DBPM shall confirm the primary care dentist selection information in a written notice to the member.
 - o If no primary care dentist is selected by the member, the DBPM shall inform the member that each family member has the right to choose his/her own primary care dentist. The DBPM may explain the advantages of selecting the same primary care dentist for all family members, as appropriate.
 - o Members, for whom the DBPM is the primary payor, who do not proactively choose a primary care dentist DBPM will be auto-assigned to a primary care dentist by the DBPM. Members, for whom the DBPM is the secondary payor, will not be assigned to a primary care dentist by the DBPM, unless the members request that the DBPM do so.
 - o The DBPM shall have written policies and procedures for handling the assignment of its members to a primary care dentist. The DBPM is responsible for linking to a primary care dentist all assigned DBPM members for whom the DBPM is the primary payor.
- Primary Care Dentist Auto-Assignments
 - o The DBPM is responsible for developing a primary care dentist automatic assignment methodology in collaboration with DHH to assign a member for whom the DBPM is the primary payor to a primary care dentist when the member:
 - Does not make a primary care dentist selection; or
 - Selects a primary care dentist within the DBPM that has restrictions/limitations (e.g. pediatric only practice).
 - o Assignment shall be made to a primary care dentist with whom, based on fee for service claims history or prior linkage, the member has a historical provider relationship. If there is no historical primary care dentist relationship, the member may be auto-assigned to a provider who is the assigned primary care dentist for an immediate family member enrolled in the DBPM. If other immediate family members do not have an assigned primary care dentist, auto-assignment shall be made to a provider with whom a family member has a historical provider relationship.
 - o If there is no member or immediate family historical usage, members shall be auto-assigned to a primary care dentist using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.

- o The final primary care dentist automatic assignment methodology must be provided thirty (30) days from the date the DBPM signs the contract with DHH, but no later than prior to the Readiness Review. Approval must be obtained from the Department prior to implementation. This methodology must be made available via the DBPM's website, and Provider Handbook.
- o The DBPM shall be responsible for providing to DHH, information on the number of Medicaid member linkages and remaining capacity of each individual primary care dentist of additional Medicaid member linkages on a quarterly basis.
- o If the member does not select a primary care dentist and is auto assigned to a primary care dentist by the DBPM, the DBPM shall allow the member to change primary care dentist.
- o If a member requests to change his or her primary care dentist, at any time, the DBPM may agree to grant this request for good cause.
- o The DBPM shall have written policies and procedures for allowing members to select a new primary care dentist, including auto-assignment, and provide information on options for selecting a new primary care dentist when it has been determined that a primary care dentist is non-compliant with provider standards (i.e. quality of care) and is terminated from the DBPM, or when a primary care dentist change is ordered as part of the resolution to a grievance proceeding, The DBPM shall allow members to select another primary care dentist within ten (10) business days of the postmark date of the termination of primary care dentist notice to members and provide information on options for selecting a new primary care dentist.
- o The DBPM shall have policies for accessing emergency/urgent care during this transition period. These policies and procedures shall be submitted within thirty (30) calendar days from the date the DBPM signs the Contract with DHH, but no later than prior to Readiness Review.

- Disenrollment

Disenrollment is any action taken by DHH or its designee to remove a DBPM member from the DBPM following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid or the DBP.

DHH will notify the DBPM of the member's disenrollment due to the following reasons:

- o Loss of Medicaid eligibility or loss of DBP enrollment eligibility;
- o Death of a member;
- o Member's intentional submission of fraudulent information;
- o Member becomes an inmate in a public institution;
- o Member moves out-of-state;
- o To implement the decision of a hearing officer in an appeal proceeding by the member against the DBPM or as ordered by a court of law.

- Disenrollment Effective Date
 - o The effective date of disenrollment shall be no later than the first day of the second month following the calendar month the request for disenrollment is submitted.
 - o If DHH or its designee fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment is submitted, the disenrollment is considered approved. The DBPM shall process all member file updates from the FI prior to the reconciliation process. Noncompliance with the reconciliation process may result in administrative sanctions.
 - o DHH and the DBPM shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.
- Enrollment and Disenrollment Updates
 - o Daily Updates
 - The FI shall make available to the DBPM daily incremental Member File updates in the format specified in the Systems Companion Guide. The DBPM shall have written policies and procedures for receiving these updates, incorporating them into its management information system and ensuring this information is available to their providers. Policies and procedures shall be available for review at the Readiness Review.
 - DHH will use its best efforts to ensure that the DBPM receives timely and accurate information to determine DBPM membership. In the event of discrepancies or irresolvable differences between DHH and the DBPM regarding members eligible for enrollment, DHH's decision is final.
 - o Weekly Reconciliation
 - Enrollment

In addition to the daily Member File updates, the FI will also provide a full Member File to the DBPM on a weekly basis. The DBPM is responsible for reconciliation of the membership list derived from the weekly Member File received from the FI against its internal records. The DBPM shall provide written notification to the FI of any data inconsistencies within 10 calendar days of receipt of the data file.
 - Payment

The DBPM will receive monthly electronic file (ASC X12N 820 Transaction) from the FI listing all members for whom the DBPM received a capitation payment and the amount received. The DBPM is responsible for reconciling this listing against its internal records. It is the DBPM's responsibility to notify the FI of any discrepancies. Lack of compliance with reconciliation requirements will result in the withholding of portion of future monthly payments and/or monetary penalties as defined in this RFP.

j) Member Education

i. General Guidelines

- Member education is defined as communication with an enrolled member of the DBPM.
- Member education can be both verbal and written.
- All member education guidelines are applicable to the DBPM, its agents, subcontractors, volunteers and/or providers.
- All member education activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of beneficiaries or the general community.
- All member education materials and activities shall comply with the requirements in 42 CFR §438.10 and the DHH requirements set forth in this RFP and the Dental Benefit Program Companion Guide.
 - o In accordance with 42 CFR §438.10(b)(1), DHH shall provide the DBPM the prevalent non-English language spoken by enrollees in the state. Prevalent is defined as five percent of the population statewide.
 - o The DBPM, as required in 42 CFR §438.10(c)(3), shall be responsible for providing to enrollees and potential enrollees written information in the prevalent non-English language in the DBPM's particular service area.
 - o In accordance with 42 CFR §438.10(c)(4)-(5) the DBPM shall provide enrollees oral interpretation services available free of charge, to all non-English languages rather than to only those DHH identifies as prevalent. The DBPM is responsible for providing all written materials in alternative formats and in a manner that considers the special needs of those who, for example, are visually limited or have limited reading proficiency.
- The DBPM is responsible for creation, production and distribution of its own member education materials to its members.
- All member education materials, in all mediums, must be reviewed and approved in writing by DHH or its designee in accordance with Social Security Act § 1932 (d)(2)(A) and 42 CFR §438.104.
- The DBPM shall assure DHH that member education materials are accurate and do not mislead, confuse, or defraud the member/potential member or DHH as specified in Social Security Act § 1932 (d) and 42 CFR §438.104.
- The DBPM shall participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members and comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Guidelines" at the following URL: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15> and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees.

ii. Marketing and Member Education Plan

- The DBPM shall develop and implement a plan detailing the member education activities it will undertake and materials it will create during the contract period. The detailed plan must be submitted to DHH for review and approval within thirty (30) calendar days from the date the contract is signed, but no later than prior to the Readiness Review.

- The DBPM shall not begin member education activities prior to the approval of the member education plan.
- The DBPM member education plan shall:
 - o List any subcontractors engaged in member education activities for the DBPM;
 - o State member education goals and strategies; and
 - o Include the DBPM's plans to monitor and enforce compliance with all member education guidelines.
- Any changes to the member education plan or included materials or activities must be submitted to DHH for approval at least thirty (30) days before implementation of the member education activity, unless the DBPM can demonstrate just cause for an abbreviated timeframe.

iii. Member Education Materials Approval Process

- The DBPM must obtain prior written approval from DHH for all member education materials as outlined in the Dental Benefit Program Companion Guide. This includes, but is not limited to, print, television and radio advertisements; handbooks, and provider directories; DBPM website screen shots; promotional items; brochures; letters and mass mailings and emails. Neither the DBPM nor its subcontractors may distribute any DBPM member education materials without DHH consent.
- DBPMs must obtain prior written approval for all materials developed by a recognized entity having no association with the DBPM that the DBPM wishes to distribute.

iv. Member Education – Required Materials and Services

The DBPM shall ensure all materials and services do not discriminate against DBP members on the basis of their health history, health status or need for healthcare services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the DBPM.

- Member Orientation –
 - o The DBPM shall have written policies and procedures for the following, but not limited to:
 - Orienting new members of its benefits and services;
 - Role of the primary care dentist;
 - What to do during the transition period;
 - How to utilize services;
 - What to do in a dental emergency or urgent dental situation; and
 - How to file a grievance and appeal.
 - o The DBPM shall identify and educate members who access the system inappropriately and provide continuing education as needed.
 - o The DBPM may propose, for approval by DHH, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.
 - o The DBPM shall have written policies and procedures for notifying newly identified members within ten (10) business days after receiving the Member File from the FI . This notification must be in

writing and include a listing of primary care dentist names (and include locations, and office telephone numbers) that the member may choose as their primary dental care provider.

- o The DBPM shall submit a copy of the procedures to be used to contact DBPM members for initial member education to DHH for approval within thirty (30) days following the date the Contract is signed by the DBPM, but no later than prior to the Readiness Review. These procedures shall adhere to the process and procedures outlined in this RFP, the Dental Benefit Program Companion Guide and the Contract.
- o New Medicaid eligibles who have not proactively selected a primary care dentist or whose choice of primary care dentist is not available will have the opportunity to select a primary care dentist within the DBPM that: 1) has entered into a subcontract with the DBPM; and 2) is within a reasonable commuting distance from their residence.

- Communication with New Members

- o DHH's FI shall send the DBPM a daily file in the format specified in the DBPM Systems Companion Guide. The file shall contain the names, addresses and phone numbers of all newly eligible members, as determined by the DBPM. The DBPM shall use the file Member File to assign primary care dentists and to identify and initiate communication with new members via welcome packet mailings as prescribed in this RFP.

- Welcome Packets

- o The DBPM shall send a welcome packet to new members within ten (10) business days from the date of receipt of the Member File from the FI. During the transition of the DBP Program from the FFS Program, the DBPM may have up to twenty-one (21) days to provide welcome packets.
 - o The DBPM must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two (2) or more new members, the DBPM is only required to send one welcome packet.
 - o All contents of the welcome packet are considered member education materials and, as such, shall be reviewed and approved in writing by DHH prior to distribution according to the provisions described in this RFP and the Dental Benefit Program Companion Guide. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:
 - A welcome letter highlighting major program features and contact information for the DBPM; and
 - A Provider Directory when specifically requested by the member (also must be available in searchable format on-line).
 - o The DBPM shall adhere to the requirements for the Provider Directory as specified in this RFP, the Dental Benefit Program Companion Guide, its attachments, and in accordance with 42 CFR §438.10 (f)(6).

v. Member Identification (ID) Cards

- DBP members shall use their DHH issued Medicaid ID card to access benefits and services covered as part of the Dental Benefit Program. The DBPM will not provide members with a separate ID card.
- The DHH issued Medicaid ID card shall not be proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by DBPM providers. These systems will contain the most current information available to DHH, including specific information regarding DBP enrollment.

vi. Provider Directory for Members

- The DBPM shall develop and maintain a Provider Directory in two (2) formats:
 - o Web-based, searchable, online directory for members and the public; and
 - o A hard copy directory for members upon request only;
- DHH or its designee shall provide the file layout for the electronic directory to the DBPM after approval of the Contract. The DBPM shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed, but no later than prior to Readiness Review.
- The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly for new members and to fulfill only requests. The web-based online version shall be updated in real time, however no less than weekly.
- In accordance with 42 CFR §438.10(f) (6), the provider directory shall include, but not be limited to:
 - o Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, primary care dentists, specialists, and providers that are not accepting new patients at a minimum;
 - o Identification of primary care dentists, specialists, and dental groups in the service area;
 - o Identification of any restrictions on the enrollee's freedom choice among network providers; and
 - o 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).

vii. Member Call Center

- The DBPM shall maintain a toll-free member service call center, physically located in the United States, The member service lines shall be adequately staffed and individuals trained to accurately respond to questions regarding:
 - o DBPM policies and procedures;
 - o Prior authorizations;
 - o Access information;

- o Information on primary care dentists or specialists;
 - o Referrals to participating specialists;
 - o Resolution of service and/or dental delivery problems; and
 - o Member grievances.
- The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday.

The toll-free line shall have an automated system, available 24-hours a day, and seven days a week, including all federal and state holidays. This automated system must include the capability of providing callers with operating instructions on what to do in case of a dental emergency and the option to leave a message, including instructions on how to leave a message and when that message will be returned. The DBPM must ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.

- The DBPM shall have sufficient telephone lines to answer incoming calls. The DBPM shall ensure sufficient staffing to meet performance standards listed in this RFP. DHH reserves the right to specify staffing ratio and/or other requirements, if performance standards are not met or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by DHH.
- The DBPM must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for DBPM performance. The DBPM must develop and implement a plan to sustain call center performance levels 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.
- The DBPM 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 DBPM shall submit these telephone help line policies and procedures, including performance standards, to DHH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The DBPM call center must have the capability to produce an electronic record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.
- The DBPM 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 DBPM shall submit call center quality criteria and protocols to DHH for review and approval at the Readiness Review and approval annually.

viii. Member Call Center Performance Standards

- Answer ninety-five (95) percent of calls within thirty (30) seconds by a live person or direct the call to an automatic call pickup system with IVR options;
- No more than one percent of incoming calls receives a busy signal;
- Maintain an average hold time (the time a caller spends waiting to speak to a live person, once requested) of three (3) minutes or less; Hold time, or wait time, for the purposes of this RFP includes 1) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person, and 2) the measure of time when a customer service representative places a caller on hold.
- Maintain abandoned rate of calls of not more than five (5) percent.
- The DBPM must conduct ongoing quality assurance to ensure these standards are met.
- If DHH determines that it is necessary to conduct onsite monitoring of the DBPM's member call center functions, the DBPM is responsible for all reasonable costs incurred by DHH or its authorized agent(s) relating to such monitoring.
- The DBPM shall have written policies regarding member rights and responsibilities. The DBPM shall comply with all applicable state and federal laws pertaining to member rights and privacy. The DBPM shall further ensure that the DBPM's employees, contractors and DBPM providers consider and respect those rights when providing services to members.

ix. ACD System

- The DBPM shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:
 - o Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;
 - o Transfer calls to other telephone lines;
 - o Provide an option to speak to a live person (during call center hours of operation);
 - o Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;
 - o Provide a message that notifies callers that the call may be monitored for quality control purposes;
 - o Measure the number of calls in the queue at peak times;
 - o Measure the length of time callers are on hold;
 - o Measure the total number of calls and average calls handled per day/week/month;
 - o Measure the average hours of use per day;
 - o Assess the busiest times and days by number of calls;
 - o Record calls to assess whether answered accurately;
 - o 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 is not disrupted;

- o Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and
- o Inform the member to dial 911 if there is an emergency.

x. Member Responsibilities

- The DBPM shall encourage each member to be responsible for his own healthcare by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate dental, 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, and/or worsening of the condition arises.
- The DBP members' responsibilities shall include but are not limited to:
 - o Presenting their DHH issued Medicaid ID card when using healthcare services;
 - o Being familiar with the DBP procedures to the best of the member's abilities;
 - o Calling or contacting the DBPM to obtain information and have questions answered;
 - o Providing participating network providers with accurate and complete dental information;
 - o 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;
 - o Living healthy lifestyles and avoiding behaviors known to be detrimental to their health;
 - o Following the grievance process established by the DBPM if they have a disagreement with a provider; and
 - o Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.

xi. Notice to Members of Provider Termination

- The DBPM shall give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.
- The DBPM shall provide notice to a member, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the DBPM becomes aware of such, if it is prior to the change occurring.
- Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, or when a provider fails credentialing or is displaced as a result

of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the DBPM becoming aware of the circumstances. The DBPM shall document the date and method of notification of termination.

xii. Additional Member Educational Materials and Programs

The DBPM shall prepare and distribute educational materials, not less than two (2) times a year, that provide information on preventive care, health promotion, access to care or other targeted dental related issues. This should include notification to its members of their right to request and obtain the welcome packet at least once a year and any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date. All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.

xiii. Oral and Written Interpretation Services

- The DBPM must make real-time oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish and Vietnamese). The member is not to be charged for interpretation services. The DBPM must notify its members that oral 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.
- The DBPM shall ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language by more than five percent of the population statewide. Within 90 calendar days of notice from DHH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the DBPM and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).

xiv. Member Materials

The DBPM shall include in all member materials the following:

- The date of issue;
- The date of revision; and/or
- If prior versions are obsolete.

xv. Member and State Fair Hearing Procedures

- The DBPM must have a grievance system that complies with 42 CFR, Part 438, Subpart F. The DBPM 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.
- The DBPM's grievance and appeals procedures must be submitted prior to the Readiness Review for review and approval and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in this RFP.

- The DBPM shall refer all DBP members who are dissatisfied with the DBPM or its subcontractor in any respect to the DBPM's designee authorized to review and respond to grievances and appeals and require corrective action
- The member must exhaust the DBPM's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.
- The DBPM shall not create barriers to timely due process. The DBPM shall be subject to sanctions if it is determined by DHH that the DBPM has created barriers to timely due process, and/or, if ten (10) percent or higher of grievance 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 creating barriers shall include but not be limited to:
 - o Labeling complaints as inquiries and funneled into an informal review;
 - o Failing to inform members of their due process rights;
 - o Failing to log and process grievances and appeals;
 - o Failure to issue a proper notice including vague or illegible notices;
 - o Failure to inform of continuation of benefits; and
 - o Failure to inform of right to State Fair Hearing

xvi. General Grievance System Requirements

- Grievance System
The DBPM must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the DBPM's appeal process has been exhausted.
- Authority to File
 - o A member, or authorized representative acting on the member's behalf, may file a grievance and a DBPM level appeal, and may request a State Fair Hearing, once the DBPM's appeals process has been exhausted.
 - o A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.
- Time Limits for Filing
The member must be allowed thirty (30) calendar days from the date on the DBPM's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.
- Procedures for Filing
 - o The member may file a grievance either orally or in writing with the DBPM.
 - o The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's written consent, may file an appeal either orally or in writing; and unless he or she orally requests an expedited resolution and follows up with a written, signed appeal request.

xvii. Notice of Grievance and Appeal Procedures

The DBPM shall ensure that all DBP members are informed of the State Fair Hearing process and of the DBPM's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the DBPM shall be available through the DBPM, and must be provided upon request of the member. The DBPM shall make all forms easily available on the DBPM's website.

xviii. Grievance/Appeal Records and Reports

- The DBPM must maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) 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 six (6) year period, whichever is later.
- The DBPM shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.
- The DBPM will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the DBPM member. DHH may submit recommendations to the DBPM regarding the merits or suggested resolution of any grievance/appeal.

xix. Handling Grievances and Appeals

- General Requirements - In handling grievances and appeals, the DBPM must meet the following requirements:
 - o Acknowledge receipt of each grievance and appeal in writing;
 - o 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/TTD and interpreter capability;
 - o Ensure that the individuals who make decisions on grievances and appeals are individuals:
 - Who were not involved in any previous level of review or decision-making; and
 - Who, if deciding any of the following, are healthcare professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease:
 - An appeal of a denial that is based on lack of medical necessity; or
 - A grievance or appeal regarding denial of expedited resolution of an appeal; or
 - A grievance or appeal that involves clinical issues.

- Special Requirements for Appeals

The process for appeals must:

- Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), unless the member or the provider requests expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing; however if filed orally the requestor must follow up in writing. No additional member follow-up is required.
- Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The DBPM must inform the member of the limited time available for this in the case of expedited resolution).
- Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including dental records, and any other documents and records considered during the appeals process.
- Include, as parties to the appeal:
 - The member and his or her representative; or
 - The legal representative of a deceased member's estate.

- Training of DBPM Staff

The DBPM's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

- Identification of Appropriate Party

The appropriate individual or body within the DBPM having decision making authority as part of the grievance/appeal procedure shall be identified.

- Failure to Make a Timely Decision

Appeals shall be resolved no later than stated time frames and all parties shall be informed of the DBPM's decision. If a determination is not made in accordance with the timeframes specified in this RFP, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

- Right to State Fair Hearing

The DBPM shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the DBPM's decision in response to an appeal and the process for doing so.

xx. Notice of Action

- Language and Format Requirements

The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) to ensure ease of understanding.

- Content of Notice of Action

The Notice of Action must explain the following:

- o The action the DBPM or its contractor has taken or intends to take;
- o The reasons for the action;
- o The member's or the provider's right to file an appeal with the DBPM;
- o The member's right to request a State Fair Hearing, after the DBPM's appeal process has been exhausted;
- o The procedures for exercising the rights specified in this section
- o The circumstances under which expedited resolution is available and how to request it;
- o 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
- o Oral interpretation is available for all languages and how to access it.

- Timing of Notice of Action

The DBPM must mail the Notice of Action within the following timeframes:

- o For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except when the period of advanced notice is shortened to five days if probable member fraud has been verified by the date of the action for the following:
 - In the death of a member,
 - A signed member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information),
 - The member's admission to an institution where he is ineligible for further services,
 - The member's address is unknown and mail directed to him has no forwarding address,
 - The member has been accepted for Medicaid services by another local jurisdiction, or
 - The member's dentist prescribes the change in the level of dental care as permitted under 42 C.F.R. §431.213 and §431.214.
- o For denial of payment, at the time of any action affecting the claim.
- o For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if
 - The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or
 - The DBPM justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

- o If the DBPM extends the timeframe in accordance, it must:
 - 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
 - Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- o On the date the timeframe for service authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.
- o For expedited service authorization decisions where a provider indicates, or the DBPM determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM 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.
- o The DBPM may extend the seventy-two (72) hours' time period by up to fourteen (14) calendar days if the member requests an extension, or if the DBPM justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.
- o DHH shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

xxi. Resolution and Notification

The DBPM must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.

- Specific Timeframes

- o Standard Disposition of Grievances
For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the DBPM receives the grievance. This timeframe may be extended under the terms of the RFP below.
- o Standard Resolution of Appeals
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 DBPM receives the appeal.
- o Expedited Resolution of Appeals
For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the DBPM receives the appeal.

- Extension of Timeframes

- o The DBPM may extend the timeframes of this section by up to fourteen (14) calendar days if:
 - The member requests the extension; or

- The DBPM shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.
 - Requirements Following Timeframe Extension
If the DBPM extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.
- Format of Notice of Disposition
 - Grievances
The DBPM will provide written notice to the member of the disposition of a grievance.
 - Appeals
For all appeals, the DBPM must provide written notice of disposition.
 - Expedited Resolution
For notice of an expedited resolution, the DBPM must also make reasonable efforts to provide oral notice.
- Content of Notice of Appeal Resolution
The written notice of the resolution must include the following:
 - The results of the resolution process and the date it was completed; and
 - For appeals not resolved wholly in favor of the members:
 - The right to request a State Fair Hearing, and how to do so;
 - The right to request to receive benefits while the hearing is pending, and how to make the request; and
 - That the member may be held liable for the cost of those benefits if the hearing decision upholds the DBPM's action.
- Requirements for State Fair Hearings
DHH shall comply with the requirements of 42 CFR §431.200(b), §431.220(5) and 42 CFR §438.414 and §438.10(g)(1). The DBPM shall comply with all requirements as outlined in this RFP.
 - **Availability**
If the member has exhausted the DBPM level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the DBPM's notice of resolution.
 - **Parties**
The parties to the State Fair Hearing include the DBPM as well as the member and his or her representative or the representative of a deceased member's estate.

xxii. Expedited Resolution of Appeals

The DBPM must establish and maintain an expedited review process for appeals, when the DBPM determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

- Prohibition Against Punitive Action
The DBPM must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, that requests an expedited resolution or supports a member's appeal.
- Action Following Denial of a Request for Expedited Resolution
 - o If the DBPM denies a request for expedited resolution of an appeal, it must:
 - Transfer the appeal to the timeframe for standard resolution in accordance with the prescribed timeframes; and
 - Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.
 - o This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.
 - o Failure to Make a Timely Decision
Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the DBPM's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.
 - o Process
 - The DBPM shall be required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. Appeals filed orally must be followed up in writing. No additional follow-up may be required.
 - The DBPM shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.
 - o Authority to File
The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required
 - o Format of Resolution Notice
In addition to written notice, the DBPM must also make reasonable effort to provide oral notice.

xxiii. Continuation of Benefits

- Terminology - As used in this section, "timely" filing means filing on or before the later of the following:
 - o Within ten (10) calendar days of the DBPM mailing the notice of action;
 - or
 - o The intended effective date of the DBPM's proposed action.
- The DBPM must continue the member's benefits if:
 - o The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely;
 - o The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

- o The services were ordered by an authorized provider;
 - o The original period covered by the original authorization has not expired; and
 - o The member requests extension of benefits.
- **Duration of Continued or Reinstated Benefits**
If, at the member's request, the DBPM continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
 - o The member withdraws the appeal;
 - o Ten (10) calendar days pass after the DBPM mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;
 - o A State Fair Hearing Officer issues a hearing decision adverse to the member; or
 - o The time period or service limits of a previously authorized service has been met.
 - **Member Responsibility for Services Furnished While the Appeal is Pending**
If the final resolution of the appeal is adverse to the member, that is, upholds the DBPM's action, the DBPM may recover the cost of the services furnished to the member while the appeal is 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).
 - **Information to Providers and Contractors**
The DBPM must provide the information specified at 42 CFR §438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.
 - **Recordkeeping and Reporting Requirements**
Reports of grievances and resolutions shall be submitted to DHH as specified in this RFP. The DBPM shall not modify the grievance procedure without the prior written approval of DHH.
 - **Services Not Furnished While the Appeal is Pending**
If the DBPM 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 DBPM must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.
 - **Services Furnished While the Appeal is Pending**
If the DBPM 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 DBPM must pay for those services, in accordance with this Contract.

k) Quality Management

i. Quality Assessment and Performance Improvement Program (QAPI)

- The DBPM shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as described in 42 CFR 438.240(a)(1), to:
 - o Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;
 - o Incorporate improvement strategies that include, but are not limited to:
 - performance improvement projects;
 - dental record audits;
 - performance measures; and
 - surveys
 - o Detect underutilization and overutilization of services
 - o Assess the quality and appropriateness of dental care furnished to enrollees with special healthcare needs.
- The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.
- The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.
- The DBPM shall submit its QAPI Program description to DHH for written approval within thirty (30) days from the date the Contract is signed, but no later than prior to the Readiness Review.
- The DBPM's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the DBPM's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the DBPM.

ii. QAPI Committee

- The DBPM shall form a QAPI Committee that shall, at a minimum include:
 - o The DBPM Dental Director must serve as either the chairman or co-chairman;
 - o Appropriate DBPM staff representing the various departments of the organization will have membership on the committee; and
 - o The DBPM is encouraged to include a member advocate representative on the QAPI Committee.
- QAPI Committee Responsibilities

The committee shall:

- o Meet on a quarterly basis;
- o Direct and review quality improvement (QI) activities;
- o Assure that QAPI activities are implemented throughout the DBPM;
- o Review and suggest new and or improved QI activities;

- o Direct task forces/committees to review areas of concern in the provision of healthcare services to members;
- o Designate evaluation and study design procedures;
- o Conduct individual primary care dentist and primary care dentist practice quality performance measure profiling;
- o Report findings to appropriate executive authority, staff, and departments within the DBPM;
- o Direct and analyze periodic reviews of members' service utilization patterns;
- o Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to DHH with other quarterly reports;
- o Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management activities; and
- o Ensure that a QAPI committee designee attends DHH Quality Committee meetings.

- QAPI Work Plan

The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) calendar days from the date the Contract with DHH is signed, but no later than prior to the Readiness Review, by the DBPM and annually thereafter, and prior to revisions. The QAPI plan, at a minimum, shall:

- o Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;
- o Include processes to evaluate the impact and effectiveness of the QAPI Program;
- o Include a description of the DBPM staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and
- o Describe the role of its providers in giving input to the QAPI Program.

- QAPI Reporting Requirements

- o The DBPM shall submit QAPI reports annually to DHH which, at a minimum, shall include:
 - Quality improvement (QI) activities;
 - Recommended new and/or improved QI activities; and
 - Evaluation of the impact and effectiveness of the QAPI program.
- o DHH reserves the right to request additional reports as deemed necessary. DHH will notify the DBPM of additional required reports no less than sixty (60) days prior to due date of those reports.

l) Performance Measures

i. The DBPM shall report clinical and administrative performance measure (PM) data on at least an annual basis, as specified by DHH.

- The DBPM shall report on PMs listed in Appendix N which include, but are not limited to, Agency for Healthcare Research and Quality Review (AHRQ), Dental Quality Alliance (DQA), , and/or other measures as determined by DHH.
- The DBPM shall have processes in place to monitor and report all performance measures.
- Clinical PM outcomes shall be submitted to DHH at least annually and upon DHH request. Detailed data shall be made available to support any summary report of Clinical outcomes QIPs.
- Administrative PMs shall be submitted to DHH at least quarterly and upon DHH request. Detailed data shall be made available to support any summary report of Administrative QIPs.
- The reports and data shall demonstrate adherence to clinical practice guidelines and shall demonstrate changes in patient outcomes.
- Performance measures may be used to create PIPs which are the DBPM's activities to design, implement and sustain systematic improvements based on their own data.

ii. Performance Measures Reporting

- All Administrative PMs are reporting measures.
 - o Administrative measure reporting is required at least quarterly and upon DHH's request.
 - o Clinical Performance measures shall be reported at least annually and upon DHH request 12 months after services begin.
- DHH may add or remove PM reporting requirements with a sixty (60) day advance notice.

iii. Performance Measure Goals

- The Department shall establish benchmarks for Performance Measures utilizing statewide data of the Medicaid Fee for Service population from 2013 with the expectation that performance improves by a certain percentage toward the benchmarks.
- The Performance Measure Goals are contained in Appendix N.
- At the department's discretion after the initial contract year, a maximum of 2.5% (0.5% for each of 5 specific performance measures) of the total monthly capitation payment may be deducted from the total capitation payment to be made in the month of October following the measurement CY if specified performance measures fall below DHH's established benchmarks for improvement.

iv. Performance Indicator Reporting Systems

- The DBPM shall utilize DHH-approved systems, operations, and performance monitoring tools and/or automated methods for monitoring. Access to such systems and tools shall be granted to DHH as needed for oversight.
- The monitoring tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.

- The DBPM shall have processes in place to monitor and self-report performance measures included by not limited to measures listed in Appendix F.
- The DBPM shall provide individual primary care dentist clinical quality profile reports.

v. Performance Measure Monitoring

- DHH will monitor the DBPM's performance using Benchmark Performance and Improvement Performance data.
- During the course of the Contract, DHH or its designee shall communicate with the DBPM regarding the data and reports received as well as meet with representatives of the DBPM to review the results of performance measures.
- The DBPM shall comply with External Quality Review, review of the Quality Assessment Committee meeting minutes and annual dental audits to ensure that it provides quality and accessible healthcare to DBPM members, in accordance with standards contained in the Contract. Such audits shall allow DHH or its duly authorized representative to review individual dental records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the reasons for member disenrollment.
- The standards by which the DBPM shall be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the DBPM must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. DHH must prior approve the CAP and will monitor the DBPM's progress in correcting the deficiencies.

vi. Performance Measure Corrective Action Plan

- A corrective action plan (CAP) shall be required for performance measures that do not reach the Department's performance benchmark.
- The DBPM shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the deficiencies identified by DHH.
- Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the DBPM shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH.
- Upon approval of the CAP, whether the initial CAP or the revised CAP, the DBPM shall implement the CAP within the time frames specified by DHH.
- DHH may impose monetary penalties, and sanctions pending attainment of acceptable quality of care.

m) Annual Member Satisfaction Survey

- i. The DBPM shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members each contract year.
- ii. Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.
- iii. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the DBPM at the time of the survey.

- iv. The surveys shall provide valid and reliable data for results statewide and by parish.
- v. Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.
- vi. The most current CAHPS DBPM Survey (currently 4.0) for Medicaid Enrollees shall be used and include:
 - Getting Needed Care
 - Getting Care Quickly
 - How Well Doctors Communicate
 - DBPM Customer Service
 - Global Ratings
 - Member Satisfaction Survey Reports are due 120 calendar days after the end of the contract year.

n) Provider Satisfaction Surveys

- i. The DBPM shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes. The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.
- ii. The DBPM shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.

o) DHH Oversight of Quality

- i. DHH shall evaluate the DBPM's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by DHH, or as otherwise specified by the Contract.
- ii. If DHH determines that the DBPM's quality performance is not acceptable, the DBPM must submit a corrective action plan (CAP) for each unacceptable performance measure. If the DBPM fails to provide a CAP within the time specified, DHH will sanction the DBPM in accordance with the provisions of sanctions set forth in the Contract.
- iii. Upon any indication that the DBPM's quality performance is not acceptable, DHH may impose sanctions or terminate the contract.
- iv. The DBPM shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.

p) Credentialing and Re-credentialing of Providers and Clinical Staff

- i. The DBPM must have a written credentialing and re-credentialing process that complies with 42 CFR 438.12, 438.206, 438.214, 438.224 and 438.230 for the review and 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 DBPM selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.
- ii. The process for periodic re-credentialing shall be implemented at least once every thirty-six (36) months.

- iii. If the DBPM has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The DBPM must require that the subcontractor provide assurance that all licensed dental professionals are credentialed in accordance with DHH's credentialing requirements. DHH will have final approval of the delegated entity.
- iv. The DBPM shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.
- v. The DBPM shall develop and implement a mechanism, with DHH's approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) calendar days from the date the Contract is signed, but no later than 30 calendar days prior to the Readiness Review, and at the time of any change.
- vi. The DBPM shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the DBPM against network provider/contractor(s) as specified in the Contract.
- vii. This process shall be submitted for review and approval thirty (30) calendar days from the date the Contract is signed, but no later than 30 calendar days prior to the Readiness Review, and at the time of any change.

4. Staffing Requirements/Qualifications

- A. The DBPM shall have in place the organizational, operational, managerial, and administrative systems capable of fulfilling all RFP requirements. The DBPM shall be staffed by qualified persons in numbers appropriate to the DBPM's size of enrollment.
- B. For the purposes of this RFP, the DBPM shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b), 42 CFR 1001.1901(b), 42 CFR 1003.102(a)(2)]. The DBPM must screen all employees and sub-contractors 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 DBPM must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The DBPM'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 DHH policy requirements, including the requirement for providing culturally competent services. If the DBPM does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by DHH, including but not limited to requiring the DBPM to hire additional staff and application of monetary penalties.
- D. The DBPM shall comply with DHH Policy 8133-98, "Criminal History Records Check of Applicants and Employees", which requires criminal background checks to be performed on all employees of DHH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide DHH 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 this Contract.
- E. Key Personnel Positions

1. An individual staff member shall not occupy more than one of the key personnel positions listed below unless prior approval is obtained by DHH or otherwise stated below.
2. The DBPM may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law.
3. The DBPM shall inform DHH in writing when an employee vacates one of the director positions listed below (this requirement does not apply to additional required staff, also listed below). The name of the interim contact person shall be included with the notification. This notification shall take place within (5) business days of the resignation/termination.
4. The DBPM shall replace any of the key personnel with a person of equivalent experience, knowledge and talent, within thirty (30) calendar days of resignation/termination of previous staff. The name and resume of the permanent employee shall be submitted, within five (5) business days of the new hire taking place along with a revised organization chart complete with key personnel time allocation.
5. Replacement of the Executive Director or Dental Director shall require or prior written approval from DHH (i.e., Medicaid Managed Care Director) which shall not be unreasonably withheld provided a suitable candidate is proposed.
6. Annually, the DBPM must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key personnel. DHH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].
7. DBPM must designate key management and technical personnel who will be assigned to the Contract. For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility for the following functional areas:
 - a) Member Services;
 - b) Management Information Systems;
 - c) Claims Processing;
 - d) Provider Network Development and Management
 - e) Benefit Administration and Utilization and Care Management;
 - f) Quality Improvement;
 - g) Financial Functions;
 - h) Reporting
 - i) Executive Director; and
 - j) Dental Director.

F. In-State Positions

The DBPM shall maintain a physical presence in Louisiana. Positions that shall be located in Louisiana are the following:

1. Executive Director
 - a) The DBPM must employ a qualified individual to serve as the Executive Director for the Dental Program. Such Executive Director must be employed full-time by the Dental Contractor, be primarily dedicated to the Dental Program, and must hold a Senior Executive or Management position in the Dental Contractor's organization, except that the Dental Contractor may propose an alternate structure for the Executive Director position, subject to DHH's prior review and written approval.\
 - b) The Executive Director must be authorized and empowered to represent the DBPM regarding all matters pertaining to the Contract prior to such representation. The

Executive Director must act as liaison between the DBPM and DHH and must have responsibilities that include, but are not limited to:

- i. Ensuring the DBPM's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance.
 - ii. Receiving and responding to all inquiries and requests made by DHH related to the Contract, in the timeframes and formats specified by DHH. Where practicable, DHH will consult with the DPBM to establish timeframes and formats reasonably acceptable to the Parties.
 - iii. Attending and participating in regular meetings or conference calls with DHH.
 - iv. Making best efforts to promptly resolve any issues identified either by the DBPM or DHH that may arise and are related to the Contract.
 - v. Meeting with DHH representative(s) on a periodic or as needed basis to review the DBPM's performance and resolve issues.
 - vi. Meeting with DHH at the time and place requested by DHH, if DHH determines that the DBPM is not in compliance with the requirements of the Contract.
2. Dental Director - must have a qualified full-time individual to serve as the Dental Director for the DBPM.
- a) The Dental Director must be currently licensed in Louisiana as a Doctor of Dentistry ("dentist,") with no restrictions or other licensure limitations. The Dental Director must comply with applicable federal and state statutes and regulations.
 - b) The Dental Director must be available during normal business hours for Utilization Review decisions, and must be authorized and empowered to represent the Dental Contractor regarding clinical issues, Utilization Review and quality of care inquiries.

3. Staff performing the Provider Network Development and Management function.

G. Written Policies, Procedures, and Job Description

1. The DBPM shall develop and maintain written policies, procedures and job descriptions for each functional area, consistent in format and style. The DBPM shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. All policies and procedures shall be reviewed at least annually to ensure that the DBPM's written policies reflect current practices. Reviewed policies shall be dated and signed by the DBPM's appropriate manager, coordinator, director or administrator. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All dental and quality management policies must be approved and signed by the DBPM's Dental Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements.
2. Based on provider or member feedback, if DHH deems a DBPM policy or process to be inefficient and/or places an unnecessary burden on the members or providers, the DBPM shall be required to work with DHH to change the policy or procedure within a time period specified by DHH.

H. Staff Training and Meeting Attendance

1. The DBPM shall ensure that all staff members have appropriate training, education, experience and orientation to fulfill their requirements of the position. DHH may require additional staffing if the DBPM has substantially failed to maintain compliance with any provision of the contract and/or DHH policies.

2. The DBPM must provide initial and ongoing staff training that includes an overview of DHH, Medicaid Policy and Procedure Manuals, and Contract and state and federal requirements specific to individual job functions. The DBPM shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.
3. New and existing prior authorization and member services representatives must be trained in the geography of Louisiana and have access to mapping search engines (e.g. MapQuest, Yahoo Maps, Google Maps, etc.) for the purposes of authorizing services in; recommending providers in; and transporting members to the most geographically appropriate location.
4. The DBPM shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by DHH. All meetings shall be considered mandatory unless otherwise indicated.
5. DHH reserves the right to attend any and all training programs and seminars conducted by the DBPM. The DBPM shall provide DHH a list of any marketing training dates and time and location, at least fourteen (14) calendar days prior to the actual date of training.

I. Annual Reporting to DHH

The DBPM must submit to the DHH the following items annually:

1. An updated organization chart complete with the key personnel positions. The chart must include the person's name, title and telephone number and portion of time allocated to the Louisiana Medicaid contract, other Medicaid contracts, and other lines of business.
2. A functional organization chart of the key program areas, responsibilities and the areas that report to that position.
3. A listing of all functions and their locations; and a list of any functions that have moved outside of the state of Louisiana in the past contract year.

5. Reporting Requirements

A. General Requirements

1. The DBPM shall comply with all the reporting requirements established by this Contract. As per 42 CFR 438.242(a)(b)(1)(2) and (3), the DBPM shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization and grievances and appeals. The DBPM shall collect data on member and provider characteristics and on services furnished to members.
2. The DBPM shall create reports or files (known as Deliverables) using the electronic formats, instructions, and timeframes as specified by DHH and at no cost to DHH. Any changes to the formats must be approved by DHH prior to implementation.
3. The DBPM shall provide DHH with a sample of all reports within forty-five (45) calendar days following the date the Contract is signed, but no later than prior to the Readiness Review.
4. In the event that there are no instances to report, the DBPM shall submit a report so stating.
5. As required by 42 CFR 438.604(a) and (b), and 42 CFR 438.606, the DBPM shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, financial reports, encounter data, and other information as specified within this RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data.

The DBPM must submit the certification concurrently with the certified data and documents. DHH will identify specific data that requires certification.

6. The data shall be certified by one of the following:
 - a) DBPM's Executive Director; or
 - b) An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

B. Ad Hoc Reports

The DBPM shall prepare and submit any other reports as required and requested by DHH, any of DHH designees, and/or CMS, that is related to the DBPM's duties and obligations under this Contract. Information considered to be of a proprietary nature shall be clearly identified as such by the DBPM at the time of submission. DHH will make every effort to provide a sixty (60) day notice of the need for submission to give the DBPM adequate time to prepare the reports. However, there may be occasions the DBPM will be required to produce reports in a shorter timeframe.

C. Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.104). Form CMS 1513, Ownership and Control Interest Statement, is to be submitted to DHH with the proposal; then resubmitted prior to implementation for each Contract period or when any change in the DBPM's management, ownership or control occurs. The DBPM shall report any changes in ownership and disclosure information to DHH within thirty (30) calendar days prior to the effective date of the change.

D. Information Related to Business Transactions

1. The DBPM shall furnish to DHH or to the HHS, information related to significant business transactions as set forth in 42 CFR 455.105. Failure to comply with this requirement may result in termination of this Contract.
2. The DBPM shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about:
 - a) The ownership of any subcontractor with whom the DBPM has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of this request; and
 - b) Any significant business transactions between the DBPM and any wholly owned supplier or between the DBPM and any subcontractor, during the five (5) year period ending on the date of this request.
3. For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the \$25,000 or five (five percent) percent of the DBPM's total operating expenses whichever is greater.
4. Report of Transactions with Parties in Interest
 - a) The DBPM shall report to DHH all "transactions" with a "party of interest" as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B), as required by Section 1903(m)(4)(A) of the Social Security Act. Federally qualified plans are exempt from this requirement.
 - i. Definition of Party in Interest – As defined in 1318(b) of the Public Health Service Act, a party in interest is:
 - Any director, officer, partner, or employee responsible for management or administration of a DBPM any person who is directly or indirectly the beneficial owner of more than five percent of the equity of the DBPM; any person who is the beneficial owner of a mortgage, deed of trust, note, or other

- interest secured by, and valuing more than five percent of the DBPM; or, in the case of a DBPM organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
 - Any organization in which a person described in subsection “I” is director, officer, or partner; has directly or indirectly a beneficial interest of more than five percent of the equity of the DBPM; or has a mortgage, deed of trust, note, or other interest valuing more than five percent of the assets of the DBPM;
 - Any person directly or indirectly controlling, controlled by, or under common control with a DBPM; or
 - Any spouse, child, or parent of an individual described in subsections a, b, or c.
- ii. Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include
- Any sale, exchange, or lease of any property between the DBPM and a party in interest;
 - Any lending of money or other extension of credit between the DBPM and the party in interest; and
 - Any furnishing for consideration of goods, services (including management services), or facilities between the DBPM and the party in interest. This does not include salaries paid to employees for services in the normal course of their employment.
- iii. The information that must be disclosed in the transactions listed in subsection b above between a DBPM and a party in interest includes
- The name of the party in interest for each transaction;
 - A description of each transaction and the quantity or units involved
 - The accrued dollar value of each transaction during the fiscal year; and
 - Justification of the reasonableness of each transaction.
- iv. DHH may require that the information on business transactions be accompanied by a consolidated financial statement for the DBPM and the party in interest.
- v. If the DBPM has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the DBPM’s business transactions must be reported.
- vi. If the contract is renewed or extended, the DBPM must disclose information on business transactions which occurred during the prior contract period.
- b) Section 1318(b) of the Public Health Service Act defines party of interest as follows:
- i. Any director, officer, partner, or employee responsible for management or administration of the DBPM; any person who is directly or indirectly the beneficial owner of more than five percent of the equity of the DBPM; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent of the DBPM; or, in the case of the DBPM organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
 - ii. Any organization in which a person described in the preceding subsection is director, officer or partner; has a direct interest of more than five percent of the equity of the DBPM; or has a mortgage, deed of trust, note, or other interest valuing more than five percent of the assets of the DBPM;

- iii. Any person directly or indirectly controlling, controlled by, or under common control with the DBPM; or
 - iv. Any spouse, child, or parent of an individual described in the preceding subsections.
- c) Business transactions that must be disclosed include the following:
 - Any sale, exchange, or lease of any property between the DBPM and a party of interest;
 - Any lending of money or other extension of credit between the DBPM and a party of interest; and
 - Any furnishing for consideration of goods, services (including management services) or facilities between the DBPM and the party of interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
 - d) Information that must be disclosed for the transactions listed includes the following:
 - The name of the party in interest for each transaction;
 - A description of each transaction and the quantity or units involved;
 - The accrued dollar value of each transaction during the fiscal year; and
 - Justification of the reasonableness of the transaction.
 - e) DHH may require that the information on business transactions be accompanied by a consolidated financial statement for the DBPM and the party of interest.
 - f) If the DBPM has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the DBPM's business transactions must be reported.
 - g) If the contract is renewed or extended, the DBPM must disclose information on business transactions which occurred during the prior contract period.

E. Encounter Data

1. The DBPM shall comply with the required format provided by DHH. Encounter data includes claims paid by the DBPM for services delivered to members through the DBPM during a specified reporting period. DHH collects and uses this data for many reasons such as: federal reporting, rate setting, service verification, managed care quality improvement program, utilization patterns, access to care, and research studies.
2. DHH may change the Encounter Data Transaction requirements with thirty (30) calendar days' written notice to the DBPM. The DBPM shall, upon notice from DHH, provide notice of changes to subcontractors.

F. Information on Persons Convicted of Crimes

The DBPM shall furnish DHH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR 455.106. Failure to comply with this requirement may lead to termination of this Contract.

G. Errors

1. The DBPM agrees to prepare complete and accurate reports for submission to DHH. If after preparation and submission, a DBPM error is discovered either by the DBPM or DHH; the DBPM shall correct the error(s) and submit accurate reports as follows:
 - a) For encounters - In accordance with the timeframes specified in the Administrative Actions, Monetary Penalties and Sanctions Section of this RFP.

- b) For all reports – Fifteen (15) calendar days from the date of discovery by the DBPM or date of written notification by DHH (whichever is earlier). DHH may at its discretion extend the due date if an acceptable corrective action plan has been submitted and the DBPM can demonstrate to DHH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.
2. Failure of the DBPM to respond within the above specified timeframes may result in a loss of any money due the DBPM and the assessment of monetary penalties as provided in Administration Actions, Monetary Penalties and Sanctions Section of this RFP.

H. Report Submission Timeframes

1. The DBPM shall ensure that all required reports or files, as stated in this RFP, are submitted to DHH in a timely manner for review and approval. The DBPM's failure to submit the reports or files as specified may result in the assessment of monetary penalties, as stated in the Administrative Actions, Monetary Penalties, and Sanctions Section of this RFP.
2. Unless otherwise specified, deadlines for submitting files and reports are as follows:
 - a) Daily reports and files shall be submitted within one (1) business day following the due date;
 - b) Weekly reports and files shall be submitted on the Wednesday following the reporting week;
 - c) Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of each month;
 - d) Quarterly reports and files shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;
 - e) Annual reports and files shall be submitted on January 31 for the prior calendar year; and
 - f) Ad Hoc reports shall be submitted within three (3) business days from the agreed upon date of delivery.

I. Report Submissions Table

The report submission table below contains a summarized list of reports or files to be submitted by the DBPM, DHH and the FI. The established format and/or layout requirements for each report or file are located in the Systems Companion Guide, Quality Companion Guide, Appendices of this RFP, or are in development (TBD). Proposers are encouraged to submit samples of existing reports for consideration by DHH for those reports identified in the report chart as TBD.

Report Submissions Table

Submitter	Report or File Name	Frequency	Format Location	Receiver
DBPM	Organizational Chart	30 days prior to "Go live " date, Annually, and Upon Request	NA	DHH – Bayou Health
DBPM	Functional Organizational Chart	30 days prior to "Go live " date, Annually, and Upon Request	NA	DHH – Bayou Health
DBPM	DBP Network Provider and Subcontractor Registry	At Readiness Review and Monthly thereafter	Appendix V	DHH – Bayou Health
DHH – Medicaid Managed Care	Readiness Review Report	As Appropriate	TBD	DBPM
DBPM	Provider Directory	Template due during Readiness Review	TBD	DHH – Bayou Health

DBPM	New Member Contact Report	A. Monthly B. Monthly with an Annual Summary	TBD	DHH – Bayou Health
DBPM	Provider Call Center	Monthly with an Annual Summary	TBD	DHH – Bayou Health
DBPM	Referral Policies	During Readiness Review, Annually thereafter, and prior to any revisions	TBD	DHH – Bayou Health
DBPM	Non-Medicaid Enrolled Providers	Monthly	Submitted via the Provider Registry as described in the Systems Companion Guide	DHH – FI
DBPM	Member Disenrollment File	Daily	Systems Companion Guide TBD	DHH – FI
DBPM	DBPM Disenrollment Report	Quarterly	Appendix W	DHH – Bayou Health
DHH – FI	DBPM PMPM Reconciliation File	Monthly	Systems Companion Guide TBD	DBPM
DBPM	EPSDT Report (CMS 416)	Quarterly and Annually, due March 31 (6 months after the end of the FFY)	Appendix X	Quarterly DHH – Bayou Health Annual - FI
DBPM	Dental Record Review	During Readiness Review, and Annually thereafter	TBD	DHH – Bayou Health
DBPM	Service Area Review of Appointment Availability /Twenty-four (24) hour Access and Availability Survey	Annually	Instrument and Survey Results	DHH – Bayou Health
DBPM	UM reports A. UM Committee Meeting minutes B. Dental Record Reviews	A. When quarterly reports are submitted B. Quarterly with an Annual Summary	TBD	DHH – Bayou Health
DBPM	Fraud and Abuse Activity Report	Quarterly with an Annual Summary	TBD	DHH – Bayou Health
DBPM	Model Attestation Letter	Attachment to all Reports	Appendix Y	DHH – Bayou Health
DBPM	Form CMS 1513 Ownership and Control Interest Statement	With proposal and Annually, by October 1st, thereafter	NA	DHH – Bayou Health
DBPM	Emergency Management Plan	During readiness review, 30 days prior to proposed changes, Annual certification	NA	DHH – Bayou Health
DBPM	Member Satisfaction Survey Report	Annually	Instrument and Survey Results	DHH – Bayou Health
DBPM	Provider Satisfaction Survey Report	Annually	Instrument and Survey Results	DHH – Bayou Health
DBPM	Network Provider Development and Management Plan	During readiness review and Annually thereafter or as requested by DHH	TBD	DHH – Bayou Health
DBPM	Grievance, Appeal and Fair Hearing Log - Redacted	Monthly, and Quarterly Summary	Appendix S	DHH – Bayou Health
DBPM	Member Education Activities A. Updates B. Annual Review	A. Due at Readiness Review B. Monthly C. Annually	Appendix R	DHH – Bayou Health
DBPM	Third Party Liability Collections	Annually	Systems Companion Guide TBD	DHH
DBPM	Claims Payment Accuracy Report	Monthly	Systems Companion Guide TBD	DHH – FI
DBPM	Claims Processing Interest Payments	Quarterly	TBD	DHH – Bayou Health

DBPM	Financial Reporting	A. Annual Audited Financial Statement B. Four Quarterly Unaudited Financial Statements and Financial Reporting Guide C. Monthly if requested by DHH	Financial Reporting Companion Guide	DHH – Bayou Health
DBPM	Encounter Submission File	Weekly	Systems Companion Guide	DHH – FI
DHH – FI	Encounter Claims Summary File	Weekly	Systems Companion Guide	DBPM
DHH – FI	Encounter Edit Disposition Summary File	Weekly	Systems Companion Guide	DBPM
DHH – FI	Edit Code Detail File	Weekly	Systems Companion Guide	DBPM
DBPM	Denied Claims Report	Weekly	Systems Companion Guide	DHH – Bayou Health
DBPM	Quality Assurance (QA) A. QAPI Program description and QAPI Plan B. Impact and effectiveness of QAPI program evaluation C. Performance Improvement Project descriptions D. Performance Improvement Projects Outcomes E. Early Warning System Performance Measures F. Level I and Level II Performance Measures G. Primary Care Dentist Profile Reports	A. During readiness review, and Annually thereafter B. Annually C. Within 3 months of execution of Contract and at the beginning of each Contract year thereafter D. Annually E. Monthly F. Annually and upon DHH request G. Quarterly with an Annual Summary	Quality Companion Guide	DHH – Bayou Health
DBPM	System Refresh Plan	Annually	Systems Companion Guide TBD	DHH – Bayou Health
DHH – FI	Claims Historical Data	At onset of implementation and Monthly thereafter	Systems Companion Guide TBD	DBPM
DBPM	Prior Authorization and Pre-Certification Summary	Annually	Systems Companion Guide TBD	DHH – Bayou Health
DBPM	SSAE-16 Report	Annually	NA	DHH – Bayou Health
DBPM	Insure Kids Now	Annual Summary of Benefits and Quarterly Provider Data	TBD	DHH-Bayou Health

J. Transition/Turnover Plan

1. Introduction

Turnover is defined as those activities that the DBPM is required to perform upon termination of the Contract in situations in which the DBPM must transition contract operations to DHH or a third party. The turnover requirements in this Section are applicable upon any termination of the Contract.

2. General Turnover Requirements

In the event the Contract is terminated for any reason, the DBPM shall:

- a) Comply with all terms and conditions stipulated in the Contract, including continuation of core dental benefits and services under the Contract, until the termination effective date;
- b) Promptly supply all information necessary for the reimbursement of any outstanding claims; and
- c) Comply with direction provided by DHH to assist in the orderly transition of equipment, services, software, leases, etc. to DHH or a third party designated by DHH.

3. Turnover Plan

- a) In the event of written notification of termination of the Contract by either party, the DBPM shall submit a Turnover Plan within thirty (30) calendar days from the date of notification, or circumstances necessitate a shorter timeframe, unless other appropriate timeframes have been mutually agreed upon by both the DBPM and DHH. The Plan shall address the turnover of records and information maintained by the DBPM relative to core dental benefits and services provided to Medicaid members for the time form specified by DHH. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by DHH.
- b) If the Contract is not terminated by written notification as provided in 22.3.1 above, the DBPM shall propose a Turnover Plan six months prior to the end of the Contract period, including any extensions to such period. The Plan shall address the possible turnover of the records and information maintained to either DHH or a third party designated by DHH. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by DHH.
- c) As part of the Turnover Plan, the DBPM must provide DHH with copies of all relevant member and core dental benefits and services data, documentation, or other pertinent information necessary, as determined by DHH, for DHH or a subsequent DBPM to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan will describe the DBPM's approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by DHH and according to the schedule approved by DHH.

4. Transfer of Data

- a) The DBPM shall transfer all data regarding the provision of member core dental benefits and services to DHH or a third party, at the sole discretion of DHH and as directed by DHH. All transferred data must be compliant with HIPAA.
- b) All relevant data must be received and verified by DHH or the subsequent DBPM. If DHH determines that not all of the data regarding the provision of member core dental benefits and services to members was transferred to DHH or the subsequent DBPM, as required, or the data is not HIPAA compliant, DHH reserves the right to hire an independent contractor to assist DHH 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 DBPM.

5. Post-Turnover Services

- a) Thirty (30) days following turnover of operations, the DBPM must provide DHH with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by DHH.

- b) If the DBPM does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for DHH or the subsequent DBPM to assume the operational activities successfully, the DBPM agrees to reimburse DHH for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.
- c) The DBPM also must pay any and all additional costs incurred by DHH that are the result of the DBPM's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.
- d) The DBPM must maintain all files and records related to members and providers for five 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, whichever is longer. The DBPM agrees to repay any valid, undisputed audit exceptions taken by DHH in any audit of the Contract.

C. Liquidated Damages

See Section K, Page 118

D. Fraud and Abuse

1. General Requirements

- A. The DBPM shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs.
- B. The DBPM shall meet with DHH and the Attorney General's Medicaid Fraud Control Unit (MFCU), periodically, at DHH's request, to discuss fraud, abuse, neglect and overpayment issues. For purposes of this Section, the DBPM's compliance officer shall be the point of contact for the DBPM.
- C. The DBPM shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, the United States Department of Health and Human Services HHS, the United States and/or Louisiana's Legislative Auditor's Office, the United States and/or Louisiana's Office of the Attorney General, the United States, General Accountability Office (GAO), Comptroller General of the United States, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) 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.
- D. The DBPM and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. Each federal and state agency shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with DBPM clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The DBPM shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.
- E. DBPM's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

- F. The DBPM shall provide access to DHH and/or its designee to all information related to grievances and appeals filed by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the DBPM's grievance procedures, in compliance with 42 CFR §§ 438.226-438.228.
- G. The DBPM shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The DBPM 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 DHH policy.
- H. The DBPM shall report to DHH, within three (3) business days, when it is discovered that any DBPM employees, network provider, contractor, or contractor's employees have been excluded, suspended, or debarred from any state or federal healthcare benefit program.

2. Fraud and Abuse Compliance Plan

- A. In accordance with 42 CFR §438.608(a), the DBPM shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.
- B. In accordance with 42 CFR §438.608(b)(2), the DBPM shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the DBPM's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The DBPM shall have an adequately staffed Medicaid compliance office with oversight by the compliance officer.
- C. The DBPM shall submit the Fraud and Abuse Compliance Plan within thirty (30) calendar days from the date the Contract is signed with the DBPM, but no later than thirty (30) calendar days prior to the Readiness Review. The DBPM shall submit updates or modifications to DHH for approval at least thirty (30) calendar days in advance of making them effective. DHH, at its sole discretion, may require that the DBPM modify its compliance plan. The DBPM compliance program shall incorporate the policy and procedures specified in Appendix U – Coordination of DBP Fraud and Abuse Complaints and Referrals and shall incorporate the following:
 - 1. written policies, procedures, and standards of conduct that articulate DBPM's commitment to comply with all applicable federal and state standards;
 - 2. effective lines of communication between the compliance officer and the DBPM's employees, providers and contractors enforced through well-publicized disciplinary guidelines;
 - 3. procedures for ongoing monitoring and auditing of DBPM systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, 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 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. provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR Part 438.608(b)(4-6);
 - 6. protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the DBPM. The DBPM shall ensure that the identity of individuals reporting violations of the compliance plan shall be held in confidence to the utmost extent possible. Anyone who believes that he or she has been retaliated against may report this violation to the Louisiana Medicaid Office of Program Integrity and/or the U.S. Office of Inspector General;

7. provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR Part 438.608(b)(7);
8. well-publicized disciplinary procedures that shall apply to employees who violate the DBPM's compliance program;
9. effective training and education for the compliance officer, managers, employees, providers and members to ensure that they know and understand the provisions of DBPM's compliance plan;
10. procedures for timely consistent exchange of information and collaboration with the DHH Program Integrity Unit; and
11. 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.

3. Prohibited Affiliations

In accordance with 42CFR §438.610, the DBPM is prohibited from knowingly having a relationship with:

- A. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The DBPM shall comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. The DBPM shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal healthcare programs. To help make this determination, the DBPM shall search the following websites:
 - Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) <http://exclusions.oig.hhs.gov/search.aspx>
 - Healthcare Integrity and Protection Data Bank (HIPDB) *The Data Banks*, www.npdb-hipdb.hrsa.gov/resources/HIPDBGuidebook.pdf
 - Data Bank homepage, <http://www.npdb-hipdb.hrsa.gov/index.jsp>
 - Excluded Parties List System (EPLS): <https://explore.data.gov/Information-and-communications/Excluded-Parties-List-System-EPLS-lbxjf-jivs>.

The DBPM 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 DHH. 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 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. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).

- B. An individual who is an affiliate of a person described above and include:
 1. A director, officer, or partner of the DBPM;
 2. A person with beneficial ownership of 5 percent or more of the DBPM's equity; or

3. A person with an employment, consulting or other arrangement with the DBPM for the provision of items and services which are significant and material to the DBPM's obligations.
- C. The DBPM shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the DBPM 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) or any contractor which could result in exclusion, debarment, or suspension of the DBPM or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

4. Excluded Providers

Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency dental services.

5. Reporting

- A. In accordance with 42 CFR § 455.1(a)(1) and §455.17, the DBPM shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the State Office and Attorney General Medicaid Fraud Control Unit (MFCU) and DHH within five (5) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the DBPM shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the DBPM or DBPM employee, network providers contractor or contractor employee 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 DBPM or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.
- B. The DBPM, through its compliance officer, shall report all activities on a quarterly basis to DHH. If fraud, abuse, waste, neglect and overpayment issues are suspected, the DBPM compliance officer shall report it to DHH immediately upon discovery. Reporting shall include, but are not limited to:
 1. Number of complaints of fraud, abuse, waste, neglect and overpayments made to the DBPM that warrant preliminary investigation;
 2. Number of complaints reported to the Compliance Officer; and
 3. For each complaint that warrants investigation, the DBPM shall provide DHH, at a minimum, the following:
 - Name and ID number of provider and member involved if available;
 - Source of complaint;
 - Type of provider;
 - Nature of complaint;
 - Approximate dollars involved if applicable; and
 - Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.
- C. Dental Records
 1. The DBPM shall have a method to verify that services for which reimbursement was made, was provided to members. The DBPM shall have policies and procedures to maintain, or require DBPM providers and contractors to maintain, an individual dental record for each member. The DBPM shall ensure the dental record is:
 - a) Accurate and legible;
 - b) 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
 - c) Readily available for review and provides dental and other clinical data required for Quality and Utilization Management review.

2. The DBPM shall ensure the dental record includes, minimally, the following:
 - a) Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);
 - b) Primary language spoken by the member and any translation needs of the member;
 - c) Services provided through the DBPM, date of service, service site, and name of service provider;
 - d) Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the DBPM;
 - e) Referrals including follow-up and outcome of referrals;
 - f) Documentation of emergency and/or after-hours encounters and follow-up;
 - g) Signed and dated consent forms (as applicable);
 - h) Documentation of advance directives, as appropriate; and
 - i) Documentation of each visit, which must include:
 - Date and begin and end times of service;
 - Chief complaint or purpose of the visit;
 - Diagnoses or dental impression;
 - Objective findings;
 - Patient assessment findings;
 - Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG);
 - Medications prescribed;
 - Health education provided;
 - Name and credentials of the provider rendering services (e.g. DDS) and the signature or initials of the provider; and
 - Initials of providers must be identified with correlating signatures.
 - j) The DBPM must provide one (1) free copy per calendar year of any part of member's record upon member's request.
 - k) All documentation and/or records maintained by the DBPM or any and all of its network providers shall be maintained for at least six (6) years after the last good, service or supply has been provided to a member or 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.

E. Technical Requirements

1. General Requirements

- A. The Contractor must maintain hardware and software compatible with current DHH requirements which are as follows:
 1. The contractor is responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in this RFP.
 2. The contractor should adhere to federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this RFP.
 3. The contractor shall clearly identify any systems or portions of systems outlined in the proposal which are considered to be proprietary in nature.
 4. Unless explicitly stated to the contrary, the contractor is responsible for all expenses required to obtain access to DHH systems or resources which are relevant to successful completion of the requirements of this RFP. The contractor is also responsible for expenses required for DHH to obtain access to the Contractor's systems or resources which are relevant to the successful completion of the requirements of this RFP. Such

expenses are inclusive of hardware, software, network infrastructure and any licensing costs.

5. Any confidential information must be encrypted to FIPS 140-2 standards when at rest or in transit.
 6. Contractor owned resources must be compliant with industry standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).
 7. Any contractor use of flash drives or external hard drives for storage of DHH data must first receive written approval from the Department and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.
 8. All contractor utilized computers and devices must:
 - a) Be protected by industry standard virus protection software which is automatically updated on a regular schedule; and
 - b) Have installed all security patches which are relevant to the applicable operating system and any other system software.
- B. The DBPM shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization that complies with DHH and federal reporting requirements. The DBPM shall ensure that its System meets the requirements of the Contract, state issued Guides (See DBP Systems Companion Guide) and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.
- C. The DBPM's application systems foundation shall employ the relational data model in its database architecture, which would entail the utilization of a relational database management system (DBPMS) such as Oracle®, DB2®, or SQL Server®. It is important that the DBPM's application systems support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.
- D. All the DBPM's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with DHH's systems and shall conform to applicable standards and specifications set by DHH.
- E. The DBPM'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.

2. HIPAA Standards and Code Sets

- A. The System shall be able to transmit, receive and process data in current HIPAA-compliant or DHH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of Systems readiness review activities. Data elements and file format requirements may be found in the DBP Systems Companion Guide.
- B. All HIPAA-conforming exchanges of data between DHH and the DBPM shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The HIPAA Business Associate Agreement (Attachment IV) shall become a part of the Contract.
- C. The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:
 1. ASC X12N 835 Claims Payment Remittance Advice Transaction;
 2. ASC X12N 837I Institutional Claim/Encounter Transaction;
 3. ASC X12N 837D Dental Claim/Encounter;

4. ASC X12N 837P Professional Claim/Encounter Transaction;
5. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;
6. ASC X12N 276 Claims Status Inquiry;
7. ASC X12N 277 Claims Status Response;
8. ASC X12N 278 Utilization Review Inquiry/Response; and
9. ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

- D. The DBPM shall not revise or modify the standardized forms or formats.
- E. Transaction types are subject to change and the DBPM shall comply with applicable federal and HIPAA standards and regulations as they occur.
- F. The DBPM shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with DHH. These shall include, but not be limited to, HIPAA based standards, federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

3. **Connectivity**

- A. DHH shall require that the DBPM interface with DHH, the Medicaid Fiscal Intermediary (FI), and its trading partners. The DBPM must have capacity for real time connectivity to all DHH approved systems. The DBPM must have the capability to allow approved DHH personnel to access internal applications to permit inquiry of eligibility, claims, encounters, reference, provider and other data. The access method should be real-time and may be coordinated with DHH via remote network connections.
- B. The System shall conform and adhere to the data and document management standards of DHH and its FI, inclusive of standard transaction code sets.
- C. The DBPM's Systems shall utilize mailing address standards in accordance with the United States Postal Service.
- D. At such time that DHH requires, the DBPM shall participate and cooperate with DHH to implement, within a reasonable timeframe, a secure, web-accessible health record for members, such as Personal Health Record (PHR) or Electronic Health Records (EHR).
- E. At such time that DHH requires, the DBPM shall participate in statewide efforts to incorporate all provider information into a statewide health information exchange.
- F. The DBPM shall meet, as requested by DHH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.
- G. 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 DHH. The DBPM is expressly prohibited from sharing or publishing DHH's information and reports without the prior written consent of DHH. In the event of a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter shall be final.
- H. The Medicaid Management Information System (MMIS) is responsible for the processing and payment of Fee-for-service and Bayou Health Shared Savings Plans claims to providers and the timely and accurate reporting to state and federal personnel and private sector partners for covered Medicaid services.
- I. The DBPM shall be responsible for all initial and recurring costs required for access to DHH system(s), as well as DHH access to the DBPM'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 DHH and the Fiscal Intermediary (FI).
- J. If required by DHH/BHSF, the DBPM shall complete an Information Systems Capabilities Assessment (ISCA), which will be provided by DHH. The ISCA shall be completed and returned to DHH no later than thirty (30) days from the date the DBPM signs the Contract with DHH.

4. Network and Back-up Capabilities

- A. Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs);
- B. Establish appropriate hardware firewalls, routers, and other security measures so that the DBPM's computer network is not able to be breached by an external entity;
- C. Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval of network server data and desktop workstation data;
- D. Ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices; and
- E. The DBPM shall establish independent generator back-up power capable of supplying necessary power for a minimum of four (4) days.

5. Resource Availability and Systems Changes

A. Resource Availability

The DBPM shall provide Systems Help Desk services to DHH, its FI staff that have direct, real-time access to the data in the DBPM's Systems. The Systems Help Desk shall:

1. Be available via local and toll-free telephone service, and via email from 7a.m. to 7p.m., Central Time, Monday through Friday, with the exception of state holidays. Upon request by DHH, the DBPM shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;
2. Answer questions regarding the DBPM'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 DHH staff;
3. Ensure individuals who place calls after hours are have the option to leave a message. The DBPM's staff shall respond to messages left between the hours of 7p.m. and 7a.m. by noon that next business day;
4. Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk shall be documented and reported to DBPM management within one (1) business day of recognition so that deficiencies are promptly corrected; and
5. Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

6. Information Systems Documentation Requirements

- A. The DBPM 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.
- B. The DBPM shall develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.
- C. The DBPM shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.
- D. The DBPM shall ensure when a System change is subject to DHH prior written approval, the DBPM will submit revision to the appropriate manuals before implementing said Systems changes.
- E. The DBPM shall ensure all aforementioned manuals and reference Guides are available in printed form and on-line; and
- F. The DBPM shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.
- G. The DBPM shall provide to DHH documentation describing its Systems Quality Assurance Plan.

7. Systems Changes

- A. The DBPM's Systems shall conform to future federal and/or DHH specific standards for encounter data exchange within ninety (90) calendar days prior to the standard's effective date or earlier, as directed by CMS or DHH.
- B. If a system update and/or change are necessary, the DBPM shall draft appropriate revisions for the documentation or manuals, and present to DHH thirty (30) days prior to implementation, for DHH 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 the actual revision.
- C. The DBPM shall submit written notice as an alert to DHH within ten (10) calendar days of identification of a required system update, change or 'fix'. This written notice shall include an overview of the system problem and its potential impact to providers, with the DBPM's estimated timeframe for implementation of a correction. The DBPM shall notify DHH of changes to its System within its span of control, ninety (90) calendar days prior to the projected date of the change, or within a timeframe specified and approved by DHH.
- D. Changes include, but are not limited to major changes, upgrades, modification or updates to application or operating software associated with the following core production System:
 - 1. Claims processing;
 - 2. Eligibility and enrollment processing;
 - 3. Service authorization management;
 - 4. Reference file processing (e.g., procedure formularies, approved diagnoses, provider payment rates, etc.);
 - 5. Provider enrollment and data management; and
 - 6. Conversions of core transaction management Systems.
- E. The DBPM shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes:
 - 1. Within five (5) calendar days of receiving notification from DHH, the DBPM shall respond in writing to notices of system problems.
 - 2. Within fifteen (15) calendar days, the correction shall be made or a written corrective action plan will be due.
 - 3. The DBPM shall correct the deficiency by an effective date to be determined by DHH.
 - 4. The DBPM's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.
 - 5. The DBPM shall put in place procedures and measures for safeguarding against unauthorized modification to the DBPM's Systems.
- F. Unless otherwise agreed to in advance by DHH, the DBPM shall not schedule Systems unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.
- G. The DBPM shall work with DHH pertaining to any testing initiative as required by DHH and shall provide sufficient system access to allow testing by DHH and/or its FI of the DBPM's System.

8. Systems Refresh Plan

- A. The DBPM shall provide to DHH an annual Systems Refresh Plan. The plan shall outline how Systems within the DBPM's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.

- B. The systems refresh plan shall also indicate how the DBPM will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the Systems component.

9. Other Electronic Data Exchange

The DBPM's system shall house indexed electronic images of documents to be used by members and providers to transact with the DBPM and that are reposed in appropriate database(s) and document management systems (i.e., Master Patient Index) as to maintain the logical relationships to certain key data such as member identification, provider identification numbers and claim identification numbers. The DBPM shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, such as interactions with a particular member about a reported problem.

10. Electronic Messaging

- A. The DBPM shall provide a continuously available electronic mail communication link (email system) to facilitate communication with DHH. This email system shall be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office (currently 2010) and any subsequent upgrades as adopted.
- B. As needed, the DBPM shall be able to communicate with DHH over a secure Virtual Private Network (VPN).
- C. The DBPM shall comply with national standards for submitting public health information (PHI) electronically and shall set up a secure emailing system that is password protected for both sending and receiving any personal health information.

11. Member Enrollment

The DBPM shall:

- A. Receive, process and update enrollment files sent daily by the Fiscal Intermediary;
- B. Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;
- C. Transmit to DHH, in the formats and methods specified by DHH, member address changes and telephone number changes;
- D. Be capable of uniquely identifying a distinct Medicaid member across multiple populations and Systems within its span of control; and
- E. Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

12. Provider Enrollment

- A. At the onset of the DBPM Contract and periodically as changes are necessary, DHH shall publish at www.lamedicaid.com the list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. In order to coordinate provider enrollment records, the DBPM shall utilize the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with DHH and the FI. The DBPM shall provide the following:

1. Provider service name, Provider billing name/DBA name, service/practice address (street, city, state, zip+4), billing address (street, city, state, zip+4), alternate practice site address (if appropriate: street, city, state, zip+4), licensing information (including effective date(s)), Tax ID/SSN, National Provider Identifier (NPI), taxonomy and bank direct deposit/EFT payment information;
 2. All relevant provider ownership information as prescribed by DHH, federal or state laws; and
 3. Performance of all federal or state mandated exclusion background checks on all providers (owners and managers). The providers shall perform the same for all their employees at least annually.
- B. Provider enrollment systems shall include, at minimum, the following functionality:
1. Audit trail and history of changes made to the provider file;
 2. Automated interfaces with all licensing and dental boards;
 3. Automated alerts when provider licenses are nearing expiration;
 4. Verification and Retention of NPI requirements;
 5. System generated letters to providers when their licenses are nearing expiration;
 6. Linkages of individual providers to groups;
 7. Credentialing information;
 8. Provider office hours; and
 9. Provider languages spoken.
- C. DBPM Contactor shall submit provider enrollment information weekly to DHH and the FI as a “registry” in a layout, format, and schedule as explained in the Systems Companion Guide. Should DHH and the FI find errors/issues with the registry submissions, the DBP Contractor will resolve to correct the errors within twenty (20) business days or face potential monetary sanctions.

13. Information Systems Availability

The DBPM shall:

- A. Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the DBPM’s span of control;
- B. Allow CMS, DHH personnel, agents of the Louisiana Attorney General’s Office or individuals authorized by DHH or the Louisiana Attorney General’s Office and upon request by CMS direct access to its data for the purpose of data mining and review;
- C. Ensure that critical member and provider Internet and/or telephone-based 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 DHH and the DBPM. Unavailability caused by events outside of the DBPM’s span of control is outside of the scope of this requirement;
- D. Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., Central Time, Monday through Friday;
- E. Ensure that the systems and processes within its span of control associated with its data exchanges with DHH’s FI and its contractors are available and operational;
- F. Ensure that in the event of a declared major failure or disaster, the DBPM’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;
- G. Notify designated DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the DBPM’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 DBPM and DHH or DHH’s FI. In its

notification, the DBPM shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;

- H. Notify designated DHH staff via phone, fax, and/or electronic mail within fifteen (15) minutes 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;
- I. Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail;
- J. Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the DBPM's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the DBPM's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability. Cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the DBPM's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period; and
- K. Within five (5) business days of the occurrence of a problem with system availability, the DBPM shall provide DHH with full written documentation that includes a corrective action plan describing how the DBPM will prevent the problem from reoccurring.

14. Contingency Plan

- A. The DBPM, 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 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 DBPM shall have a Contingency Plan that must be submitted to DHH for approval no later than thirty (30) calendar days from the date the Contract is signed, but no later than thirty (30) calendar days prior to the Readiness Review.
- D. At a minimum, the Contingency Plan shall address the following scenarios:
 - 1. The central computer installation and resident software are destroyed or damaged;
 - 2. The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that is active in a live system at the time of the outage;
 - 3. 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;
 - 4. 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; and
 - 5. The Plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

- E. The DBPM shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to DHH that it can restore Systems functions.
- F. In the event the DBPM fails to demonstrate through these tests that it can restore Systems functions, the DBPM shall be required to submit a corrective action plan to DHH describing how the failure shall be resolved within ten (10) business days of the conclusion of the test.

15. Offsite Storage and Remote Backup

- A. The DBPM shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.
- B. The data back-up policy and procedures shall include, but not be limited to:
 - Descriptions of the controls for back-up processing, including how frequently back-ups occur;
 - Documented back-up procedures;
 - The location of data that has been backed up (off-site and on-site, as applicable);
 - Identification and description of what is being backed up as part of the back-up plan; and
 - Any change in back-up procedures in relation to the DBPM's technology changes.
- C. DHH shall be provided with a list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

16. Records Retention

- A. The DBPM shall have online retrieval and access to documents and files for six (6) years in live systems for audit and reporting purposes, ten (10) years in archival systems. Services which have a once in a life-time indicator (i.e., Surgical Removal of Erupted Tooth) are denoted on DHH's procedure formulary file and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The DBPM shall provide forty-eight (48) hour turnaround or better on requests for access to information that is six (6) years old, and seventy-two (72) hour turnaround or better 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 not less than six (6) years, following generally accepted retention guidelines.
- C. Audit Trails shall be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old.

17. Information Security and Access Management

The DBPM'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:
 - 1. Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only, will not be permitted to modify information;
 - 2. 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 DHH and the DBPM; and

3. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.
- B. Make System information available to duly authorized representatives of DHH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.
- C. 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 DBPM and DHH.
- D. 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 and/or document;
 4. Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and
 5. Facilitate auditing of individual records as well as batch audits.
- E. Have inherent functionality that prevents the alteration of finalized records;
- F. Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The DBPM shall provide DHH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;
- G. 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;
- H. Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;
- I. Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of the DBPM's span of control. This includes, but is not limited to, any provider or member service applications that are directly accessible over the Internet, shall be appropriately isolated to ensure appropriate access;
- J. Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as a Virtual Private Network (VPN), which must be prior approved by DHH no later than fifteen (15) calendar days after the Contract award; and
- K. Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the DBPM shall conduct a security risk assessment and communicate the results in an information security plan provided no later than fifteen (15) calendar days after the Contract award. The risk assessment shall also be made available to appropriate federal agencies.

18. Systems Audit Requirements

A. State Audits

1. The DBPM shall provide to state auditors (including legislative auditors), 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 DHH and/or state auditor's facilities. The DBPM shall provide information necessary to assist the state auditor in processing or utilizing the files.

2. If the auditor's findings point to discrepancies or errors, the DBPM shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report.
3. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the DBPM's EDP manual.

B. Independent Audits

1. The DBPM shall be required to contract with an independent firm, subject to the written approval of DHH, which has experience in conducting systems and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract's Systems application. These requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the DBPM.
2. The independent firm shall perform a comprehensive audit on a calendar year basis, for controls placed in operation and operation effectiveness, to determine the DBPM's compliance with the obligations specified in the Contract and the Systems Companion Guide.
3. The auditing firm shall deliver to the DBPM and to DHH a report of findings and recommendations by March 31st of each year. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews.
4. DHH shall use the findings and recommendations of each report as part of its monitoring process.
5. The DBPM shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the independent auditing firm. These findings are reviewed by DHH and shall become a part of the DBPM's EDP manual.
6. Audits shall include a scope necessary to fully comply with the Statement on Standards for Attestation Engagements no. 16 (SSAE 16) issued by the Auditing Standards Board of the American Institute of Certified Public Accounts.

19. Claims Management

A. Electronic Claims Management (ECM) Functionality

1. The DBPM shall annually comply with DHH's electronic data interchange (EDI) policies for certification of electronically submitted claims.
2. To the extent that the DBPM compensates providers on a FFS or other basis requiring the submission of claims as a condition of payment, the DBPM shall process the provider's claims for covered services provided to members, consistent with applicable DBPM policies and procedures and the terms of the Contract and the Systems Companion Guide, including, but not limited to, timely filing, and compliance with all applicable state and federal laws, rules and regulations.
3. The DBPM shall maintain an electronic claims management system that will:
 - a) Uniquely identify the attending and billing provider NPI of each service;
 - b) Identify the date of receipt of the claim (the date the DBPM receives the claim and encounter information);
 - c) Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, pending, appealed, etc., and follow up information on appeals;
 - d) Identify the date of payment, the date & number of the check or other form of payment such as electronic funds transfer (EFT);
 - e) Identify all data elements as required by DHH for electronic encounter data submission as stipulated in this Section of the RFP and the Systems Companion Guide; and

- f) Allow submission of non-electronic and electronic claims by contracted providers.
- 4. The DBPM shall ensure that an electronic claims management (ECM) capability that accepts and processes claims submitted electronically is in place.
- 5. The DBPM shall ensure the ECM system shall function in accordance with information exchange and data management requirements as specified in this Section of the RFP and the Systems Companion Guide.
- 6. The DBPM shall ensure that as part of the ECM function it can provide on-line and phone-based capabilities to obtain processing status information.
- 7. The DBPM shall support access to an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.
- 8. The DBPM shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the DBPM 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 and/or charges.
- 9. The DBPM shall require that their providers comply at all times with the American Dental Association (ADA) National coding standards (ADA form), and standardized billing forms and formats, and all future updates for Dental and Professional claims (CMS 1500).
- 10. The DBPM 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.
- 11. The DBPM agrees that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, the DBPM shall comply with said recommendations within ninety (90) calendar days from notice by DHH.
- 12. The DBPM shall have procedures approved by DHH, available to providers in written and web form for the acceptance of claim submissions which include:
 - a) The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims;
 - b) The process for reviewing claims for accuracy and acceptability;
 - c) The process for prevention of loss of such claims, and
 - d) The process for reviewing claims for determination as to whether claims are accepted as clean claims.
- 13. The DBPM shall have a procedure approved by DHH available to providers in written and web form for notifying providers of batch rejections. The report, at a minimum, should contain the following information:
 - a) Date batch was received by the DBPM;
 - b) Date of rejection report;
 - c) Name or identification number of DBPM issuing batch rejection report;
 - d) Batch submitters name or identification number; and
 - e) Reason batch is rejected.
- 14. The DBPM shall assume all costs associated with claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the DBPM or to the design of systems within the DBPM's span of control.
- 15. The DBPM shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from DHH.
- 16. For purposes of network management, the DBPM shall notify all contracted providers to file claims associated with covered services directly with the DBPM, or its contractors, on behalf of Louisiana Medicaid members.

17. At a minimum, the DBPM shall run one (1) provider payment cycle per week, on the same day each week, as determined by the DBPM and approved by DHH.

B. Claims Processing Methodology Requirements

The DBPM shall perform system edits, including, but not limited to applicable edits as established by DHH policy:

1. Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by DHH and the FI that applies to the period during which the charges were incurred;
2. A review of the entire claim within five (5) working 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:
 - a) Member name;
 - b) Provider claim number, patient account number, or unique member identification number;
 - c) Date of service;
 - d) Total billed charges;
 - e) DBPM's name; and
 - f) The date the report was generated.
3. Medical necessity;
4. Prior Approval – The system shall determine whether a covered service required prior approval and if so, whether the DBPM granted such approval;
5. Duplicate Claims – 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;
6. Covered Services - Ensure that the system can verify that a service is a covered service and is eligible for payment;
7. Provider Validation - Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted;
8. Quantity of Service - Ensure that the system shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied; and
9. Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span.

C. Explanation of Benefits

1. The DBPM shall within forty-five (45) calendar days of payment of claims, provide individual notices, Explanation of Benefits (EOBs), to a sample group of the members who received services. The required notice must specify:
 - The service furnished;
 - The name of the provider furnishing the service;
 - The date on which the service was furnished; and
 - The amount of the payment made for the service.
2. The DBPM shall also:
 - a) Include in the sample, claims for services with hard benefit limits, denied claims with member responsibility, and paid claims (excluding ancillary and anesthesia services);
 - b) Stratify paid claims sample to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the DBPM considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may over

sample the group. The paid claims sample should be for a minimum of two hundred (200) to two hundred-fifty (250) claims per year; and

- c) The DBPM shall track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or a referral to DHH. The DBPM shall use the feedback received to modify or enhance the EOB sampling methodology.

D. Remittance Advices

In conjunction with its payment cycles, each remittance advice generated by the DBPM to a provider shall, if known at that time, clearly identify for each claim, the following information:

- The name of the member;
- Unique member identification number;
- Patient claim number or patient account number;
- Date of service;
- Total provider charges;
- Member liability, specifying any co-insurance, deductible, copayment, or non-covered amount;
- Amount paid by the DBPM;
- Amount denied and the reason for denial; and
- 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 and/or state laws."

E. Adherence to Key Claims Management Standards

1. Prompt Payment to Providers

- a) The DBPM shall ensure that ninety percent (90%) of all clean claims for payment of services delivered to a member are paid by the DBPM to the provider within fifteen (15) business days of the receipt of such claims.
- b) The DBPM shall process and, if appropriate, pay within thirty (30) calendar days, ninety-nine percent (99%) of all clean claims to providers for covered services delivered to a member.
- c) If a clean claim is denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall not constitute a new claim for purposes of establishing the timeframe for timely filing.
- d) 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 the time period specified in the provider contract between the provider and the DBPM, or if a time period is not specified in the contract:
 - i. The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or
 - ii. If the DBPM is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from DHH.
- e) The DBPM 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. In situations of third party benefits, the

timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.

- f) The DBPM shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or CHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.

2. Claims Dispute Management

- a) The DBPM shall develop an internal claims dispute process for those claims or group of claims that have been denied or for which the payment has been reduced. The process must be submitted to DHH for approval within thirty (30) days of the date the Contract is signed, but no later than prior to the Readiness Review.
- b) The claims dispute management process must include, at a minimum, the following components:
 - i. A designated telephone number for provider relations staff so that if a provider has a question or is not satisfied with the information they have received related to a claim, they can contact appropriate staff;
 - ii. Specific timeframes during which time all requests for claim reconsideration or adjustment must be received;
 - iii. Guidelines for submitting a paper claim for review or reconsideration; and
 - iv. A list of required information for submission of requests for claim reconsideration or adjustment in either electronic or paper format.
- c) The DBPM shall systematically capture the status and resolution of all claim disputes as well, as all associated documentation.

3. Claims Payment Accuracy Report

- a) On a monthly basis, the DBPM shall submit a claims payment accuracy percentage report to DHH. A copy of the report format and instructions is provided in the Systems Companion Guide. The report shall be based on an audit conducted by the DBPM. The audit shall be conducted by an entity or staff independent of claims management as specified in this Section of the RFP, 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 hundred (200) to two hundred-fifty (250) claims per year, 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;
 - ii. Claim is associated with the correct provider;
 - iii. Proper authorization was obtained for the service;
 - iv. Member eligibility at processing date correctly applied;
 - v. Allowed payment amount agrees with contracted rate;
 - vi. Duplicate payment of the same claim has not occurred;
 - vii. Denial reason applied appropriately;
 - viii. Copayment application considered and applied, if applicable;
 - ix. Effect of modifier codes correctly applied; and
 - x. Proper coding.
- 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 or paid in error;
 - iii. Explanation of the erroneous processing for each claim processed 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 or paid in error have been corrected.
- d) If the DBPM contracted for the provision of any covered services, and the DBPM's contractor is responsible for processing claims, then the DBPM shall submit a claims payment accuracy percentage report for the claims processed by the contractor.
- e) Encounter Data
- i. The DBPM's system shall be able to transmit to and receive electronic encounter data from the DHH FI's system as required for the appropriate submission of encounter data.
 - ii. Within sixty (60) days of operation, the DBPM's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format. The DBPM must incur all costs associated with certifying HIPAA transactions readiness through a third-party, EDIFECS, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the DBP Systems Companion Guide. All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (D – Dental, P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.
 - iii. The DBPM shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.
 - iv. The DBPM shall have the ability to update CDT, CPT/HCPCS, ICD-9-CM, ICD-10-CM and other codes based on HIPAA standards and move to future versions as required. In addition to CDT, CPT, ICD-9-CM, ICD-10-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the DBPM and DHH to evaluate performance measures. The DBPM will not be permitted to submit paper encounters to DHH's FI.
 - v. The DBPM shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to DHH's FI.
 - vi. The FI encounter process shall utilize a DHH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from an electronic batch submission by the DBPM. 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 DBPM for immediate correction.
 - vii. DHH and its FI shall determine which claims processing edits are appropriate for encounters and shall set encounter edits to "pay" or "deny". Encounter denial codes shall be deemed "repairable" or "non-repairable". An example of a repairable encounter is "Date of Service is not valid". An example of a non-repairable encounter is "exact duplicate". The DBPM is required to be familiar with the FI exception codes and dispositions for the purpose of repairing denied encounters.
 - viii. As specified in the DBP Systems Companion Guide, denials for the following reasons will be of particular interest to DHH:
 - Denied for Medical Necessity including lack of documentation to support necessity;
 - Member has other insurance that must be billed first;
 - Prior authorization not on file;
 - Claim submitted after filing deadline; and
 - Service not covered by DBPM.

- ix. The DBPM shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The DBPM shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with DHH and its FI's billing requirements.
- x. Due to the need for timely data and to maintain integrity of processing sequence, the DBPM shall address any issues that prevent processing of an encounter; acceptable standards shall be ninety percent (90%) of reported repairable errors are addressed within thirty (30) calendar days and ninety-nine percent (99%) of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by DHH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.
- xi. For encounter data submissions, the DBPM shall submit ninety-five (95) percent of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount (\$0.00) and encounters in which the DBPM has a capitation arrangement with a provider. The DBPM CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.
- xii. The DBPM shall ensure that all encounter data from a contractor is incorporated into a single file from the DBPM. The DBPM shall not submit separate encounter files from DBPM contractors.
- xiii. The DBPM shall ensure that files contain settled claims and claim adjustments 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 DBPM has a capitation arrangement.
- xiv. The DBPM shall ensure the level of detail associated with encounters from providers with whom the DBPM has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the DBPM received and settled a FFS claim.
- xv. The DBPM shall adhere to federal and/or department 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 DHH across all DBPMs.
- xvi. Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the DBPMs applicable reimbursement methodology for that service.

F. Subcontracting

The contractor shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of the Department. The contractor shall not substitute any subcontractor without the prior written approval of the Department. For subcontractor(s), before commencing work, 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:

- The subcontractor(s) will provide a written commitment to accept all contract provisions.
- 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.

G. Insurance Requirements

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.

1. Contractor's Insurance

The Contractor shall not commence work under this 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. The Contractor shall not allow any subcontractor to commence work on subcontract until all similar insurance required for the subcontractor has been obtained and approved. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the Department before work is commenced. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days' written notice in advance to the Department and consented to by the Department in writing and the policies shall so provide.

2. Workers' Compensation Insurance

Before any work is commenced, the Contractor shall obtain and maintain during the life of the contract, Workers' Compensation Insurance for all of the Contractor's employees employed to provide services under the contract. In case any work is sublet, the Contractor shall require the subcontractor similarly to provide Workers' Compensation Insurance for all the latter's employees, 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 subcontractors to provide Employer's Liability Insurance for the protection of such employees not protected by the Workers' Compensation Statute.

3. Commercial General Liability Insurance

The Contractor shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect Contractor, the Department, 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 the Department. Such insurance shall name the Department as additional insured for claims arising from or as the result of the operations of the Contractor or its subcontractors. 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 \$1,000,000.

4. Insurance Covering Special Hazards

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.

5. Licensed and Non-Licensed Motor Vehicles

The Contractor shall maintain during the life of the contract, Automobile Liability Insurance in an amount not less than combined single limits of \$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.

6. Subcontractor's Insurance

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.

H. Contract Monitoring

The DHH/BHSF/ Medicaid Managed Care Program will be responsible for the primary oversight of the Contract, including Medicaid policy decision making and Contract interpretation. As appropriate, DHH will provide clarification of DBP requirements and Medicaid policy, regulations and procedures and will schedule meetings as necessary with the DBPM.

1. Contact Personnel

A. The DBPM shall designate an employee of its administrative staff to act as the liaison between the DBPM and DHH for the duration of the Contract. Medicaid Managed Care Program staff will be the DBPM's point of contact and shall receive all inquiries and requests for interpretation regarding the Contract and all required reports unless otherwise specified in the Contract. The DBPM shall also designate a member of its senior management who shall act as a liaison between the DBPM's senior management and DHH when such communication is required. If different representatives are designated after approval of the Contract, notice of the new representative shall be provided in writing within seven (7) calendar days of the designation.

B. Contract Monitor

All work performed by the DBPM will be monitored by the Medicaid Managed Care Director or his/her designee:

Mary Johnson
Department of Health and Hospitals
Bureau of Health Services Financing
Bayou Health Program
628 North 4th St.
Baton Rouge, LA 70821
Phone: (225) 342-1304
Email: mary.johnson@la.gov

C. Notices

Any notice given to a party under the Contract is deemed effective, if addressed to the party as addressed below, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

DHH
Name: Medicaid Managed Care Director
628 North 4th Street
Baton Rouge, LA 70821

Contractor
Name TBD
Address TBD

Either party may change its address for notification purposes by providing written notice stating the change, effective date of change and setting forth the new address at least 10 calendar days prior to the effective date of the change of address. If different representatives are designated after execution of the Contract, notice of the new representative will be given in writing to the other party and attached to originals of the Contract.

Whenever DHH is required by the terms of this RFP and Contract to provide written notice to the DBPM, such notice will be signed by the Medicaid Director or his/her designee.

D. Notification of DBPM Policies and Procedures

DHH will provide the DBPM with updates to appendices, information and interpretation of all pertinent federal and state Medicaid regulations, DBPM policies, procedures and guidelines affecting the provision of services under this Contract. The DBPM will submit written requests to DHH for additional clarification, interpretation or other information. Provision of such information does not relieve the DBPM of its obligation to keep informed of applicable federal and state laws related to its obligations under this Contract.

E. Required Submissions

Within thirty (30) calendar days from the date the Contract is signed by the DBPM, but prior to the Readiness Review, the DBPM shall submit documents as specified in this RFP. DHH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the DBPM's responsibilities under the terms of the Contract. Refer to Appendix Z, Transition Requirements for a listing of submission requirements.

F. Readiness Review Prior to Operations Start Date

DHH will assess the performance of the DBPM prior to and after the May 1, 2014 begin date for operations. DHH will complete readiness reviews of the DBPM prior to implementation. This includes evaluation of the DBPM's program components including IT, administrative services and medical management. Each readiness review will be performed on site at the DBPM's Louisiana administrative offices. Refer to Appendix Z, Transition Period Requirements.

G. Ongoing Contract Monitoring

1. DHH will monitor the DBPM's performance to assure the DBPM is in compliance with the Contract provisions. However this does not relieve the DBPM of its responsibility to continuously monitor its providers' performance in compliance with the Contract provisions.
2. DHH or its designee shall coordinate with the DBPM to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.
3. DHH or its designee will, at a minimum annually, monitor the operation of the DBPM for compliance with the provisions of this Contract, and applicable federal and state laws and regulations. Inspection may include the DBPM's facilities, as well as auditing and/or review of all records developed under this Contract including, but not limited to, periodic dental audits, grievances, enrollments, disenrollment, utilization and financial

- records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.
4. The DBPM shall provide access to documentation, dental records, premises, and staff as deemed necessary by DHH.
 5. The DBPM 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 DHH finalizes the results of monitoring and/or audit report, the DBPM must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions and/or enrollment restrictions.

H. DBPM On-Site Reviews

DHH will conduct on-site readiness reviews prior to member enrollment during initial implementation of the DBP and as an ongoing activity during the Contract period. The DBPM's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of DBPM performance. These focus areas may include, but are not limited to the following

- Administrative capabilities
- Governing body
- Subcontracts
- Provider network capacity and services
- Provider Complaints
- Member services
- Primary care dentist assignments and changes
- Member grievances and appeals
- Health education and promotion
- Quality improvement
- Utilization review
- Data reporting
- Coordination of care
- Claims processing
- Fraud and abuse

I. Monitoring Reports

DHH will require the DBPM to submit monthly, quarterly, and annual reports that will allow DHH to assess the DBPM's performance.

J. Corrective Action

When DHH establishes that the DBPM is out of compliance with any of the above monitored activities, the DBPM will be required to provide corrective action plans to ensure that the goals of the program will be met. DHH may assess liquidated damages commensurate with the offense and at its discretion as provided by the contract .

I. Payment Terms

The contractor shall submit deliverables in accordance with established timelines and shall submit itemized invoices monthly or as defined in the contract terms. Payment of invoices is subject to approval of the Medicaid Director or his/her designee. Continuation of payment is dependent upon available funding.

J. Term of Contract

The contract shall commence on or near the date approximated in the Schedule of Events. The term of this contract is for the period 3 years. With all proper approvals and concurrence with the successful contractor, agency may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term. Subsequent to the extension of the contract beyond the initial 36 month term, prior 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 to the Office of Contractual Review (OCR) to extend contract terms beyond the initial 3 year term.

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 the Office of Contractual Review. Total contract term, with extensions, shall not exceed five (5) years. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

K. Administrative Actions, Corrective Action Plans, Monetary Penalties, and Sanctions

1. Administrative Actions

- A. DHH shall notify the DBPM through a written Notice of Action its intention to take administrative action when it is determined the DBPM is deficient or non-compliant with requirements or deliverables of the Contract. Administrative actions exclude the assessment of monetary penalties and , intermediate actions and administrative actions include, but are not limited to:
 1. a warning through written notice or consultation;
 2. education requirement regarding program policies and billing procedures; The DBPM may be required by DHH to participate in a provider education program as a condition of continued participation. DBPM education programs may include a letter of warning or clarification on the use and format of provider manuals; instruction on the use of procedure codes; review of key provisions of the Medicaid Program; instruction on reimbursement rates; instructions on how to inquire about coding or billing problems; and quality/dental issues;
 3. review of prior authorization implementation processes;
 4. referral to the Louisiana Department of Insurance for investigation;
 5. referral for review by appropriate professional organizations;
 6. referral to the Office of the Attorney General for fraud investigation; and/or
 7. require submission of a corrective action plan (CAP).

2. Corrective Action Plan with the Assessment of Monetary Penalties

If DHH determines a CAP is required, the DBPM shall:

- A. Submit a CAP, by the deadline specified by DHH, for the deficiencies identified by DHH.
- B. Within fifteen (15) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP in writing. If disapproved, the DBPM shall resubmit, (within ten (10) calendar days), a new CAP that addresses the deficiencies identified by DHH.
- C. Once DHH has approved a CAP, it will monitor implementation of such a plan and set appropriate timelines to bring activities of the DBPM into compliance with state and federal regulations. DHH may monitor via required reporting on a specified basis and/or through on-site evaluations, the effectiveness of the plan. Before imposing intermediate sanctions, DHH shall give the DBPM timely written notice that explains the basis and nature of the sanction and any other due process protections that DHH elects to provide and shall provide notification to CMS.

- D. The DBPM shall implement the CAP within the time frames specified by DHH
- E. If the initial or revised CAP is disapproved, DHH may at its discretion, may assess monetary penalties against Contractor until pending attainment of acceptable CAP has been approved
- F. If the initial or revised CAP performance/outcomes are not achieved, DHH may at its discretion assess monetary penalties against the Contractor until acceptable performance has been obtained.
- G. Whenever monetary penalties are assessed against the DBPM for failure to meet performance standards specified within the contract,, including failure to comply with any requirements established in a CAP, for a single occurrence that exceeds \$25,000.00, DHH staff will meet with DBPM staff to discuss the causes for the occurrence and to negotiate a reasonable plan for corrective action of the occurrence. Once a corrective action plan has been approved by DHH, collection of monetary penalties during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for the correction of the occurrence. Should that date for correction be missed by the DBPM, the original schedule of monetary penalties will be reinstated, including collection of monetary penalties for the corrective action period, and monetary penalties will continue until satisfactory correction as determined by DHH of the occurrence has been made.

3. Monetary Penalties and Sanctions

A. Purpose

1. The purpose of establishing and imposing monetary penalties is to provide a means for DHH to obtain the services and level of performance required for successful operation of the Contract. DHH's failure to assess monetary penalties in one or more of the particular instances described herein will in no event waive the right for DHH to assess additional monetary penalties or actual damages.
2. The decision to impose monetary penalties shall include consideration of the following factors:
 - The duration of the violation;
 - Whether the violation (or one that is substantially similar) has previously occurred;
 - The DBPM's history of compliance;
 - The severity of the violation and whether it imposes an immediate threat to the health or safety of the Medicaid members; and
 - The "good faith" exercised by the DBPM in attempting to stay in compliance.
3. For purposes of this section, violations including individual, unrelated enrollees shall not be considered as arising out of the same action.

Monetary Penalties Table

Failed Deliverable	Sanction
Operations Start Date	Ten thousand dollars (\$10,000.00) per calendar day for each day beyond the Operations Start Date that the DBPM is not operational until the day that the DBPM is operational, including all systems.
Operations Readiness	Final versions of the Provider Directory must be submitted no later than 7 days prior to the Operational Start Date. One thousand (\$1,000.00) per calendar day for each day the directory is late, inaccurate or incomplete.
System Readiness Review • Disaster Recovery Plan • Business Continuity Plan • Systems Quality Assurance Plan	DBPM must submit to DHH or the Readiness Review Contractor the subject plans no later than 120 days prior to Operational Start Date. One thousand (\$1,000.00) per calendar day for each day a deliverable is late, inaccurate, or incomplete.
Encounter Data	Ten thousand dollars (\$10,000.00) per calendar day for each day after the due date that the monthly encounter

	data has not been received in the format and per specifications outlined in the RFP. Ten thousand dollars (\$10,000.00) per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the DBPM for correction because submission data was in excess of the five (5) percent error rate threshold, until acceptance of the data by the fiscal intermediary. Ten thousand dollars (\$10,000.00) per return by the fiscal intermediary of re-submission of encounter data that was returned to the DBPM, as submission data was in excess of the five (5) percent error rate threshold, for correction and was rejected for the second time. Ten thousand dollars (\$10,000.00) per occurrence of dental record review by DHH or its designee where the DBPM or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented. Penalties specified above shall not apply for encounter data for the first three months after direct services to DBPM members have begun to permit time for development and implementation of a system for exchanging data and training of staff and healthcare providers.
Prompt Pay Ninety percent (90%) of all clean claims must be paid within fifteen (15) business days of the date of receipt. Ninety-nine percent (99%) of all clean claims must be paid within thirty (30) calendar days of the date of receipt. The DBPM shall pay providers interest at 12% per annum, calculated daily for the full period in which the clean claim remains adjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid the same date that the claim is adjudicated.	Five thousand dollars (\$5,000.00) for the first quarter that the DBPM's claims performance percentages by claim type fall below the performance standard. Twenty-five thousand dollars (\$25,000.00) per quarter for each additional quarter that the claims performance percentages by claim type fall below the performance standards. One thousand dollars (\$1,000.00) per claim if the DBPM fails to timely pay interest.
Claims Summary Report	One thousand dollars (\$1,000.00) per calendar day the report is late, inaccurate, or incomplete.
Quality Assessment and Performance Improvement Reports	Two thousand dollars (\$2,000.00) per report for each calendar day the Quality Assessment and Performance Improvement Plan (QAPI), performance measure, and/or performance improvement project reports are late or incorrect as outlined in this RFP and the Quality Companion Guide.
Member and/or Provider Satisfaction Report(s)	Two thousand dollars (\$2,000.00) per calendar day the report(s) are late or incorrect.
Member Services Activities	Five thousand dollars (\$5,000.00) per calendar day for failure to provide access to primary care dentists that offer extended office hours as defined by the RFP. Five thousand dollars (\$5,000.00) per calendar day for failure to provide member services functions from 7 a.m. to 7 p.m. Central Time, Monday through Friday, to address non-emergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members.

	Five thousand dollars (\$5,000.00) per calendar day for failure to operate a toll-free hotline that members can call 24 hours a day, seven (7) days a week.
Member Call Center • Answer 90% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than five percent	One hundred dollars (\$100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period. One hundred dollars (\$100.00) for each 30 second time increment, or portion thereof, by which the DBPM's average hold time exceeds the maximum acceptable hold time.
Administrative Service	Failure which results in actual harm to a member, places a member at risk of imminent harm, or materially affects DHH's ability to administer the Program. Five thousand dollars (\$5,000.00) per calendar day for each incident of non-compliance.
Provider Demographics	Five thousand dollars (\$5,000.00) per calendar day for failure to provide and validate provider demographic data on a quarterly basis to ensure current, accurate, and clean data is on file for all contracted providers.
Provider Service Activities	Five thousand dollars (\$5,000.00) per calendar day for failure to provide for arrangements to handle emergent provider issues on a twenty-four (24) hour, seven (7) days-a-week basis. Five thousand dollars (\$5,000.00) per calendar day for failure to furnish provider services functions from 7 a.m. to 5 p.m. Central Time, Monday through Friday to address non-emergency issues encountered by providers.
Provider Call Center • Answer ninety-five percent of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than five percent	One hundred dollars (\$100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period. One hundred dollars (\$100.00) for each thirty (30) second time increment, or portion thereof, by which the DBPM's average hold time exceeds the maximum acceptable hold time.
Covered Services	Failure to provide a DBPM covered service that is not otherwise associated with a performance standard and such failure results in actual harm to a member or places a member at risk of imminent harm. Seventy-five hundred dollars (\$7,500.00) per calendar day for each incident of non-compliance.
Management Information System	In the event of a declared major failure or disaster, the DBPM's core eligibility, enrollment, and claims processing system shall be back on line within seventy-two (72) hours of the failure or disaster's occurrence. Five thousand dollars (\$5,000.00) per calendar day of non-compliance per parish.
Transfer of Data	The DBPM must transfer all data regarding the provision of covered services to members to DHH, at the sole discretion of DHH and as directed by DHH. Ten thousand dollars (\$10,000.00) per calendar day that the data is late, inaccurate or incomplete.

Termination Transition Plan	Six months prior to the end of the Contract period or any extension thereof or if earlier, within thirty (30) days of Notice of Termination One thousand dollars (\$1,000.00) per calendar day the plan is late, inaccurate, or incomplete.
Ad Hoc Reports as required by this Contract or upon request by DHH.	Two thousand dollars (\$2,000.00) per calendar day for each business day that a report is late or incorrect.
Member File Updates	Failure to upload all Member File updates prior to end of month reconciliation process with files submitted to the DBPM by the FI. Five thousand dollars (\$5,000.00) for each occurrence of non-compliance.
Corrective Action Plan	Two thousand dollars (\$2,000.00) per each calendar day the CAP is late or incorrect.
Network Adequacy	Ten thousand dollars (\$10,000) per occurrence the DBPM has not meet the network adequacy requirements outlined in this RFP.
Access Standards and Guidelines, Timeliness	One thousand dollars (\$1,000) per occurrence the DBPM is not in compliance with Sections 7.3 through 7.5 of this RFP.
Covered Services	Five thousand dollars (\$5,000) per occurrence if a DBPM provider refuses to provide services without timely notifying recipients or making alternative arrangements. One thousand dollars (\$1,000) plus the cost of the service for a member in which the DBPM was asked to provide the service by DHH and refused to provide the core benefit or service(s).

4. DHH shall utilize the following guidelines to determine whether a report is correct and complete:

- The report must contain 100% of the DBPM's data;
- 99% of the required items for the report must be completed; and
- 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DHH.

B. Other Reporting and/or Deliverable Requirements

1. For each day that a deliverable is late, incorrect or deficient, the DBPM may be liable to DHH for monetary penalties in an amount per calendar day per deliverable as specified in the table below for reports and deliverables not otherwise specified in the above Table of Monetary Penalties, or requirement/activity of noncompliance.
2. Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Contract, inclusive of any contract extensions.

Monetary Penalties Escalation Table

Occurrence	Daily Amount for Days 1 - 14	Daily Amount for Days 15-30	Daily Amount for Days 31-60	Daily Amount for Days 61 and Beyond
1-3	\$750	\$1,200	\$2,000	\$3,000
4-6	\$1,000	\$1,500	\$3,000	\$5,000
7-9	\$1,500	\$2,000	\$4,000	\$6,000
10-12	\$1,750	\$3,500	\$5,000	\$7,500
13 and beyond	\$2,000	\$4,000	\$7,500	\$10,000

C. Employment of Key and Licensed Personnel

1. Seven hundred dollars (\$700.00) per calendar day for failure to have a full-time acting or permanent Executive Director for more than seven (7) consecutive calendar days for each day the Executive Director has not been appointed;
2. Seven hundred dollars (\$700.00) per calendar day for failure to have a full-time acting or permanent Dental Director for more than seven (7) consecutive calendar days for each day the Dental Director has not been appointed.
3. Two hundred fifty dollars (\$250.00) per calendar day for each day per employee that is not licensed as required by applicable state and federal laws and/or regulations.

D. Excessive Reversals on Appeal

Twenty-five thousand dollars (\$25,000.00) for exceeding ten percent (10%) member appeals over a twelve month period (January-December or twelve months from the effective date of the Contract) which have been overturned in final appeal outcome for each occurrence over 10%; or for each occurrence in which the DBPM does not provide the dental services or requirements set forth in a final outcome of the administrative decision by DHH or the appeals decision of the State Fair Hearing.

E. Member Education Violations

1. Whenever DHH determines that the DBPM, its agents, subcontractors, volunteers or providers has engaged in any unfair, deceptive, or prohibited member education practices in connection with proposing, offering, selling, soliciting, and providing any services, one or more of the remedial actions outlined this RFP shall apply.
2. Unfair, deceptive, or prohibited practices shall include, but is not limited to:
 - a) Failure to secure written approval before distributing member education materials;
 - b) Failure to meet time requirements for communication with new members;
 - c) Failure to provide interpretation services or make materials available in required languages;
 - d) Engaging in any of the prohibited member education practices detailed in this RFP;
 - e) False, misleading oral or written statement, visual description, advertisement, or other representation of any kind which has the capacity, tendency, or effect of deceiving or misleading DBPM potential enrollees or enrollees with respect to any services, provider, or the Medicaid Managed Care Program;
 - f) Representation that the DBPM or network provider offers any service, benefit, access to care, or choice which it does not have;
 - g) Representation that the DBPM or healthcare provider has any status, certification, qualification, sponsorship, affiliation, or licensure which it does not have;
 - h) Use of any information related to an eligible Medicaid recipient' or any other person's information which is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a state or federal confidentiality law, including:
 - Dental records information, and
 - Information which identifies the recipient or any member of his or her group as a recipient of any government sponsored or mandated health coverage program.
 - i) If DHH determines the DBPM has violated any of the outreach activities outlined in the Contract, the DBPM may be subject to remedial sanctions and/or a monetary sanction of up to \$10,000 per violation/incident. The amount and type of sanctions shall be at the sole discretion of DHH.

F. Remedial Action(s) for Member Education Violations

DHH shall notify the DBPM in writing of the determination of the non-compliance, of the remedial action(s) that must be taken, and of any other conditions related such as the length of time the remedial actions shall continue and of the corrective actions that the DBPM must perform.

1. DHH may require the DBPM to recall the previously authorized material(s);
2. DHH may deduct the amount of capitation payment for members enrolled as a result of non-compliant practices from the next monthly capitation payment made to the DBPM and shall continue to deduct such payment until correction of the failure; and
3. DHH may require the DBPM to contact each member affected during by the compliance, in order to explain the nature of the non-compliance.

G. Cost Avoidance Requirements

Whenever DHH determines that the DBPM is not actively engaged in cost avoidance the DBPM shall be subject to sanctions in an amount not less than three (3) times the amount that could have been cost avoided.

H. Failure to Provide Core Dental Benefits and Services

In the event that DHH determines that the DBPM failed to provide one or more core dental benefits and services, DHH shall direct the DBPM to provide such service. If the DBPM continues to refuse to provide the core dental benefit or service(s), DHH shall authorize the members to obtain the covered service from another source and shall notify the DBPM in writing that the DBPM shall be charged the actual amount of the cost of such service. In such event, the charges to the DBPM shall be obtained by DHH in the form of deductions of that amount from the next monthly capitation payment made to the DBPM. With such deductions, DHH shall provide a list of the members from whom payments were deducted, the nature of the service(s) denied, and payments DHH made or will make to provide the medically necessary covered services.

I. Failure to Maintain an Adequate Network of Contract Providers

In the event that DHH determines that the DBPM 1) failed to maintain an adequate network of mandatory contract provider types as specified in the Provider Network Requirement Section of this RFP, 2) did not comply with the requirement to make three documented attempts to contract with the provider, and 3) is required to pay for medically necessary services to a non-network provider, a monetary penalty of up to \$10,000 per incident may be assessed.

J. Intermediate Sanctions

1. DHH shall notify the DBPM and CMS in writing of its intent to impose sanctions for violating the terms and conditions of the Contract or violation of federal Medicaid rules and regulations and will explain the process for the DBPM to employ the dispute resolution process as described in this RFP. The following are non-exhaustive grounds for which intermediate sanctions may be imposed when the DBPM acts or fails to act. The DBPM:
 - a) Fails substantially to provide medically necessary services that the DBPM is required to provide, under law or under the Contract, to a member covered under the Contract;
 - b) Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid DBP;

- c) Acts to discriminate among members on the basis of their health status or need for healthcare services; this includes termination of enrollment or refusal to reenroll a member or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future dental services.
 - d) Misrepresents or falsifies information that it furnishes to CMS or to DHH;
 - e) Misrepresents or falsifies information that it furnishes to a member, potential member, or a healthcare provider;
 - f) Fails to comply with the requirements for Provider Incentive Plans, as set forth (for Medicare) in 42 CFR §422.208 and §422.210;
 - g) Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHH or that contain false or materially misleading information; or
 - h) Violates any of the other applicable requirements of Section 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations.
2. The intermediate sanctions that DHH may impose upon the DBPM shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §438.700-730 and may include any of the following:
- a) Civil monetary penalties in the following specified amounts:
 - b) A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or falsification of statements to members, potential members, or healthcare providers; failure to comply with Provider Incentive Plan requirements; or marketing violations;
 - c) A maximum of \$100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or falsification to CMS or DHH;
 - d) A maximum of \$15,000 for each member DHH determines was discriminated against based on the member's health status or need for services (subject to the \$100,000 limit above);
 - e) A maximum of \$25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Louisiana Medicaid DBP Program. DHH shall return the amount of overcharge to the affected member(s);
 - f) Suspension of payment for members enrolled after the effective date of the sanction and until CMS or DHH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
 - g) Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.
 - h) The following factors will be considered in determining sanction(s) to be imposed:
 - i) Seriousness of the offense(s);
 - j) Patient quality of care issues;
 - k) Failure to perform administrative functions;
 - l) Extent of violations; history of prior violations; prior imposition of sanctions;
 - m) Prior provision of provider education; provider willingness to obey program rules;
 - n) Whether a lesser sanction will be sufficient to remedy the problem; and
 - o) Actions taken or recommended by peer review groups or licensing boards.

K. Misconduct for Which Intermediate Sanctions May Be Imposed

DHH may impose sanctions against the DBPM if the agency finds any of the following non-exclusive actions/occurrences:

1. The DBPM has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH;
2. The DBPM has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;
3. The DBPM or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the Contract with DHH or of fraudulent billing practices or of negligent practice resulting in death or injury to the DBPM's member;
4. The DBPM 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;
5. The DBPM 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 DHH;
6. The DBPM has rebated or accepted a fee or portion of fee or charge for a patient referral;
7. The DBPM has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;
8. The DBPM has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;
9. The DBPM has failed to furnish any information requested by DHH regarding payments for providing goods or services;
10. The DBPM has made, or caused to be made, any false statement or representation of a material fact to DHH or CMS in connection with the administration of the Contract;
11. The DBPM has furnished goods or services to a member which at the sole discretion of DHH, and based on competent dental judgment and evaluation are determined to be 1) insufficient for his or her needs, 2) harmful to the member, or 3) of grossly inferior quality.

L. Notice to CMS

DHH will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700 specifying the affected DBPM, the kind of sanction, and the reason for DHH's decision to lift a sanction. Notice will be given no later than thirty (30) days after DHH imposes or lifts the sanction.

M. Federal Sanctions

Section 1903(m)(5)(A) and (B) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a DBPM for members who enroll after the date on which the DBPM has been found to have committed one or more of the violations identified below. Therefore, whenever, and for so long as, federal payments are denied, DHH shall deduct the total amount of federal payments denied from the next monthly capitation payment made to the DBPM.

1. Substantial failure to provide required medically necessary items or services when the failure had adversely affected (or has substantial likelihood of adversely affecting) a member;
2. Discrimination among members with respect to enrollment, re-enrollment, or disenrollment on the basis of the member's health status or requirements for healthcare services;
3. Misrepresentation or falsification of certain information; or
4. Failure to comply with the requirements for Provider Incentive Plans as specified herein.

N. Sanction by CMS—Special Rules Regarding Denial of Payment

Payments provided under this Contract may be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS, in accordance with the requirements in 42 CFR 438.730.

O. Payment of Monetary Penalties

1. Any monetary penalties assessed by DHH that cannot be collected through withholding from future PMPM payments shall be due and payable to DHH within thirty (30) calendar days after the DBPM's receipt of the notice of monetary penalties. However, in the event an appeal by the DBPM results in a decision in favor of the DBPM, any such funds withheld by DHH will be returned to the DBPM.
2. DHH has the right to recovery of any amounts overpaid as the result of deceptive practices by the DBPM and/or its contractors, and may consider trebled damages, civil penalties, and/or other remedial measures.
3. A monetary sanction may be applied to all known affiliates, subsidiaries and parents of the DBPM, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the DBPM is affiliated where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

L. Additional Terms and Conditions

1. The DBPM shall comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws and 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 as amended (42 U.S.C. 7401, et seq.) and 20 USC §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);
 - c. The Age Discrimination Act of 1975, as amended, 42 U.S.C § 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;
 - d. The Omnibus Budget Reconciliation Act of 1981, as amended, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;
 - e. The Balanced Budget Act of 1997, as amended, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;
 - f. All applicable standards, orders, or regulations issued pursuant to the Louisiana Revised Statute 49:1001 – 1021;
 - g. The Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 82;
 - h. Title IX of the Education Amendments of 1972 regarding education programs and activities; and
 - i. Byrd Anti-Lobbying Amendment Contractors who apply or bid shall file the require 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 tier up to the recipient (45 CFR Part 3).

2. Assessment of Fees/Payment of Premium Taxes

- a. The Contractor and DHH agree that DHH may elect to deduct any assessed fees from payments due or owing to the DBPM or direct the DBPM to make payment directly to DHH for any and all assessed fees. The choice is solely and strictly DHH's.
- b. The DBPM shall be responsible for payment of all premium taxes paid through the capitation payments by DHH to the Louisiana Department of Insurance according to the schedule established by DHH.

3. Attorney's Fees

In the event DHH should prevail in any legal action arising out of the performance or non-performance of the Contract, the DBPM shall pay, in addition to any monetary penalties, 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.

4. Confidentiality of Information

- a. The DBPM shall comply with the HIPAA Privacy Rule, with other applicable federal and state laws and regulations, and with the provisions of this Contract in its use and disclosure of dental 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 DBPM's performance under this Contract, whether verbal, written, electronic file, or otherwise. The DBPM 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 this Contract.
- b. All information as to personal facts and circumstances concerning members or potential members obtained by the DBPM shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DHH or the member/potential member unless required by applicable state or federal law or otherwise permitted by the HIPAA Privacy Rule, 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 this Contract.

5. Conflict of Interest

The DBPM may not contract with Louisiana Medicaid unless such safeguards at least equal to federal safeguards (41 USC §423:27) are in place per state Medicaid Director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

6. Contract Language Interpretation

The DBPM and DHH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DHH's interpretation of the Contract language in dispute shall control and govern.

7. Cooperation with Other Contractors

- a. In the event that DHH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder including but not limited to fiscal intermediary and actuary, the DBPM agrees to cooperate fully with such other contractors. The DBPM shall not commit any act that will interfere with the performance of work by any other contractor.

- b. The DBPM's failure to cooperate and comply with this provision, shall be sufficient grounds for DHH to halt all payments due or owing to the DBPM until it becomes compliant with this or any other contract provision. DHH's determination on the matter shall be conclusive and not subject to Appeal.

8. Copyrights

If any copyrightable material is developed in the course of or under this Contract, DHH shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for DHH purposes.

9. Corporation Requirements

If the DBPM 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 DBPM must file a Disclosure of Ownership form with the Louisiana Secretary of State.
- b. If the DBPM is a corporation not incorporated under the laws of the state of Louisiana, the DBPM must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.
- c. The DBPM must provide written assurance to DHH from the DBPM's legal counsel that the DBPM 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.

10. Debarment/Suspension/Exclusion

- a. The DBPM agrees to comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. As a condition of enrollment, the DBPM must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal healthcare programs. To help make this determination, the DBPM may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) <http://exclusions.oig.hhs.gov/search.aspx>; the Health Integrity and Protection Data Bank (HIPDB) <http://www.npdb-hipdb.hrsa.gov/index.jsp> and/or the Excluded Parties List System (EPLS) www.EPLS.gov.
- b. The DBPM shall conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. 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 doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).

11. Effect of Termination on DBPM's HIPAA Privacy Requirements

- a. Upon termination of this Contract for any reason, the DBPM shall return or destroy all Protected Health Information received from DHH, or created or received by the DBPM on behalf of DHH. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of the DBPM. The DBPM shall not retain any copies of the Protected Health Information.
- b. In the event that the DBPM determines that returning or destroying the Protected Health Information is not feasible, the DBPM shall provide to DHH notification of the conditions

that make return or destruction not feasible. Upon a mutual determination that return or destruction of Protected Health Information is not feasible, the DBPM shall extend the protections of the Contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as the DBPM maintains such Protected Health Information.

12. Emergency Management Plan

- a. The DBPM shall submit an emergency management plan as part of the contract document execution process. The emergency management plan shall specify actions the DBPM shall conduct to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. Revisions to the DHH approved emergency plan shall be submitted to DHH for approval no less than 30 days prior to implementation of requested changes. The DBPM shall submit an annual certification (from the date of the most recently approved plan) to DHH certifying that the emergency plan is unchanged from the previously approved plan.
- b. At a minimum, the plan should include the following:
 - j) Educating members and providers regarding hurricane preparedness and evacuation planning;
 - k) Provide a DBPM contact list (phone and email) for members and providers to contact to determine where healthcare services may be accessed/rendered;
 - l) Use of EHR to provide healthcare providers access to member's health history and receive information of care provided during evacuation; and
 - m) Emergency contracting with out-of-state healthcare providers to provide healthcare services to evacuated members.

13. Employee Education about False Claims Recovery

If the DBPM receives annual Medicaid payments of at least \$5,000,000, the DBPM must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

14. Employment of Personnel

- a. In all hiring or employment made possible by or resulting from this Contract, the DBPM agrees that:
 - 1) There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin; and
 - 2) Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all state and federal laws applicable to employment of personnel.
 - 3) This requirement 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 DBPM 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 handicap, age, race, color, religion, sex, or national origin.
 - 4) All inquiries made to the DBPM concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the DBPM concerning employment made possible as a result of this Contract shall conform to federal, state, and local regulations.

15. Entire Contract

- a. This Contract, together with the RFP and addenda issued thereto by DHH, the proposal submitted by the proposer in response to DHH's RFP, and any exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect to the subject matter.
- b. The DBPM shall comply with all provisions of the Contract and shall act in good faith in the performance of the provisions of said Contract. The DBPM shall be bound by all applicable Department issued guides. The DBPM agrees that failure to comply with the provisions of the Contract may result in the assessment of monetary penalties, sanctions and/or termination of the Contract in whole or in part, as set forth in the Contract.
- c. The DBPM shall comply with all applicable DHH policies and procedures in effect throughout the duration of the Contract period.
- d. The DBPM shall comply with all applicable DHH provider manuals, rules, regulations, and guides.
- e. DHH, at its discretion, will issue correspondence to inform the DBPM of changes in Medicaid policies and procedures which may affect the Contract. **Unless otherwise specified** in the Medicaid correspondence, the DBPM will be given sixty (60) calendar days to implement such changes.

16. Force Majeure

The DBPM and DHH may be excused from performance under this Contract for any period they may be prevented from performance by an Act of God; strike, war, civil disturbance or court order. The DBPM shall, however, be responsible for the development and implementation of an Emergency Management Plan.

17. Hold Harmless

- a. The DBPM shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:
 - 1) Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the DBPM in connection with the performance of this Contract;
 - 2) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by DBPM, its agents, officers, employees, or subcontractors in the performance of this Contract;
 - 3) Any claims for damages or losses resulting to any person or firm injured or damaged by the DBPM, its agents, officers, employees, or subcontractors by DBPM's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;
 - 4) Any failure of the DBPM, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
 - 5) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and
 - 6) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or their agents, officers or employees, through the intentional conduct, negligence or omission of the DBPM, its agents, officers, employees or subcontractors.
- b. In the event of circumstances not reasonably within the control of the DBPM or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the DBPM, DHH, 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 this Contract remains in full force and effect, the DBPM shall be liable for the core dental benefits and services required to be provided or arranged for in accordance with this Contract.

- c. DHH will provide prompt notice of any claim against it that is subject to indemnification by DBPM under this Contract. The DBPM may, at its sole option, assume the defense of any such claim. DHH may not settle any claim subject to indemnification hereunder without the advance written consent of DBPM, which shall not be unreasonably withheld.

18. Hold Harmless as to the DBPM Members

- a. The DBPM 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, DBPM members, or persons acting on their behalf, for healthcare services which are rendered to such members by the DBPM and its subcontractors, and which are core dental benefits and services.
- b. The DBPM further agrees that the DBP member shall not be held liable for payment for core dental 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 DBPM provided the service directly. The DBPM agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by DBPM and insolvency of the DBPM.
- c. The DBPM further agrees that this provision shall be construed to be for the benefit of DBPM members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the DBPM and such members, or persons acting on their behalf.

19. Homeland Security Considerations

- a. The DBPM shall perform the services to be provided under this Contract entirely within the boundaries of the United States. In addition, the DBPM will not hire any individual to perform any services under this 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.
- b. If the DBPM performs services, or uses services, in violation of the foregoing paragraph, the DBPM shall be in material breach of this Contract and shall be liable to DHH for any costs, fees, damages, claims, or expenses it may incur. Additionally, the DBPM shall be required to hold harmless and indemnify DHH pursuant to the indemnification provisions of this Contract.
- c. The prohibitions in this Section shall also apply to any and all agents and subcontractors used by the DBPM to perform any services under this Contract.

20. Incorporation of Schedules/Appendices

All schedules/appendices referred to in this RFP are attached hereto, are expressly made a part hereof, and are incorporated as if fully set forth herein.

21. Independent Provider

It is expressly agreed that the DBPM and any subcontractors and agents, officers, and employees of the DBPM or any subcontractors in the performance of this Contract shall act in an independent capacity and not as officers, agents, express or implied, or employees of DHH or the state of Louisiana. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the DBPM or any subcontractor and DHH and the state of Louisiana.

22. Integration

This Contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The DBPM 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 effect 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.

23. Interest

Interest generated through investments made by the DBPM under this Contract shall be the property of the DBPM and shall be used at the DBPM's discretion.

24. Interpretation Dispute Resolution Procedure

- a. The DBPM may request in writing an interpretation of the issues relating to the Contract from the Medicaid Managed Care Director. In the event the DBPM disputes the interpretation by the Medicaid Managed Care Director, the DBPM shall submit a written reconsideration request to the Medicaid Director.
- b. The DBPM shall submit, within twenty-one (21) days of said interpretation, a written request disputing the interpretation directly to the Medicaid Director. The ability to dispute an interpretation does not apply to language in the Contract that is based on federal or state statute, regulation or case law.
- c. The Medicaid Director shall reduce the decision to writing and provide a copy to the DBPM. The written decision of the Medicaid Director shall be final of DHH. The Medicaid Director will render his/her final decision based upon the written submission of the DBPM and the Medicaid Managed Care Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by the DBPM and the Medicaid Managed Care Director or his/her designee. If such a presentation is allowed, the information presented will be considered in rendering the decision.
- d. Pending final determination of any dispute over a DHH decision, the DBPM shall proceed diligently with the performance of the Contract and in accordance with the direction of DHH.

25. Loss of Federal Financial Participation (FFP)

The DBPM hereby agrees to be liable for any loss of FFP suffered by DHH due to the DBPM's, or its subcontractors', failure to perform the services as required under this Contract. Payments provided for under this Contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

26. Misuse of Symbols, Emblems, or Names in Reference to Medicaid

No person or DBPM 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 "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from DHH. Specific written authorization from DHH is required to reproduce, reprint, or distribute any DHH 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 DHH terms does not provide a defense. Each piece of mail or information constitutes a violation.

27. National Provider Identifier (NPI)

The HIPAA Standard Unique Health Identifier regulations (45 CFR 162 Subparts A & 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 (NPES).

28. Non-Discrimination

In accordance with 42 CFR 438.6 (d) (3) and (4), the DBPM shall not discriminate in the enrollment of Medicaid individuals into the DBPM. The DBPM agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin, or basis of health status or need for healthcare services shall be excluded from participation in, or be denied benefits of the DBPM's program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the DBPM. The DBPM shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts.

29. Non-Waiver of Breach

- a. The failure of DHH at any time to require performance by the DBPM of any provision of this Contract, or the continued payment of the DBPM by DHH, shall in no way affect the right of DHH to enforce any provision of this 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 this Contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable.
- b. Waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

30. Offer of Gratuities

By signing this Contract, the DBPM 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 this Contract. This Contract may be terminated by DHH 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.

31. Order of Precedence

In the event of any inconsistency or conflict among the document elements of this Contract, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

- The body of the Contract with exhibits and attachments excluding the RFP and the contractor's proposal;
- This RFP and any addenda and appendices;
- DBP Systems Companion Guide;
- DBP Quality Companion Guide; and
- The Proposal submitted by the DBPM in response to this RFP.

32. Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this 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".

33. Prohibited Payments

Payment for the following shall not be made:

- Non-emergency dental services provided by or under the direction of an excluded individual;
- Any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; and
- Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan.

34. Rate Adjustments

- a. The DHH agreed upon monthly capitation rates shall be in effect during the period identified on the in their contract. Rates may be adjusted during the Contract period and subject to CMS review and approval.
- b. The DBPM and DHH both agree that the adjustments to the monthly capitation rate(s) required pursuant to this section shall occur only by written amendment to the Contract. Should either the DBPM or DHH refuse to accept the revised monthly capitation rate, the provisions of the RFP for contract termination and turnover shall apply.

35. Record Retention for Awards to Recipients

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 DHH, 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

36. Release of Records

The DBPM shall release dental records upon request by members or authorized representative, as may be directed by authorized personnel of DHH, appropriate agencies of the State of Louisiana, or the United States Government and subject to reasonable charges. Release of dental records shall be consistent with the provisions of confidentiality as expressed in this Contract. The ownership and procedure for release of dental records shall be controlled by the Louisiana revised statutes, including but not limited to, LSA-R.S. 40:1299.96, LSA-R.S. 13:3734, and LA.C. Art. 510; and the 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) and subject to reasonable charges. The DBPM shall not charge DHH/BHSF or their designated agent for any copies requested.

37. Reporting Changes

The DBPM shall immediately notify DHH of any of the following:

- Change in business address, telephone number, facsimile number, and email address;
- Change in corporate status or nature;
- Change in business location;
- Change in solvency;
- Change in corporate officers, executive employees, or corporate structure;
- Change in ownership, including but not limited to the new owner's legal name, business address, telephone number, facsimile number, and email address;

- Change in incorporation status;
- Change in federal employee identification number or federal tax identification number; or
- Change in DBPM litigation history, current litigation, audits and other government investigations both in Louisiana and in other states.

38. Safeguarding Information

The DBPM 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 this Contract. The DBPM's written safeguards shall

- Be comparable to those imposed upon the DHH by 42 CFR Part 431, Subpart F (2005, as amended) and La R.S. 45:56;
- State that the DBPM 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;
- 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;
- Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
- Specify appropriate personnel actions to sanction violators.

39. Safety Precautions

DHH assumes no responsibility with respect to accidents, illnesses or claims arising out of any activity performed under this Contract. The DBPM shall take necessary steps to ensure the protection of its members, itself, and its personnel. The DBPM agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

40. Software Reporting Requirement

All reports submitted to DHH by the DBPM must be in format accessible and modifiable by the standard Microsoft Office Suite of products, Version 2003 or later, or in a format accepted and approved by DHH.

41. Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this Contract become unavailable after the effective date of this Contract, or prior to the anticipated Contract expiration date, DHH may terminate the Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by DHH.

42. Time is of the Essence

Time is of the essence in this Contract. Any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

43. Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

44. Use of Data

DHH shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the DBPM resulting from this Contract.

45. Waiver

The waiver by DHH of any breach of any provision contained in this 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 this Contract and shall not establish a course of performance between the parties contradictory to the terms hereof.

46. Warranty of Removal of Conflict of Interest

The DBPM 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 DBPM shall periodically inquire of its officers and employees concerning such conflicts, and shall inform DHH promptly of any potential conflict. The DBPM shall warrant that it shall remove any conflict of interest prior to signing the Contract.

IV. PROPOSALS

A. General Information

This section outlines the provisions which govern determination of compliance of each proposer's response to the RFP. The Department shall determine, at its sole discretion, whether or not the requirements have been reasonably met. Omissions of required information shall be grounds for rejection of the proposal by the Department.

B. Contact After Solicitation Deadline

After the date for receipt of proposals, no proposer-initiated contact relative to the solicitation will be allowed between the proposers and DHH until an award is made.

C. Code of Ethics

Proposers are responsible for determining that there will be no conflict or violation of the Ethics Code if their company is awarded the contract. The Louisiana Board of Ethics is the only entity which can officially rule on ethics issues. Notwithstanding, any potential conflict of interest that is known or should reasonably be known by a proposer as it relates to the RFP should be immediately reported to the Department by proposer.

D. Rejection and Cancellation

Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts or to enter into a contract after an award has been made. The Department reserves the right to take any of the following actions that it determines to be in its best interest:

1. Reject all proposals received in response to this solicitation;
2. Cancel this RFP; or
3. Cancel or decline to enter into a contract with the successful proposer at any time after the award is made and before the contract receives final approval from the Division of Administration, Office of Contractual Review.

In accordance with the provisions of R.S. 39:2192, in awarding contracts after August 15, 2010, any public entity is authorized to reject a proposal or bid from, or not award the contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the following provisions of the Louisiana Revised Statutes of 1950 governing public contracts: Title 38, Chapter 10 (public contracts); Title 39, Chapter 16 (professional, personal, consulting, and social services procurement); or Title 39, Chapter 17 (Louisiana Procurement Code).

E. Award Without Discussion

The Secretary of DHH reserves the right to make an award without presentations by proposers or further discussion of proposals received.

F. Assignments

Any assignment, pledge, joint venture, hypothecation of right or responsibility to any person, firm or corporation should be fully explained and detailed in the proposal. Information as to the experience and qualifications of proposed subcontractors or joint ventures should be included in the proposal. In addition, written commitments from any subcontractors or joint ventures should be included as part of the proposal. All assignments must be approved of by the Department.

G. Proposal and Contract Preparation Costs

The proposer assumes sole responsibility for any and all costs and incidental expenses associated with the preparation and reproduction of any proposal submitted in response to this RFP. The proposer to which the contract is awarded assumes sole responsibility for any and all costs and incidental expenses that it may incur in connection with: (1) the preparation, drafting or negotiation of the final contract; or (2) any activities that the proposer may undertake in preparation for, or in anticipation or expectation of, the performance of its work under the contract before the contract receives final approval from the Division of Administration, Office of Contractual Review. The proposer shall not include these costs or any portion thereof in the proposed contract cost. The proposer is fully responsible for all preparation costs associated therewith even if an award is made but subsequently terminated by the Department.

H. Errors and Omissions

The Department reserves the right to make corrections due to minor errors of proposer identified in proposals by the Department or the proposer. The Department, at its option, has the right to request clarification or additional information from proposer.

I. Ownership of Proposal

All proposals become the property of the Department and will not be returned to the proposer. The Department retains the right to use any and all ideas or adaptations of ideas contained in any proposal received in response to this solicitation. Selection or rejection of the offer will not affect this right. Once a contract is awarded, all proposals will become subject to the Louisiana Public Records Act.

J. Procurement Library/Resources Available To Proposer

1. Electronic copies of material relevant to this RFP will be posted at the following web address:

<http://www.makingmedicaidbetter.com>.

2. These documents are provided as components of the RFP and are necessary for the submission of the proposal as indicated. The documents consist of appendices, guides, and templates that are an integral part of the contract.

3. Potential proposers may receive historic Medicaid de-identified claims data at the parish of residence level for SFY 2011 and SFY 2012, for DBP core dental benefits DBP populations under the following conditions:

- a) Submit non-binding Letter of Intent to Propose to the RFP Coordinator;
- b) Sign and submit the DBP Data Use Agreement (Appendix H) to the RFP Coordinator; and
- c) Mail or deliver a computer flash drive or hard drive with a capacity of at least 16GB on which to load the historic claims data, along with the name and address to which DHH will mail the data via first class mail, return receipt requested. Alternatively, provide the name of the person

who will be picking up and signing for the data at the DHH Bienville Building, 628 North 4th Street, 6th Floor, Baton Rouge, LA . The storage drive and request for routing should be routed to the RFP Coordinator.

K. Proposal Submission

1. All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.
2. Proposer **shall** submit one (1) original hard copy (The Certification Statement must have original signature signed in ink) and should submit one (1) electronic copy (cd or flash drive) of the entire proposal and six (6) hard copies of the proposal. Proposer may provide one electronic copy of the Redacted (cd or flash drive). No facsimile or emailed proposals will be accepted; however, for mailing purposes, all packages may be shipped in one container.
3. Proposals must be submitted via U.S. mail, courier or hand delivered to:

If courier mail or hand delivered:

Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
628 N 4th Street, 5th Floor
Baton Rouge, LA 70802

If delivered via US Mail:

Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
P.O. Box 1526
Baton Rouge, LA 70821-1526

L. Proprietary and/or Confidential Information

1. Pursuant to the Louisiana Public Records Act (La. R.S. 44:1 et. seq.), all public proceedings, records, contracts, and other public documents relating to this RFP shall be open to public inspection. Proposers should refer to the Louisiana Public Records Act for further clarification, including protections sought for proprietary and/or trade secret information. Those protections for technical proposals must be claimed by the proposer at the time of submission of its technical proposal.

M. Proposal Format

1. An item-by-item response to the Request for Proposals is requested.
2. Emphasis should be on simple, straightforward and concise statements of the proposer's ability to satisfy the requirements of the RFP.

N. Requested Proposal Outline:

- Introduction/Administrative Data
- Work Plan/Project Execution
- Relevant Corporate Experience
- Personnel Qualifications

- Additional Information
- Corporate Financial Condition

O. Proposal Content

1. Proposals should include information that will assist the Department in determining the level of quality and timeliness that may be expected. The Department shall determine, at its sole discretion, whether or not the RFP provisions have been reasonably met. The proposal should describe the background and capabilities of the proposer, and give details on how the services will be provided. Work samples may be included as part of the proposal.
2. Proposals should address how the proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with federal and state laws, regulations, policies, and procedures.
3. Proposals should define proposer's functional approach in providing services and identify the tasks necessary to meet the RFP requirements of the provision of services.
4. Introduction/Administrative Data
 - a. The introductory section should contain summary information about the proposer's organization. This section should state proposer's knowledge and understanding of the needs and objectives of DHH/Bureau of Health Services Financing as related to the scope of this RFP. It should further cite its ability to satisfy provisions of the Request for Proposal.
 - b. This introductory section should include a description of how the proposer's organizational components communicate and work together in both an administrative and functional capacity from the top down. This section should contain a brief summary setting out the proposer's management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication Systems. This section should include an organizational chart displaying the proposer's overall structure.
 - c. This section should also include the following information:
 - i. Location of Administrative Office with Full Time Personnel, include all office locations (address) with full time personnel;
 - ii. Name and address of principal officer;
 - iii. Name and address for purpose of issuing checks and/or drafts;
 - iv. For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation;
 - v. If out-of-state proposer, give name and address of local representative; if none, so state;
 - vi. If any of the proposer's personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number;
 - vii. If the proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state; and
 - viii. Proposer's state and federal tax identification numbers.
 - ix. Veteran/Hudson Initiative: Proposer should demonstrate participation in Veteran Initiative and Hudson Initiative Small Entrepreneurships or explanation if not applicable. (See Attachment I).
 - d. The following information **must** be included in the proposal:

- i. Certification Statement: The proposer must sign and submit an original Certification Statement (See Attachment II).

5. Work Plan/Project Execution

The proposer should articulate an understanding of, and ability to effectively implement services as outlined within the RFP. In this section the proposer should state the approach it intends to use in achieving each objective of the project as outlined, including a project work plan and schedule for implementation. In particular, the proposer should:

- a. Provide a written explanation of the organizational structures of operations and program administration, and how those structures will support service implementation. Individual components should include plans for supervision, training, technical assistance, as well as collaboration as appropriate.
- b. Provide a strategic overview including all elements to be provided.
- c. Demonstrate an ability to hire staff with the necessary experience and skill set that will enable them to effectively meet the needs of consumers served.
- d. Demonstrate an understanding of, and ability to implement, the various types of organizational strategies to be integrated within the day to day operations, which are critical in organizing their functioning and maximizing productivity.
- e. Demonstrate knowledge of services to be provided and effective strategies to achieve objectives and effective service delivery.
- f. Describe approach and strategy for project oversight and management.
- g. Articulate the need for, and the ability to implement, a plan for continuous quality improvement; this includes (but is not limited to) reviewing the quality of services provided and staff productivity.
- h. Demonstrate the ability to establish standards for quality that reflect prevailing standards of care and evidence-based processes.
- i. Demonstrate an understanding of and ability to implement data collection as needed.
- j. Explain processes that will be implemented in order to complete all tasks and phases of the project in a timely manner.
- k. Articulate the ability to develop and implement an All Hazards Response plan in the event of an emergency event.
- l. Refer to specific documents and reports that can be produced as a result of completing tasks, to achieve the requested deliverables.
- m. Identify all assumptions or constraints on tasks.
- n. Discuss what flexibility exists within the work plan to address unanticipated problems which might develop during the contract period.
- o. If the proposer intends to subcontract for portions of the work, include specific designations of the tasks to be performed by the subcontractor.
- p. Document procedures to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.

6. Relevant Corporate Experience

- a. The proposal should indicate the proposer's firm has a record of prior successful experience in the implementation of the services sought through this RFP.
- b. Proposers should include statements specifying the extent of responsibility on prior projects and a description of the projects scope and similarity to the projects outlined in this RFP. All experience under this section should be in sufficient detail to allow an adequate evaluation by the Department.

- c. The proposer should have implemented a similar type project. Proposers should give at least two customer references for projects implemented. References shall include the name, email address and telephone number of each contact person.
- d. The proposer should demonstrate a history of making prompt claims payments to providers.
- e. The proposer should demonstrate a history of achieving high provider satisfaction.
- f. The proposer should demonstrate a history of producing quality outcomes in the fields of services being sought through this RFP.
- g. The proposer should demonstrate a proven record for successfully resolving disputes with providers.
- h. In this section, a statement of the proposer's involvement in litigation that could affect this work should be included. If no such litigation exists, proposer should so state.

7. Personnel Qualifications

- a. The purpose of this section is to evaluate the relevant experience, resources, and qualifications of the proposed staff to be assigned to this project. The experience of proposer's personnel in implementing similar services to those to be provided under this RFP will be evaluated. The adequacy of personnel for the proposed project team will be evaluated on the basis of project tasks assigned, allocation of staff, professional skill mix, and level of involvement of personnel.
- b. Proposers should state job responsibilities, workload and lines of supervision. An organizational chart identifying individuals and their job titles and major job duties should be included. The organizational chart should show lines of responsibility and authority.
- c. Job descriptions, including the percentage of time allocated to the project and the number of personnel should be included and should indicate minimum education, training, experience, special skills and other qualifications for each staff position as well as specific job duties identified in the proposal. Job descriptions should indicate if the position will be filled by a sub-contractor.
- d. Key personnel and the percentage of time directly assigned to the project should be identified.
- e. Résumés of all known personnel should be included. Resumes of proposed personnel should include, but not be limited to:
 - Experience with proposer,
 - Previous experience in projects of similar scope and size.
 - Educational background, certifications, licenses, special skills, etc.
- f. If subcontractor personnel will be used, the proposer should clearly identify these persons, if known, and provide the same information requested for the proposer's personnel.

8. Additional Information

As an appendix to its proposal, if available, proposers should provide copies of any policies and procedures manuals applicable to this contract, inclusive of organizational standards or ethical standards. This appendix should also include a copy of proposer's All Hazards Response Plan, if available.

9. Corporate Financial Condition

- a. The organization's financial solvency will be evaluated. The proposer's ability to demonstrate adequate financial resources for performance of the contract or the ability to

obtain such resources as required during performance under this contract will be considered.

- b. Proposal should include for each of the last three (3) years, copies of financial statements, preferably audited, including at least a balance sheet and profit and loss statement, or other appropriate documentation which would demonstrate to the Department the proposer's financial resources sufficient to conduct the project.

V. Evaluation and Selection

A. Evaluation Criteria

The following criteria will be used to evaluate proposals:

1. Evaluations will be conducted by a Proposal Review Committee.
2. Evaluations of the financial statements will be conducted by a member of the DHH Office of the Secretary Division of Fiscal Management
3. Scoring will be based on a possible total of 1250 points and the proposal with the highest total score will be recommended for award.
4. Evaluation Criteria and Assigned Weights:

Qualifications and Experience	155
Planned Approach to Project	75
Member Enrollment	20
Service Coordination	75
Provider Network	100
Utilization Management	100
EPSDT	40
Quality Management	100
Member Materials	15
Member/Provider Service	100
Emergency Management Plan	20
Grievance and Appeals	25
Fraud and Abuse	25
Third Party Liability	25
Claims Management	125
Information Systems	125
Veteran or Hudson Initiative	125
Total	1250

B. Evaluation Team

The evaluation of proposals will be accomplished by an evaluation team, to be designated by the Department, which will determine the proposal most advantageous to the Department, taking into consideration cost and the other evaluation factors set forth in the RFP.

C. Administrative and Mandatory Screening

All proposals will be reviewed to determine compliance with administrative and mandatory requirements as specified in the RFP. Proposals that are not in compliance will be excluded from further consideration.

D. Clarification of Proposals

The Department reserves the right to seek clarification of any proposal for the purpose of identifying and eliminating minor irregularities or informalities, including resolving inadequate proposal content, or contradictory statements in a proposer's proposal.

E. Announcement of Award

Subject to the provisions of Paragraph IV.D above, the Department will award the contract to the proposer with the highest graded proposal and deemed to be in the best interest of the Department. All proposers will be notified of the contract award. The Department will notify the successful proposer and proceed to negotiate contract terms. Mandatory requirements established by the Department and/or the Evaluation Team are not subject to negotiation.

VI. CONTRACTUAL INFORMATION

- A. The contract between DHH and the Contractor shall include the standard DHH contract form CF-1 (Attachment III) including a negotiated scope of work, the RFP and its amendments and addenda, and the Contractor's proposal. The attached CF-1 contains basic information and general terms and conditions of the contract to be awarded.
- B. Mutual Obligations and Responsibilities: The state requires that the mutual obligations and responsibilities of DHH and the successful proposer be recorded in a written contract. While final wording will be resolved at contract time, the intent of the provisions will not be altered and will include all provisions as specified in the attached CF-1 (Attachment III).
- C. Retainage
The Department shall secure a retainage of 10% from all billings under the contract as surety for performance. On successful completion of contract deliverables, the retainage amount may be released on an annual basis. Within ninety (90) days of the termination of the contract, if the contractor has performed the contract services to the satisfaction of the Department and all invoices appear to be correct, the Department shall release all retained amounts to the contractor.

Attachments:

- I. Veteran and Hudson Initiatives
- II. Certification Statement
- III. DHH Standard Contract Form (CF-1)
- IV. HIPAA BAA
- V. Summary of Required Providers
- VI. Proposal Submission and Evaluation Documents
- VII. Reference Questionnaire

Attachment I

**Veteran-Owned and Service-Connected Small Entrepreneurships
(Veteran Initiatives) And Louisiana Initiative For Small Entrepreneurships
(Hudson Initiative) Programs**

***Participation of Veteran Initiative and Hudson Initiative small entrepreneurships will be scored
as part of the technical evaluation.***

The State of Louisiana Veteran and Hudson Initiatives are designed to provide additional opportunities for Louisiana-based small entrepreneurship (sometimes referred to as LaVet's and SE's respectively) to participate in contracting and procurement with the state. A certified Veteran-Owned and Service- Connected Disabled Veteran-Owned small entrepreneurship (LaVet) and a Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) small entrepreneurship are businesses that have been certified by the Louisiana Department of Economic Development. All eligible vendors are encouraged to become certified. Qualification requirements and online certification are available at <https://smallbiz.louisianaforward.com/index 2.asp>.

Ten percent (10%) of the total evaluation points on this RFP are reserved for proposers who are themselves a certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiatives small entrepreneurship as subcontractors.

Reserved points shall be added to the applicable proposers' evaluation score as follows:

Proposer Status and Reserved Points

- Proposer is a certified small entrepreneurship: Full amount of the reserved points
- Proposer is not a certified small entrepreneurship but has engaged one or more certified small entrepreneurship to participate as subcontractors or distributors. Points will be allocated based on the following criteria:
 - the number of certified small entrepreneurship to be utilized
 - the experience and qualifications of the certified small entrepreneurship(s)
 - the anticipated earnings to accrue to the certified small entrepreneurship(s)

If a proposer is not a certified small entrepreneurship as described herein, but plans to use certified small entrepreneurship(s), proposer shall include in their proposal the names of their certified Veteran Initiative or Hudson Initiative small entrepreneurship subcontractor(s), a description of the work each will perform, and the dollar value of each subcontract.

During the term of the contract and at expiration, the Contractor will also be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship subcontractor or distributor participation and the dollar amount of each.

The statutes (R.S 39:2171 *et. seq.*) concerning the Veteran Initiative may be viewed at <http://legis.la.gov/lss/lss.asp?doc=671504> and the statutes (R.S 39:2001 *et. seq.*) concerning the Hudson Initiative may be viewed at:

<http://legis.la.gov/lss/lss.asp?doc=96265> The rules for the Veteran Initiative (LAC 19: VII. Chapters 11 and 15) and for the Hudson Initiative (LAC 19: VIII Chapters 11 and 13) may be viewed at <http://www.doa.louisiana.gov/osp/se/se.htm>

A current list of certified Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship may be obtained from the Louisiana Economic Development Certification System at <https://smallbiz.louisianaforward.com/index 2.asp>. Additionally, a list of Hudson and Veteran Initiative small entrepreneurship, which have been certified by the Louisiana Department of Economic Development and who have opted to register in the State of Louisiana LaGov Supplier Portal https://lagoverpvendor.doa.louisiana.gov/irj/portal/anonymous?guest_user=self_reg may be accessed from the State of Louisiana Procurement and Contract (LaPAC) Network <http://wwwprd1.doa.louisiana.gov/osp/lapac/vendor/srchven.cfm>. When using this site, determine the search criteria (i.e. alphabetized list of all certified vendors, by commodities, etc.) and select SmallE, VSE, or DVSE.

REV 12/1/11

CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT: The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

Date	
Official Contact Name	
Email Address	
Fax Number with Area Code	
Telephone Number	
Street Address	
City, State, and Zip	

Proposer certifies that the above information is true and grants permission to the Department to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

- 1. The information contained in its response to this RFP is accurate;
- 2. Proposer complies with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein;
- 3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
- 4. Proposer's technical proposals are valid for at least 90 days from the date of proposer's signature below;
- 5. Proposer understands that if selected as the successful Proposer, he/she will have **45** calendar days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.
- 6. Proposer certifies, by signing and submitting a proposal for \$25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at <https://www.sam.gov>).

Authorized Signature:

Original Signature Only: Electronic or Photocopy Signature are NOT Allowed

Print Name:

Title:

DHH - CF - 1
Revised: 2011-06

CONTRACT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

CFMS:
DHH:
Agency #

AND

FOR

☐ Personal Services ☐ Professional Services ☐ Consulting Services ☐ Social Services

1) Contractor (Legal Name if Corporation)		5) Federal Employer Tax ID# or Social Security # (Must be 11 Digits)	
2) Street Address		6) Parish(es) Served	
City	State	Zip Code	7) License or Certification #
3) Telephone Number		8) Contractor Status	
4) Mailing Address (if different)		Subrecipient: ☐ Yes ☐ No	
		Corporation: ☐ Yes ☐ No	
		For Profit: ☐ Yes ☐ No	
		Publicly Traded: ☐ Yes ☐ No	
City	State	Zip Code	8a) CFDA#(Federal Grant #)
9) Brief Description Of Services To Be Provided:			
10) Effective Date			
11) Termination Date			
12) This contract may be terminated by either party upon giving thirty (30) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.			
13) Maximum Contract Amount			
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:			
Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.			
PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	First Name		Last Name
	Title		Phone Number
15) Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):			

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

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, 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, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.
2. Contractor shall abide by the laws and regulations concerning confidentiality which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)
3. The State 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 three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and 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 DHH Policy requiring an audit of the 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 contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, 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 DHH Office**.

4. 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 74:53 (b) 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 the contractor's site, without expense to the Department.
5. 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 Contractual Review.
6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.
7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, 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.
8. 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 which shall be inclusive of all charges including fees and travel expenses.
9. 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.
10. Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.

11. All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to 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 State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.
12. 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 the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.
13. 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 R.S. 42:1113 as amended in the 2008 Regular Session of the Louisiana Legislature.
14. 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 which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.
15. 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 \$20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502..
16. 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. 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 contract exceeds \$20,000, approved by the Director of the Office of Contractual Review, Division of Administration. 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.
18. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.
19. 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 DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH 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. Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with 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 \$1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH 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 contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.
21. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, 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, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (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 DHH.

22. 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 and Federal law, or applicable State or Federal regulations.
23. 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 the current contract.

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.

SIGNATURE	DATE
NAME	
TITLE	

SIGNATURE	DATE
NAME	
TITLE	

SIGNATURE	DATE
NAME	
TITLE	

SIGNATURE	DATE
NAME	
TITLE	

This HIPAA Business Associate Addendum is hereby made a part of this contract in its entirety as Attachment ____ to the contract.

1. The Louisiana Department of Health and Hospitals (“DHH”) is a Covered Entity, as that term is defined herein, because it functions as a health plan and as a health care provider that transmits health information in electronic form.
2. Contractor is a Business Associate of DHH, as that term is defined herein, because contractor either: (a) creates, receives, maintains, or transmits PHI for or on behalf of DHH; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for DHH involving the disclosure of PHI.
3. **Definitions:** As used in this addendum –
 - A. The term “HIPAA Rules” refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 C.F.R. 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.
 - B. 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 C.F.R. § 160.103.
 - C. The term “security incident” has the same meaning as set forth in 45 C.F.R. § 164.304.
 - D. The terms “breach” and “unsecured protected health information” (“unsecured PHI”) have the same meaning as set forth in 45 C.F.R. § 164.402.
4. 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 and addendum as required by the HIPAA Rules and by this contract and addendum.
5. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule or regulation (including the HIPAA Rules) or as otherwise required or permitted by this contract and addendum.
6. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this contract and addendum, 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 DHH.
7. In accordance with 45 C.F.R. § 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 and addendum.
8. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1. 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 DHH, any harm or damage resulting from any use or disclosure which violates this contract and addendum shall be mitigated, to the extent practicable, either: (a) by contractor at its own expense; or (b) by DHH, in which case contractor shall reimburse DHH for all expenses that DHH is required to incur in undertaking such mitigation activities.
9. To the extent that contractor is to carry out one or more of DHH’s obligations under 45 C.F.R. Part 164, Subpart E, contractor shall comply with the requirements of Subpart E that apply to DHH in the performance of such obligation(s).
10. Contractor shall make available such information in its possession which is required for DHH 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 DHH 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.
11. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR § 164.524.
12. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
13. 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 DHH available to the Secretary of the U. S. DHHS for purposes of determining DHH’s compliance with the HIPAA Rules.
14. Contractor shall indemnify and hold DHH harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys’ fees resulting from any violation of this addendum 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.
15. The parties agree that the legal relationship between DHH and contractor is strictly an independent contractor relationship. Nothing in this contract and addendum shall be deemed to create a joint venture, agency, partnership, or employer-employee relationship between DHH and contractor.
16. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any provision of the HIPAA Rules or any material term of this addendum.
17. At the termination of the contract, or upon request of DHH, whichever occurs first, contractor shall return or destroy (at the option of DHH) 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.

BAYOU HEALTH - Dental Benefit Program Name
Summary of Required
Providers o

ATTACHMENT V

PARISH	PROVIDER TYPE							
	General Dentist	Endodontist	Oral & Maxillofacial Surgeons	Orthodontist	Pedodontist	Periodontist	Prosthodontist	Special Needs Pedodontist
ACADIA								
ALLEN								
ASCENSION								
ASSUMPTION								
AVOUELLES								
BEAUREGARD								
BIENVILLE								
BOSSIER								
CADDO								
CALCASIEU								
CALDWELL								
CAMERON								
CATAHOULA								
CLAIBORNE								
CONCORDIA								
DESOTO								
EAST BATON ROUGE								
EAST CARROLL								
EAST FELICIANA								
EVANGELINE								
FRANKLIN								
GRANT								
IBERIA								

IBERVILLE								
JACKSON								
JEFFERSON								
JEFFERSON DAVIS								
LAFAYETTE								
LAFOURCHE								
LASALLE								
LINCOLN								
LIVINGSTON								
MADISON								
MOREHOUSE								
NATCHITOCHES								
ORLEANS								
OUACHITA								
PLAQUEMINES								
POINTE COUPEE								
RAPIDES								
RED RIVER								
RICHLAND								
SABINE								
ST BERNARD								
ST CHARLES								
ST HELENA								
ST JAMES								
ST JOHN								
ST LANDRY								
ST MARTIN								
ST MARY								
ST TAMMANY								
TANGIPAHOA								
TENSAS								
TERREBONNE								

UNION								
VERMILION								
VERNON								
WASHINGTON								
WEBSTER								
WEST BATON ROUGE								
WEST CARROLL								
WEST FELICIANA								
WINN								
STATEWIDE UNDUPLICATED TOTAL	0	0	0	0	0	0	0	0

DBP PROPOSAL EVALUATION POINTS SUMMARY
PART I – MANDATORY

ATTACHMENT VI

Section	Category	Total Possible Points
A	Mandatory Requirements	Pass/Fail

PART II – TECHNICAL - Total Possible Points – 1250

Section	Category	Total Possible Points
B	Qualifications and Experience	155
C	Planned Approach to Project	75
D	Member Enrollment	20
E	Service Coordination	75
F	Provider Network	100
G	Utilization Management	100
H	EPSDT	40
I	Quality Management	100
J	Member Materials	15
K	Member/Provider Service	100
L	Emergency Management Plan	20
M	Grievance and Appeals	25
N	Fraud and Abuse	25
O	Third Party Liability	25
P	Claims Management	125
Q	Information Systems	125
S	Veteran or Hudson Initiative	125
	Total	1250

LOUISIANA BAYOU HEALTH PROGRAM
DBP PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS
RFP # 305PUR-DHHRFP-DENTAL-PAHP-MVA

PROPOSER NAME

THE PROPOSER MUST COMPLETE THIS FORM AND SUBMIT WITH THEIR PROPOSAL.

PART ONE: MANDATORY REQUIREMENTS

The Proposer shall address ALL Mandatory Requirements section items and should provide, in sequence, the information and documentation as required (referenced with the associated item references).

The DHH Division of Contracts and Procurement Support will review all general mandatory requirements.

The DHH Division of Contracts and Procurement Support will also review the proposal to determine if the Mandatory Requirement Items (below) are met and mark each with included or not included.

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said Contract (Refer to Section IV and V of RFP).

The Proposer shall adhere to the specification outlined in Section IV and V of the RFP in responding to this RFP. The Proposer should complete all columns marked in **ORANGE ONLY**.

NOTICE: In addition to these requirements, DHH will also evaluate compliance with ALL other RFP provisions.

Proposal Section and Page Number	PART ONE: MANDATORY REQUIREMENT ITEMS	For State Use Only	
		INCLUDED/NOT INCLUDED	DHH COMMENTS
	A.1 Provide the Proposal Certification Statement (RFP Attachment II) completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract. <i>The Proposer must sign the Proposal Certification Statement without exception or qualification.</i>		
	A.2 Provide a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract guaranteeing that there will be no conflict or violation of the Ethics Code if the Proposer is awarded a contract. Ethics issues are interpreted by the Louisiana Board of Ethics.		

PART II: TECHNICAL PROPOSAL & EVALUATION GUIDE

The Proposer should adhere to the specifications outlined in Section V of the RFP in responding to this RFP. The Proposer should address ALL section items and provide, in sequence, the information and documentation as required (referenced with the associated item references and text and complete all columns marked in **ORANGE ONLY.**

Proposal Evaluation Teams, made up of teams of State employees, will evaluate and score the proposal’s responses.

For those items in Part II that state “Included/Not Included” the proposals will be scored as follows:

- a. All items scored Included = 0 points**
- b. If 1-3 items are scored “Not Included” = -10 points**
- c. If 4-5 items are scored “Not Included” = -20 points**
- d. If more than 6 items are scored “Not Included” = -30 points**

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract.

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B. Qualifications and Experience (Sections 2, 3, and 4 of the RFP)	155		
	B.1 Indicate your organization’s legal name, trade name, <i>dba</i>, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization’s ultimate parent (<i>e.g.</i> publicly traded corporation). Describe your organization’s form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any oral health care professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest. Provide your federal taxpayer identification number and Louisiana taxpayer identification number. Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provider the name and address of the local representative; if none, so state. If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.	Included/Not Included		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.	Included/Not Included		
	B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled <i>nolo contendere</i> to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.	0 to - 25		
	B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality dental services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.	0 to - 25		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.	0 to - 50		
	B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report. Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.	0 to - 10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.	Included/Not Included		
	B.8 Describe your organization’s number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization’s parent organization, affiliates, and subsidiaries.	Included/Not Included		
	B.9 Provide a narrative description of your proposed Bayou Health project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level.	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience. If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number. If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages. For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.	15		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.11 Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than \$100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located. In addition, as part of the response to this item, for each major subcontractor that is not your organization’s parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B10 and, B.16 through B.27 If the major subcontractor is your organization’s parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B11; note, however, responses to various other items in Section B must include information on your organization’s parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization’s parent organization, affiliate, or subsidiary.	5		
	B.12 Provide a description your Corporate Compliance Program including the Compliance Officer’s levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.13 Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature.	5		
	B.15 Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:31: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.16 Identify, in Excel format, all of your organization’s publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization’s parent organization, affiliates, and subsidiaries.	25		
	B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization’s parent organization, affiliates, and subsidiaries.	Included/Not Included		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.	0 to - 50		
	B.19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following: • AM Best Company (financial strengths ratings); • TheStreet.com, Inc. (safety ratings); and • Standard & Poor's (long-term insurer financial strength).	Included/Not Included		
	B.20 For any of your organization's contracts to provide oral health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.	0 to - 20		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.21 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2012. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization’s parent organization, affiliates, and subsidiaries) in response to the report.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.22 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.	0 to - 15		
	B.23 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.	0 to - 10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.24 Submit customer references (minimum of two, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Attachment VII. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps: - Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Attachment VII (for your organization or for subcontractors, adding the following customized information: - Your/Subcontractor's name; - Reference organization's name; and - Reference contact's name, title, telephone number, and email address. - Send the form to each reference contact along with a new, sealable standard #10 envelope; - Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal; - Instruct the reference contact to: - Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission); - Sign and date it; - Seal it in the provided envelope; - Sign the back of the envelope across the seal; and - Return it directly to you. - Enclose the unopened envelopes in easily identifiable and labeled larger	20		

	envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references. THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE. Each completed questionnaire should include: • Proposing Organization/Subcontractor’s name; • Reference Organization’s name; • Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work; • Date reference form was completed; and • Responses to numbered items in RFP Attachment # (as applicable). DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.			
	B.25 Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence (<i>e.g.</i> Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.	Included/Not Included		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.26 Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.	0 to - 10		
	B.27 Provide the following as documentation of financial responsibility and stability: • a current written bank reference, in the form of a letter, indicating that the Proposer’s business relationship with the financial institution is in positive standing; • two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by an accredited credit bureau within the last 6 months; • a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate; and • a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer’s name) for a general line of credit in the amount of five-hundred thousand dollars (\$500,000.00).	25		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.28 Provide the following as documentation of the Proposer’s sufficient financial strength and resources to provide the scope of services as required: • The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be: ○ Prepared with all monetary amounts detailed in U.S. currency; ○ Prepared under U.S. generally accepted accounting principles; and ○ Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor’s opinion letter, financial statements, and the notes to the financial statements. • The Proposer’s four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows. • Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable. Proposer shall include the Proposer’s parent organization.	25		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section C: Planned Approach to Project	75		
	Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by May 1, 2014. C.1 Discuss your approach for meeting the implementation requirements and include: • A detailed description of your project management methodology. The methodology should address, at a minimum, the following: ○ Issue identification, assessment, alternatives analysis and resolution; ○ Resource allocation and deployment; ○ Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and ○ Automated tools, including use of specific software applications.	20		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	C.2 Provide a work plan for the implementation of the Louisiana Medicaid DBP Program. At a minimum the work plan should include the following: • Tasks associated with your establishment of a “project office” or similar organization by which you will manage the implementation of the DBP Program; • An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the DBP Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables. ○ All activities to prepare for and participate in the Readiness Review Process; and ○ All activities necessary to obtain required contracts for mandatory dental care providers as specified in this RFP. • An estimate of person-hours associated with each activity in the Work Plan; • Identification of interdependencies between activities in the Work Plan; and • Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the DBP shall understand DHH shall not be obligated to meet the DBP’s expectation.)	15		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	C.3 Describe your Risk Management Plan. • At a minimum address the following contingency scenarios that could be encountered during implementation of the program: - o Delays in building the appropriate Provider Network as stipulated in this RFP; - o Delays in building and/or configuring and testing the information systems within your organization’s Span of Control required to implement the DBP program; - o Delays in hiring and training of the staff required to operate program functions; - o Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions; - o Delays in enrollment processing during the implementation of DBP; and - o Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents. • For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following: - o Risk identification and mitigation strategies; - o Risk management implementation plans; and - o Proposed or recommended monitoring and tracking tools.	15		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	C.4. Provide a copy of the work plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with this activities.	15		
	C.5 Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the provider network.	5		
	C.6 Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section D: Member Enrollment and Disenrollment	20		
	D.1 Describe how you will ensure that you will coordinate with DHH and its Agent to transmit and obtain files sent by the Fiscal Intermediary.	20		
	D.2 Describe the steps you will take to assign a member to a different Provider in the event a Primary Care Dentist requests the Member be assigned elsewhere.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section E: Service Coordination	75		
	E.1 DHH intends to provide DBPs with two years of historic claims data for members enrolled in the DBP effective the start date of operations. Describe how you will ensure the continuation of all active prior authorized services for members effective the start date of operations. The description should include: • How you will identify these enrollees, and how you will uses this information to identify these enrollees; • What additional information you will request from DHH, if any, to assist you in ensuring continuation of services; • How you will ensure continuation of services and use of non-contract providers; • What information, education, and training you will provide to your providers to ensure continuation of services; and • What information you will provide your members to assist with the transition of care.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	E.2 Provide your communication plans with the Bayou Health Plans and Medicaid fee-for-service in coordinating the following services which will continue to be provided by the Medicaid fee-for-service and Bayou Health programs: • Outpatient facility fees for dental services • Fluoride Varnish performed by Primary Care Physician • Current Procedural Terminology (CPT) codes billed by Oral Surgeons .	20		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	E.3 What specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?	15		
	E.4 Detail the strategies you will use to influence the behavior of members to access oral health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid DBP members.	20		
	E.5 Much faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct oral health services. Describe what specific ways would you leverage these resources to support the oral health and wellness of your members.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section F: Provider Network	100		
	F.1 Provide a listing of the proposed provider network using the List of Required In-Network and Allowable Out-of-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per primary care dentist. Using providers, with whom you have signed letters of intent or executed contracts, provide individual maps and coding by parish. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types, if applicable (i.e, pediatrics, general dentist and orthodontist). The DBP should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library) 1. Practitioner Last Name, First Name and Title - For types of service such as primary care dentist and specialist, list the practitioner's name and practitioner title such as DDS, DMD, etc. 2. Practice Name/Provider Name - - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable. 3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code 4. Provider Type and Specialty Code - Indicate the practitioner's specialty using	30		

	Medicaid Provider Type and Specialty Codes. 5. New Patient - Indicate whether or not the provider is accepting new patients. 6. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a provider only sees patients up to age 19, indicate < 19; if a provider only sees patients age 13 or above, indicate > 13. 7. Primary Care Dentist - the number of potential linkages. 8. If LOI or contract executed. 9. Designate if Significant Traditional Provider. 10. Maps for this location.			
	F.2 Describe how you will handle the potential loss (i.e., contract termination, closure) in a parish of all providers within a certain specialty.	5		
	F.3 The DBP is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the DBP's subcontract. DHH will make available on www.MakingMedicaidBetter.com a listing of STPs by provider type by parish. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.1) are STPs.	15		
	F.4 Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the parish(es) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each parish of the following provider types/services: - o Primary Care - o Specialty Care - o FQHC/RHC	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	F.5 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.	10		
	F.6 Describe your primary care dentist assignment process and the measures taken to ensure that every member in your DBP is assigned in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their primary care dentist and whether you allow specialists to be credentialed to act as primary care dentists..	5		
	F.7 Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following: - o Compliance with cost sharing requirements; - o Compliance with medical record documentation standards; - o Compliance with conflict of interest requirements; - o Compliance with lobbying requirements; - o Compliance with disclosure requirements; and - o Compliance with member education requirements.	5		
	F.8 Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	F.9 Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.	5		
	F.10 Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.	5		
	F.11 Describe your practice of profiling the quality of care delivered by network general dentists, and any other acute care providers including the methodology for determining which and how many Providers will be profiled. - o Submit sample quality profile reports used by you, or proposed for future use (identify which). - o Describe the rationale for selecting the performance measures presented in the sample profile reports. - o Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.	5		
	F.12 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	F.13 If the Department receives written or verbal complaints on behalf of any provider in regards to excessive, unwarranted, and/or aggressive attempts to require any information to fulfill network adequacy requirements during the RFP process.	0 to -50		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section G: Utilization Management (UM)	100		
	G.1 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.	30		
	G.2 If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.	20		
	G.3 Regarding your utilization management (UM) staff: • Provide a detailed description of the training you provide your UM staff; • Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item K.1; • If your UM phone line will handle both Louisiana DBP and non-Louisiana DBP calls, - o explain how you will track DBP calls separately; and - o how you will ensure that applicable DHH timeframes for prior authorization decisions are met.	25		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	G.4 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system. Individuals who will make medical necessity determinations must be identified if the criteria are based on the dental training, qualifications, and experience of the DBP dental director or other qualified and trained professionals	25		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section H: EPSDT	40		
	H.1 Describe your system for tracking each member’s screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.	10		
	H.2 Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in H.1 above and any innovative/non-traditional mechanisms. Include: • How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods; • How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and How you will design and monitor your education and outreach program to ensure compliance with the RFP.	20		
	H.3 Describe your approach to ensuring that providers deliver and document all required components of EPSDT screening.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section I: Quality Management	100		
	I.1 Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following: • Reduction of inappropriate utilization of emergent services • EPSDT • Children with special health care needs • Case management • Reduction in racial and ethnic health care disparities to improve health status	25		
	I.2 Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.	5		
	I.3 Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2002 and how issues and root causes were identified, and what was changed.	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	I.4 Describe your proposed Quality Assessment and Performance Improvement (QAPI). Such description should address: • The QAPI proposed to be implemented during the term of the contract. • How the proposed QAPI s will expand quality improvement services. • How the proposed QAPI will improve the health care status of the Louisiana Medicaid population. • Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues. • How your will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner. • How the proposed QAPIs may include, but is not necessarily, limited to the following: - o New innovative programs and processes. - o Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.	20		
	I.5 Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	I.6 Provide, in Excel format, the proposer’s results for: 1) HEDIS measures specified below for the last three measurement years (2009, 2010, and 2011) for each of your State Medicaid contracts. ▪ If you do not have results for a particular measure or year, provide the results that you do have. ▪ If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line. ▪ If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state). ▪ If you do not have HEDIS results for five states, provide the results that you do have. ▪ In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer’s parent organization, affiliates, and subsidiaries. Provide results for the following HEDIS measures:	40		

	1. Annual Dental Visit 2) CMS 416 Report measures specified below for the last three measurement years (20010, 2011, and 2012) for each of your State Medicaid contracts. • Line 12a - Total Eligibles Receiving Any Dental Services - • Line 12b - Total Eligibles Receiving Preventive Dental Services • Line 12c - Total Eligibles Receiving Dental Treatment • Line 12d — Total Eligibles Receiving a Sealant on a Permanent Molar Tooth, and • Line 12e — Total Eligibles Receiving Diagnostic Dental Services ▪ For each of your State Medicaid contracts that received a CMS State Focused Dental Review (2008), please outline all findings, recommendations, etc. revealed in the State-specific reports, as well as the steps that were taken to improve recommendations and rectify all findings. Focus			
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Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section J: Member Materials	15		
	J.1 Describe proposed content for your member educational materials) and attach a examples used with Medicaid or CHIP populations in other states.	5		
	J.2 Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6 th) grade reading level requirement.	2.5		
	J.3 Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.	5		
	J.4 Describe how you will fulfill Internet presence and Web site requirements, including: • Your procedures for up-dating information on the Web site; • Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and • The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction.	2.5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section K: Member/Provider Service	100		
	K.1 Provide a narrative with details regarding your member services line including: - o Training of customer service staff (both initial and ongoing); - o Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity); - o Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired; - o Monitoring process for ensuring the quality and accuracy of information provided to members; - o Monitoring process for ensuring adherence to performance standards; - o How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (eg., Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and - o After hours procedures.	25		
	K.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2013 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the rate.	25		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	K.3 Describe the procedures a Member Services representative will follow to respond to the following situations: - o A Member has received a bill for payment of covered services from a network provider or out-of-network provider; - o A Member is unable to reach his/her a provider within the network after normal business hours; - o A Member is having difficulty scheduling an appointment for preventive care with her primary care dentist; and - o A Member becomes ill while traveling outside of the state.	20		
	K.4 Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.	15		
	K.5 Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.	15		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section L: Emergency Management Plan	20		
	L.1 Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery: - o Employee training; - o Identified essential business functions and key employees within your organization necessary to carry them out; Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; - o Communication with staff and suppliers when normal systems are unavailable; - o Specifically address your plans to ensure continuity of services to providers and members; and - o How your plan will be tested.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	L.2 Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community. • You have thirty thousand (30,000) or more DBP members residing in hurricane prone parishes. Louisiana parishes include coastal and inland areas subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and certain parishes are under a mandatory evacuation order. State assisted evacuations and self-evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States. • Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section M: Grievances and Appeals	25		
	M.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process which comply with the RFP requirements, including your approach for meeting the general requirements and plan to: - o Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member’s primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal; - o Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and - o Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member’s health. As part of this process, explain how you will determine when the expedited process is necessary. Include in the description how data resulting from the grievance system will be used to improve your operational performance.	25		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section N: Fraud & Abuse	25		
	N.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.	25		
	Section O: Third Party Liability	25		
	O.1 Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL) specified in this RFP, including: - o How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance; - o Collection process for pay and chase activity and how it will be accomplished; - o How subrogation activities will be conducted; - o How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements; - o Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and - o What routine systems/business processes are employed to test, update and validate enrollment and TPL data.	25		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section P: Claims Management	125		
	P.1 Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.	75		
	P.2 Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response: • The process for auditing a sample of claims as described in Key Claims Management Standards Section; • The sampling methodology itself; • Documentation of the results of these audits; and • The processes for implementing any necessary corrective actions resulting from an audit.	25		
	P.3 Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures, are met.	25		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section Q: Information Systems	125		
	Q.1 Describe your approach for implementing information systems in support of this RFP, including: • Demonstrate capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements; • Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements; • System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of DBP enrollees, claims/service utilization history for the initial set of DBP enrollees, active/open service authorizations for the initial set DBP enrollees, etc.; and • Internal and joint (DBP and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data. • Provide a Louisiana Medicaid DBP-Program-specific work plan that captures: - o Key activities and timeframes and - o Projected resource requirements from your organization for implementing information systems in support of this contract. • Describe your historical data process including but not limited to: - o Number of years retained;	20		

	- o How the data is stored; and - o How accessible is it. The work plan should cover activities from contract award to the start date of operations.			
	Q.2 Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH and the Enrollment Broker. In your description, address separately the encounter data-specific requirements in, Encounter Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handing of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.	10		
	Q.3 Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan. Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to previous paragraph, or indicate whether these technologies and management strategies are already in place. Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Q.4 Describe in detail: - How your <i>key production systems</i> are designed to <i>interoperate</i>. In your response address all of the following: - How identical or closely related data elements in different systems are named, formatted and maintained: - Are the data elements named consistently; - Are the data elements formatted similarly (# of characters, type-text, numeric, etc.); - Are the data elements updated/refreshed with the same frequency or in similar cycles; and - Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.). - All exchanges of data between key production systems. - How each data exchange is triggered: a manually initiated process, an automated process, etc. - The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc. - As part of your response, provide diagrams that illustrate: - point-to-point interfaces, - information flows, - internal controls and - the networking arrangement (AKA “network diagram”) associated with the information systems profiled. These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana	10		

	Medicaid DBP Program.			
Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Q.5 Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response: • Explain whether and how your systems meet (or exceed) each of these requirements. • Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in the Technical Requirements section. Also, explain how that experience will apply to the Louisiana Medicaid DBP Program. • If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (4) Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Q.6 Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response: • Explain whether and how your systems meet (or exceed) each of these requirements. • Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in the Technical Requirements section. Also, explain how that experience will apply to the Louisiana Medicaid DBP Program. • If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. • Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.	5		
	Q.7 Describe the ability within your systems to meet (or exceed) each of the requirements in the Technical Requirements section. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Q.8 Describe your information systems change management and version control processes. In your description address your production control operations.	10		
	Q.9 Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address: • provider contract loads and associated business rules; • eligibility/enrollment data loads and associated business rules; • claims processing and adjudication logic; and • encounter generation and validation prior to submission to DHH.	5		
	Q.10 Describe your reporting and data analytic capabilities including: • generation and provision to the State of the management reports prescribed in the RFP; • generation and provision to the State of reports on request; • the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an <i>ad-hoc</i> basis; and • Reporting back to providers within the network.	5		
	Q.11 Provide a detailed profile of the key information systems within your span of control.	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Q.12 Provide a profile of your current and proposed Information Systems (IS) organization.	5		
	QR.13 Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.	5		
	Q.14 Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.	Included/Not Included		
	Q.15 Describe your plans and ability to support network providers’ “meaningful use” of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.	10		
	Q.16 Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section R: Veteran or Hudson Initiative R.1 Certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiatives small entrepreneurships as subcontractors. (See Attachment I)	125		

RFP # 305PUR-DHHRFP-DENTAL-PAHP-MVA

PROPOSAL REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: < INSERT NAME OF PROPOSER >

The “reference subject” specified above, intends to submit a proposal to the Louisiana Department of Health & Hospitals (DHH) in response to the Request for Proposals (RFP) indicated for Medicaid managed care services through the Louisiana Medicaid Coordinated Care Network Program. As a part of such proposal, the reference subject must include a number of completed and sealed reference questionnaires (using this form).

Each individual responding to this reference questionnaire is asked to follow these instructions:

- complete this questionnaire (either using the form provided or an exact duplicate of this document);
- sign and date the completed questionnaire;
- seal the completed, signed, and dated questionnaire in a new standard #10 envelope;
- sign in ink **across the sealed portion** of the envelope; and
- return the sealed envelope containing the completed questionnaire directly to the reference subject.

(1) What is the name of the individual, company, organization, or entity responding to this reference questionnaire?

(2) Please provide the following information about the individual completing this reference questionnaire on behalf of the above-named individual, company, organization, or entity.

NAME:	
TITLE:	
TELEPHONE #	
E-MAIL ADDRESS:	

(3) What services does /did the reference subject provide to your company or organization?

(4) What is the level of your overall satisfaction with the reference subject as a vendor of the services described above?

Please respond by circling the appropriate number on the scale below.

12345

least satisfied | | | | | most satisfied

If you circled 3 or less above, what could the reference subject have done to improve that rating?

(5) If the services that the reference subject provided to your company or organization are completed, were the services completed in compliance with the terms of the contract, on time, and within budget? If not, please explain.

- (6) If the reference subject is still providing services to your company or organization, are these services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.
- (7) How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?
- (8) In what areas of service delivery does /did the reference subject excel?
- (9) In what areas of service delivery does /did the reference subject fall short?
- (10) What is the level of your satisfaction with the reference subject's project management structures, processes, and personnel?

Please respond by circling the appropriate number on the scale below.

1

2

3

4

5

least satisfied

most satisfied

What, if any, comments do you have regarding the score selected above?

- (11) Considering the staff assigned by the reference subject to deliver the services described in response to question 3 above, how satisfied are you with the technical abilities, professionalism, and interpersonal skills of the individuals assigned?

Please respond by circling the appropriate number on the scale below.

1

2

3

4

5

least satisfied

most satisfied

What, if any, comments do you have regarding the score selected above?

- (12) Would you contract again with the reference subject for the same or similar services?

Please respond by circling the appropriate number on the scale below.

1

2

3

4

5

least satisfied

most satisfied

What, if any, comments do you have regarding the score selected above?

REFERENCE SIGNATURE:
(by the individual completing this
request for reference information)

(must be the same as the signature across the envelope seal)

DATE:
