REQUEST FOR PROPOSALS

BAYOU HEALTH
MANAGED CARE ORGANIZATIONS

LOUISIANA MEDICAID PROGRAM

DEPARTMENT OF HEALTH AND HOSPITALS

BUREAU OF HEALTH SERVICES FINANCING

RFP # 305PUR-DHHRFP-BH-MCO-2014-MVA

Proposal Due Date/Time:

Release Date:

Table of Contents

1.0 General Information 1
1.1. Background 1
1.2. Purpose of RFP 1
1.3. Invitation to Propose 2
1.4. RFP Coordinator 3
1.5. Communications 3
1.6. Proposer Comments 3
1.7. Letter of Intent to Propose 4
1.8. Pre-Proposal Conference 5
1.9. Schedule of Events 5
1.10. RFP Addenda 6
2.0 SCOPE OF WORK 7
2.1. Requirements for MCO 7
2.2. MCO Project Overview 7
2.3. General MCO Requirements 8
2.4. Moral and Religious Objections 11
2.5. Insurance Requirements 11
2.6. Bond Requirements 14
3.0 Medicaid Eligibility 16
3.1 Eligibility Determinations 16
3.2 Duration of Medicaid Eligibility 16
3.3 Eligibility in Bayou Health 16
3.4 Mandatory MCO Populations – All Covered Services 17
3.5 Voluntary Opt-In Populations 20
3.6 Mandatory MCO Populations – Specialized Behavioral Health and Non-Emergency Ambulance Transportation 21
3.7 Mandatory MCO Populations – Specialized Behavioral Health and NEMT Services 21
3.8 Excluded Populations 21
4.0 STAFF REQUIREMENTS AND SUPPORT SERVICES 23
4.1. General Staffing Requirements 23
4.2 Key Staff Positions 24
4.3 Additional Required Staff 31
4.4 In-State Staff Positions 34
4.5 Written Policies, Procedures, and Job Descriptions 35
4.6 Staff Training and Meeting Attendance 35
5.0 MCO REIMBURSEMENT 38

5.1. Capitated Payments 3838
5.2. Maternity Kick Payments 3838
5.3. MCO Payment Schedule 3838
5.4. Withhold of Capitated Payment 3838
5.5. Payment Adjustments 4242
5.6. Risk Sharing 4343
5.7. Determination of MCO Rates 4343
5.8. Risk Adjustment 4444
5.9. Medical Loss Ratio 4545
5.10. Return of Funds 4646
5.11. Other Payment Terms 4646
5.12. Cost Sharing 4646
5.13. Third Party Liability (TPL) 4747
5.14. Coordination of Benefits 5454
5.15. Financial Disclosures for Pharmacy Services 5454
5.16. Health Insurance Provider Fee (HIPF) Reimbursement 5555
5.17. Responsibility for Payment for Specialized Behavioral Health Services Provided to Coordinated System of Care (CSoC) Recipients 5656
6.0 CORE BENEFITS AND SERVICES 5858
6.1. General Provisions 5858
6.2. Eye Care and Vision Services 6262
6.3. Pharmacy Services 6262
6.4. Behavioral Health Services 7070
6.5. Laboratory and Radiological Services 7575
6.6. EPSDT Well Child Visits 7575
6.7. Immunizations 7777
6.8. Emergency Medical Services and Post Stabilization Services 7777
6.9. Emergency Ancillary Services Provided at the Hospital 7979
6.10. Sexually Transmitted Infection (STI) Prevention 7979
6.11. Prenatal Care Services 8080
6.12. Maternity Services 8181
6.13. Perinatal Services 8181
6.14. Family Planning Services 8181
6.15. Hysterectomies 8383
6.16. Sterilization 8383
6.17. Limitations on Abortions 8484
6.18. Institutional Long-Term Care Facilities/Nursing Homes 8585
6.19. Services for Special Populations 8585
6.20. DME, Prosthetics, Orthotics, and Certain Supplies (DMEPOS) 8787

6.21. Women, Infant, and Children (WIC) Program Referral 8787
6.22. Preventative and Safety Educational Programs/Activities 8787
6.23. Medical Transportation Services 8888
6.24. Excluded Services 9090
6.25. Prohibited Services 9191
6.26. Value-Added Benefits and Services 9191
6.27. Cost-Effective Alternative Services 9393
6.28. Care Management 9494
6.29. Referral System for Specialty Healthcare 9595
6.30. Care Coordination, Continuity of Care, and Care Transition 9696
6.31. Referrals for Tobacco Cessation and Problem Gaming 9898
6.32. Continuity of Care for Pregnant Women 9999
6.33. Preconception/Inter-conception Care 9999
6.34. Continuity of Care for Individuals with Special Health Care Needs 9999
6.35. Continuity of Care for Pharmacy Services 100100
6.36. Continuity for Behavioral Health Care 100100
6.37. Continuity for DME, Prosthetics, Orthotics, and Certain Supplies 102102
6.38. Care Transition 103103
6.39. Case Management 104104
6.40. Case Management Policies and Procedures 109109
6.41. Case Management Reporting Requirements 110110
6.42. Chronic Care Management Program (CCMP) 111111
6.43. Predictive Modeling 112112
6.44. CCMP Reporting Requirements 113113
6.45. Services for Co-occurring Behavioral Health and Developmental Disabilities 113113
6.46. Applied Behavior Analysis (ABA) 113113
6.47. Care Management Evaluation 114114
7.0 PROVIDER NETWORK REQUIREMENTS 115115
7.1. General Provider Network Requirements 115115
7.2. Appointment Availability Access Standards 116116
7.3. Geographic Access Requirements 117117
7.4. Provider to Member Ratios 120120
7.5. Monitoring and Reporting on Provider Networks 120120
7.6. Provider Enrollment 120120
7.7. Mainstreaming 124124
7.8. Primary Care 125125
7.9. Network Provider Development Management Plan 135135
7.10. Patient-Centered Medical Home (PCMH) 140140

7.11. Material Change to Provider Network 141141
7.12. Coordination with Other Service Providers 144144
7.13. Provider Subcontract Requirements 144144
7.14. Credentialing and Re-credentialing of Providers and Clinical Staff 147147
7.15. Credentialing Committee 149149
7.16. Provider-Member Communication Anti-Gag Clause 153153
7.17. Pharmacy Network, Access Standards and Reimbursement 154154
7.17. Provider Satisfaction Surveys 159159
7.18. Provider Directory 160160
8.0 UTILIZATION MANAGEMENT 161161
8.1. General Requirements 161161
8.2. Utilization Management Committee 165165
8.3. Utilization Management Reports 167167
8.4. Service Authorization 167167
8.5. Timing of Service Authorization Decisions 170170
8.6. Service Authorization Pharmacy Services 174174
8.7. Step Therapy and/or Fail First Protocols 175175
8.8. Medication Therapy Management 175175
8.9. Lock-In (Restriction) Program 176176
8.10. Pharmacy Administrative Simplification 177177
8.11. Medical History Information 177177
8.12. PCP and Behavioral Health Provider Utilization and Quality Profiling 177177
8.13. PCP and Behavioral Health Provider Utilization & Quality Profile Reporting Requirements 178178
8.14. Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay 178178
9.0 PROVIDER REIMBURSEMENT 179179
9.1. Diagnosis Related Groups 179179
9.2. Minimum Reimbursement to In-Network Providers 179179
9.3. FQHC/RHC Contracting and Reimbursement 179179
9.4. Indian Health Care Providers (IHCPs) 180180
9.5. Reimbursement to Out-of-Network Providers 180180
9.6. Effective Date of Payment for New Members 180180
9.7. Claims Processing Requirements 180180
9.8. Inappropriate Payment Denials 181181
9.9. Payment for Emergency Services and Post-stabilization Services 181181
9.10. Physician Incentive Plans 183183
9.11. Payment for Newborn Care 185185
9.12. Payment for Hospital Services 185185

9.13. Payment for Ambulance Services 185185
9.14. Payment for Physician Services 185185
10.0 PROVIDER SERVICES 186186
10.1. Provider Relations 186186
10.2. Provider Toll-free Telephone Line 186186
10.3. Provider Website 186186
10.4. Provider Handbook 188188
10.5. Provider Education and Training 190190
10.6. Provider Complaint System 191191
11.0 ELIGIBILITY, ENROLLMENT AND DISENROLLMENT 195195
11.1. Maintenance of MCO for Enrollees 195195
11.2. Voluntary Selection of MCO for New Enrollees After February 1, 2015 195195
11.3. Special Enrollment Period for Specialized Behavioral Health Integration 196196
11.4. Automatic Assignment 196196
11.5. MCO Lock-In Period 197197
11.6. Voluntary Opt In Enrollees 197197
11.7. Assistance with Medicaid Eligibility Renewal 198198
11.8. Annual Open Enrollment 198198
11.9. Suspension of and/or Limits on Enrollments 199199
11.10. MCO Enrollment Procedures 199199
11.11. Disenrollment 202202
11.12. Enrollment and Disenrollment Updates 205205
11.13. Daily Updates 205205
11.14. Weekly Reconciliation 205205
12.0 MARKETING AND MEMBER EDUCATION 206206
12.1. General Guidelines 206206
12.2. Marketing and Member Education Plan 207207
12.3. Prohibited Marketing Activities 209209
12.4. Allowable Marketing Activities 211211
12.5. Marketing and Member Materials Approval Process 211211
12.6. Events and Activities Approval Process 212212
12.7. MCO Provider Marketing Guidelines 213213
12.8. MCO Marketing Representative Guidelines 215215
12.9. Written Materials Guidelines 215215
12.10. MCO Website Guidelines 217217
12.11. Member Education – Required Materials and Services 218218
12.12. MCO Member Handbook 222222
12.13. Member Identification (ID) Cards 228228

12.14. Provider Directory for Members 230230
12.15. Member Call Center 231231
12.16. 24-hour Behavioral Health Crisis Line 233233
12.17. ACD System 233233
12.18. Notice to Members of Provider Termination 235235
12.19. Oral Interpretation and Written Translation Services 236236
12.20. Marketing Reporting and Monitoring 236236
12.21. Pharmacy-Related Marketing and Member Education 237237
12.22. Web and Mobile-Based Member Applications 237237
13.0 Member Grievance and Appeals Procedures **239239**
13.1. Applicable Definitions – See Glossary 239239
13.2. General Grievance System Requirements 239239
13.3. Grievance/Appeal Records and Reports 240240
13.4. Handling of Grievances and Appeals 241241
13.5. Notice of Action 243243
13.6. Resolution and Notification 245245
13.7. Expedited Resolution of Appeals 247247
13.8. Continuation of Benefits 248248
13.9. Information to Providers and Contractors 249249
13.10. Recordkeeping and Reporting Requirements 249249
13.11. Effectuation of Reversed Appeal Resolutions 249249
14.0 QUALITY MANAGEMENT **251251**
14.1 Quality Assessment and Performance Improvement Program (QAPI) 251251
14.2 QAPI Committee 253253
14.3 External Independent Review 262262
14.4 Health Plan Accreditation 262262
14.5 Member Advisory Council 263263
14.6 Fidelity to Evidence-Based Practices 263263
14.7 Best Practices in Children's Behavioral Health Residential Treatment 264264
14.8 Adverse Incident Reporting 264264
14.9 Provider Monitoring Plan and Reporting 264264
14.10 Outcome Assessment for Specialized Behavioral Health Services 266266
15.0 FRAUD, ABUSE, AND WASTE PREVENTION **267267**
15.1. General Requirements 267267
15.2. Fraud, Waste, and Abuse Compliance Plan 271271
15.3. Prohibited Affiliations 274274
15.4. Payments to Excluded Providers 276276
15.5. Reporting 276276

15.6. Medical Records 277277
15.7. Rights of Review and Recovery by MCO and DHH 279279
16.0 SYSTEMS AND TECHNICAL REQUIREMENTS 283283
16.1. General Requirements 283283
16.2 HIPAA Standards and Code Sets 285285
16.3 Connectivity 286286
16.4. Resource Availability and Systems Changes 288288
16.5. Systems Refresh Plan 291291
16.6. Other Electronic Data Exchange 291291
16.7. Electronic Messaging 292292
16.8. Eligibility and Enrollment Data Exchange 292292
16.9. Provider Enrollment 292292
16.10. Information Systems Availability 293293
16.11. Contingency Plan 295295
16.12. Off Site Storage and Remote Back-up 296296
16.13. Records Retention 297297
16.14. Information Security and Access Management 297297
17.0 CLAIMS MANAGEMENT 300300
17.1 Functionality 300300
17.2 Claims Processing 301301
17.3 Payment to Providers 304304
17.4 Remittance Advices 305305
17.5 Sampling of Paid Claims 305305
17.6 Claims Dispute Management 306306
17.7 Claims Payment Accuracy Report 307307
17.8 Encounter Data 308308
17.9 Claims Summary Report 311311
17.10 Pharmacy Claims Processing 311311
17.11 Audit Requirements 314314
18.0 REPORTING 318317
18.1 Ownership Disclosure 318317
18.2 Information Related to Business Transactions 318317
18.3 Report of Transactions with Parties in Interest 319318
18.4 Key Staff Reporting 319318
18.5 Encounter Data 320319
18.6 Financial Reporting 320319
18.7 Information on Persons Convicted of Crimes 320319
18.8 Errors 321320

18.9 Submission Timeframes 321320
18.10 Recurring Reports 322321
18.11 *Ad Hoc* Reports 322321
18.12 Pharmacy Reporting 322321
18.13 PASRR Reporting 322321
18.14 Court-Ordered Reporting 322321
18.15 Substance Abuse and Mental Health Block Grant Data Collection Requirements 323322
18.16 Report Submission 323322
18.17 Health Information System Requirements 323322
18.18 Transparency Report 323322
19.0 CONTRACT MONITORING 325324
19.1. Contract Personnel 325324
19.2. Notices 325324
19.3. Notification of MCO Policies and Procedures 326325
19.4. Required Submissions 326325
19.5. Readiness Review Prior to Operations Start Date 326325
19.6. Ongoing Contract Monitoring 327326
19.7. MCO On-Site Reviews 328327
20.0 CONTRACT NON-COMPLIANCE 330329
20.1. Administrative Actions 330329
20.2. Corrective Action Plans (CAP) 330329
20.3. Monetary Penalties 330329
20.4. Employment of Key and Licensed Personnel 339338
20.5. Excessive Reversals on Appeal 339338
20.6. Marketing and Member Education Violations 340339
20.7. Remedial Action(s) for Marketing Violations 341340
20.8. Cost Avoidance Requirements 342341
20.9. Failure to Provide Core Benefits and Services 342341
20.10. Failure to Maintain an Adequate Network of Contract Providers 342341
20.11. Failure to Have Subject Appropriate Staff Member(s) Attend Onsite Meeting 342341
21.0 INTERMEDIATE SANCTIONS 344343
21.1 Acts or Failures to Act Subject to Intermediate Sanctions 344343
21.2. Other Misconduct Subject to Intermediate Sanctions 344343
21.3. Sanction Types 345344
21.4. Notice to CMS 346345
21.5. Payment of Monetary Penalties and Sanctions 346345
21.6. Termination of MCO Contract 346345

21.7. Payment of Outstanding Monies or Collections from MCO 347346
21.8. Provider Sanctions 347346
21.9. Independent Assurances 347346
22.0 PROPOSAL AND EVALUATION 349348
22.1. General Information 349348
22.2. Blackout Period 349348
22.3. Rejection and Cancellation 350349
22.4. Code of Ethics 350349
22.5. Award Without Discussion 350349
22.6. Assignments 350349
22.7. Proposer Prohibition 350349
22.8. Determination of Responsibility 350349
22.9. Proposal and Contract Preparation Costs 351350
22.10. Ownership of Proposal 351350
22.11. Procurement Library/Resources Available To Proposer 351350
22.12. Proposal Submission 352351
22.13. Proprietary and/or Confidential Information 353352
22.14. Errors and Omissions 354353
22.15. Proposal Clarifications 354353
22.16. Interpretive Conventions 354353
22.17. Proposal Content 354353
22.18. Proposal Format 355354
22.19. Evaluation Criteria 355354
22.20 Administrative and Mandatory Screening 356355
22.21 Withdrawal of Proposal 356355
23.0 EVALUATION CATEGORIES AND MAXIMUM POINTS 357356
23.1 Announcement of Awards 357356
23.2 Notice of Contract Awards 357356
24.0 TURNOVER REQUIREMENTS 359358
24.1 Introduction 359358
24.2 General Turnover Requirements 359358
24.3. Turnover Plan 359358
24.4. Transfer of Data 360359
24.5. Post-Turnover Services 360359
24.6. Transition to Managed Long-Term Supports and Services 360359
25.0 TERMS AND CONDITIONS 362361
25.1 Amendments 362361
25.2 Applicable Laws and Regulations 363362

25.3 Assessment of Fees ..... 364~~363~~
25.4 Attorney's Fees ..... 365~~364~~
25.5 Board Resolution/Signature Authority ..... 365~~364~~
25.6 Confidentiality of Information ..... 365~~364~~
25.7 Conflict of Interest ..... 366~~365~~
25.8 Contract Controversies ..... 366~~365~~
25.9 Contract Language Interpretation ..... 366~~365~~
25.10 Cooperation with Other Contractors ..... 366~~365~~
25.11 Copyrights ..... 366~~365~~
25.12 Corporation Requirements ..... 366~~365~~
25.13 Debarment/Suspension/Exclusion ..... 367~~366~~
25.14 Effect of Termination on MCO's HIPAA Privacy Requirements ..... 367~~366~~
25.15 Emergency Management Plan ..... 368~~367~~
25.16 Employee Education about False Claims Recovery ..... 368~~367~~
25.17 Employment of Personnel ..... 368~~367~~
25.18 Entire Contract ..... 369~~368~~
25.19 Force Majeure ..... 369~~368~~
25.20 Fraudulent Activity ..... 369~~368~~
25.21 Governing Law and Place of Suit ..... 370~~369~~
25.22 HIPAA Business Associate ..... 370~~369~~
25.23 Confidentiality Compliance ..... 370~~369~~
25.24 Hold Harmless ..... 372~~371~~
25.25 Hold Harmless as to the MCO Members ..... 373~~372~~
25.26 Homeland Security Considerations ..... 373~~372~~
25.27 Incorporation of Schedules/Appendices ..... 374~~373~~
25.28 Independent Provider ..... 374~~373~~
25.29 Integration ..... 374~~373~~
25.30 Interest ..... 374~~373~~
25.31 Interpretation Dispute Resolution Procedure ..... 374~~373~~
25.32 Loss of Federal Financial Participation (FFP) ..... 375~~374~~
25.33 Misuse of Symbols, Emblems, or Names in Reference to Medicaid ..... 375~~374~~
25.34 National Provider Identifier (NPI) ..... 375~~374~~
25.35 Non-Discrimination ..... 375~~374~~
25.36 Non-Waiver of Breach ..... 376~~375~~
25.37 Offer of Gratuities ..... 376~~375~~
25.38 Order of Precedence ..... 376~~375~~
25.39 Physician Incentive Plans ..... 376~~375~~
25.40 Political Activity ..... 376~~375~~

25.41 Prohibited Payments ..... 377~~376~~
25.42 Rate Adjustments ..... 377~~376~~
25.43 Record Retention for Awards to Recipients ..... 377~~376~~
25.44 References to Statutes, Rules, or Regulations ..... 378~~377~~
25.45 Release of Records ..... 378~~377~~
25.46 Reporting Changes ..... 378~~377~~
25.47 Right to Audit ..... 378~~377~~
25.48 Safeguarding Information ..... 378~~377~~
25.49 Safety Precautions ..... 379~~378~~
25.50 Severability ..... 379~~378~~
25.51 Software Reporting Requirement ..... 379~~378~~
25.52 Termination for Convenience ..... 379~~378~~
25.53 Termination Due to Serious Threat to Health of Members ..... 379~~378~~
25.54 Termination for MCO Insolvency, Bankruptcy, Instability of Funds ..... 380~~379~~
25.55 Termination for Ownership Violations ..... 380~~379~~
25.56 Termination for Unavailability of Funds ..... 380~~379~~
25.57 Time is of the Essence ..... 381~~380~~
25.58 Titles ..... 381~~380~~
25.59 Use of Data ..... 381~~380~~
25.60 Waiver of Administrative Informalities ..... 381~~380~~
25.61 Waiver ..... 381~~380~~
25.62 Warranty to Comply with State and Federal Regulations ..... 381~~380~~
25.63 Warranty of Removal of Conflict of Interest ..... 381~~380~~
25.64 Withholding in Last Month of Payment ..... 381~~380~~
25.65 Termination for Failure to Accept Revised Monthly Capitation Rate ..... 382~~381~~
GLOSSARY ..... 383~~382~~
ACRONYMS ..... 417~~416~~
LIST OF APPENDICES TO RFP ..... 424~~423~~
LIST OF MCO COMPANION GUIDES ..... 426~~425~~

1.0 GENERAL INFORMATION

1.1. Background

1.1.1. The mission of the Department of Health and Hospitals (DHH) is to develop and provide health and medical services for the prevention of disease for the citizens of Louisiana, particularly those individuals who are indigent and uninsured, persons with mental illness, persons with developmental disabilities and those with addictive disorders.

1.1.2. DHH is comprised of the Bureau of Health Services Financing (BHSF) which is the single state Medicaid agency, the 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.

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

1.1.4. BHSF consists of the following Sections: Director's Office, Medicaid Managed Care, Medicaid Benefits & Services, Medicaid Quality Management Statistics and Reporting, Medicaid Management Information Systems (MMIS), Medical Vendor Administration Budget and Contracts, Medical Vendor Payments Budget and Managed Care Finance, Medicaid Health Economics, Medicaid Program Support and Waivers, Medicaid Policy and Compliance, Eligibility Field Operations, Medicaid Member Support, Eligibility Systems Section, Eligibility Supports Section, Recovery and Premium Assistance, and Rate Setting and Audit. The Medicaid Managed Care Section has primary responsibility for implementation, ongoing operations and oversight of Medicaid managed care delivery systems including the delivery system for acute care hereafter referred to as the Bayou Health program.

1.2. Purpose of RFP

1.2.1. The purpose of this Request for Proposals (RFP) is to solicit proposals from qualified Managed Care Organizations (MCOs) to provide healthcare services statewide to Medicaid enrollees participating in the Bayou Health program, utilizing the most cost effective manner and in accordance with the terms and conditions set forth herein.

Through this RFP, DHH will solicit proposals from entities to serve as a Bayou Health MCO, hereafter referred to as "MCO."

1.2.2. DHH anticipates that the Bayou Health Program will achieve the following outcomes:

- Improved coordination of care;
- A patient-centered medical home for Medicaid recipients;

- Better health outcomes;
- Increased quality of care as measured by metrics such as HEDIS;
- Greater emphasis on disease prevention and management of chronic conditions;
- Earlier diagnosis and treatment of acute and chronic illness;
- Improved access to essential specialty services;
- Outreach and education to promote healthy behaviors;
- Increased personal responsibility and self-management;
- A reduction in the rate of avoidable hospital stays and readmissions;
- A decrease in fraud, abuse, and wasteful spending;
- Greater accountability for the dollars spent;
- A more financially sustainable system; and
- Cost savings to the state compared to a fee-for-service Medicaid delivery system.

1.2.3. This RFP solicits proposals, details proposal requirements, defines DHH's minimum service requirements, and outlines the state's process for evaluating proposals and selecting Bayou Health MCOs.

1.2.4. Through this RFP, DHH seeks to contract for the needed services and to give ALL qualified businesses, including those that are owned by minorities, women, persons with disabilities, and small business enterprises, opportunity to do business with the state through either direct ownership of an MCO or by providing services to selected MCOs.

1.2.5. This RFP process is being used so that DHH may selectively contract with at least three (3) and up to five (5) MCO entities but no more than required to meet Medicaid enrollment capacity requirements and assure choice for Medicaid recipients as required by federal statute. Notwithstanding the above, all parties agree that the final number of contracts awarded is within the sole discretion of the Secretary.

1.2.6. A contract is necessary to provide DHH with the ability to ensure accountability while improving access, coordinated care and promoting healthier outcomes.

1.2.7. State authority for the Bayou Health Program is contained in L.R.S. 36:254 which provides the Secretary of DHH with the authority to implement coordinated care requirements of Act 11 of the 2010 Regular Session of the Louisiana Legislature.

1.2.8. Current Federal Authority for the Bayou Health program is contained in Section 1932(a)(1)(A) of the Social Security Act and 42 CFR Part 438. DHH operates its Bayou Health program under the authority of a State Plan Amendment. The Department may pursue a change in federal authority for the Bayou Health Program to 1915(b) of the Social Security Act.

1.3. Invitation to Propose

DHH is inviting qualified proposers to submit proposals to provide specified health care services statewide for Medicaid recipients enrolled in the Bayou Health program in return for a monthly capitation payment made in accordance with the specifications and conditions set forth herein.

1.4. RFP Coordinator

1.4.1. 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
P.O. Box 1526
Baton Rouge, LA 70821-1526
(225) 342-5266
Mary.Fuentes@la.gov

1.4.2. This RFP is available at the following web links:

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

http://www.makingmedicaidbetter.com; and

http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/dspBid.cfm?search=department&term=4 (official site)

1.5. Communications

All communications relating to this RFP must be directed to the DHH RFP contact person named above. Proposers agree that they shall not rely on any other communications. 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.

1.6. Proposer Comments

1.6.1. Each Proposer should carefully review this RFP, including but not limited to the *pro forma* contract (Appendix B), and all Department issued Companion Guides for comments, questions, defects, objections, or any other matter requiring clarification or correction (collectively called “comments”).

1.6.2. Proposers must notify DHH of any ambiguity, conflict, discrepancy, exclusionary specification, omission or other error in the RFP by the deadline for submitting questions and comments. If a proposer fails to notify DHH of these issues, it will submit a proposal at its own risk, and:

1.6.2.1. Has waived any claim of error or ambiguity in the RFP or resulting Contract;

1.6.2.2. Cannot contest DHH’s interpretation of such provision(s); and

1.6.2.3. Will not be entitled to additional compensation, relief or time by reason of the ambiguity, error, or its later correction.

1.6.3. Comments and questions must be made in writing and received by the RFP Coordinator no later than the Deadline for Receipt of Written Questions detailed in the Schedule of Events. This will allow issuance of any necessary addenda. DHH reserves the right to amend answers prior to the proposal submission deadline.

1.6.4. The Proposer shall provide an electronic copy of the comments in an MS Word table in the format specified below:

Submitter Name	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question

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 links:

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

http://www.makingmedicaidbetter.com; and

http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/dspBid.cfm?search=department&term=4 (official site)

1.6.5. DHH reserves the right to determine, at its sole discretion, the appropriate and adequate responses to written comments, questions, and requests for clarification. DHH's official responses and other official communications pursuant to this RFP shall constitute an addendum to this RFP.

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

1.7. Letter of Intent to Propose

1.7.1. Each potential proposer should submit a Letter of Intent to Propose to the RFP Coordinator by the deadline detailed in the RFP Schedule of Events. The notice should include:

- Company name
- Name and title of a contact person
- Mailing address, email address, telephone number, and facsimile number of the contact person

NOTICE: A Letter of Intent to Propose creates no obligation and is not a prerequisite for making a proposal.

1.7.2. Copies of Notices of Intent to Propose received by DHH will be posted upon receipt at the web links listed above.

1.8. Pre-Proposal Conference

1.8.1. A pre-proposal conference will be held on the date and time listed on the Schedule of Events. While attendance is not mandatory, prospective proposers are encouraged to participate in the conference to obtain clarification of the requirements of the RFP and to receive answers to relevant questions. Attendees are encouraged to bring a copy of the RFP as it will be frequently referenced during the conference.

1.8.2. Although impromptu questions will be permitted and spontaneous answers will be provided during the conference, the only official answer or position of DHH will be stated in writing in response to written questions. Therefore, proposers should submit all questions in writing (even if an answer has already been given to an oral question). After the conference, questions will be researched and the official response will be posted on the Internet at the following links:

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

http://www.makingmedicaidbetter.com; and

http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/dspBid.cfm?search=department&term=4 (official site)

Neither formal minutes of the conference nor written records of questions/communications will be maintained.

Attendees are strongly encouraged to advise the RFP Coordinator within five (5) calendar days of the scheduled pre-proposal conference of any special accommodations needed for persons with disabilities who will be attending the conference and/or meeting so that these accommodations can be made.

1.9. Schedule of Events

DHH reserves the right to deviate from the Schedule of Events.

SCHEDULE OF EVENTS	TENTATIVE DATE
Public Notice of RFP	July 28, 2014
Proposal Conference	July 31, 2014 9 AM to Noon CT Room 118 Bienville Building 628 North 4th Street Baton Rouge, LA 70802
Systems and Technical Conference	July 31, 2014 1 PM to 4 PM CT Room 118, Bienville Building 628 North 4th St Baton Rouge, LA 70802

Deadline for Receipt of Written Questions	August 4, 2014 11 PM CT
Deadline for Receipt of Letter of Intent to Propose	August 8, 2014 4:00 PM CT
DHH Responses to Written Questions	August 18, 2014 11:00 PM CT
Deadline for Receipt of Follow-Up Written Questions	August 25, 2014 4:00 PM CT
DHH Responses to Follow-Up Written Questions	September 2, 2014
Deadline for Receipt of Written Questions Related to Rate Certification Only	September 8, 2014 4:00 PM CT
DHH Responses to Written Questions Related to Rate Certification Only	September 15, 2014 11:00 PM CT
Deadline for Receipt of Written Proposals	September 26, 2014 4:00 PM CT
Proposal Evaluation Begins	October 1, 2014
Contract Award Announced	October 243, 2014
Contract Begin Date	February 1, 2015

1.10. RFP Addenda

In the event it becomes necessary to revise any portion of the RFP for any reason, DHH shall post addenda, supplements, and/or amendments to the following web addresses:

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

http://www.makingmedicaidbetter.com; and

http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/dspBid.cfm?search=department&term=4 (official site)

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

INTENTIONALLY LEFT BLANK

2.0 SCOPE OF WORK

2.1. Requirements for MCO

2.1.1. In order to participate as an MCO, an entity must:

2.1.1.1. Meet the federal definition of a Medicaid Managed Care Organization as defined in Section 1903 (m) of the Social Security Act and 42 CFR §438.2;

2.1.1.2. Possess a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as a Medicaid risk bearing entity pursuant to La. R.S. 22:1016 at the time the proposal is submitted;

2.1.1.3. Be certified by the Louisiana Secretary of State, pursuant to La. R.S. 12:24, to conduct business in the state;

2.1.1.4. Meet solvency standards as specified in federal regulations and Title 22 of the Louisiana Revised Statutes;

2.1.1.5. Except for licensure and financial solvency requirements, no other provisions of Title 22 of the Louisiana Revised Statutes shall apply to an MCO participating in the Louisiana Medicaid Program. Neither the HIPAA assessment nor the Fraud Assessment levied by the Department of Insurance shall be payable by a Medicaid MCO;

2.1.1.6. Meet NCQA Health Plan Accreditation or agree to submit an application for accreditation at the earliest possible date allowed by NCQA and once achieved, maintain accreditation through the life of this Contract;

2.1.1.7. Have a network capacity to enroll a minimum of 250,000 Medicaid members;

2.1.1.8. Not have an actual or perceived conflict of interest that, in the discretion of DHH, would interfere or give the appearance of possibly interfering with its duties and obligations under this Contract or any other contract with DHH, and any and all appropriate DHH written policies. Determinations of a Conflict of Interest are at the sole discretion of DHH. Conflict of interest shall include, but is not limited to, being the Louisiana Medicaid fiscal intermediary contractor;

2.1.1.9. Be a successful proposer, be awarded a contract with DHH, and successfully complete the Readiness Review prior to the start date of operations;

2.1.1.10. Be willing and able to provide core benefits and services to all assigned members, whether chosen or auto-assigned, on the contract start date.

2.2. MCO Project Overview

2.2.1. The Bayou Health program is a full risk-bearing, Managed Care Organization (MCO) health care delivery system responsible for providing specified Medicaid core benefits and services included in the Louisiana Medicaid State Plan to Medicaid recipients.

2.2.2. An MCO assumes full risk for the cost of core benefits and services under the Contract and incurs loss if the cost of furnishing these core benefits and services exceeds the payment received for providing these services.

2.2.3. DHH shall establish a Per Member Per Month (PMPM) actuarially sound risk-adjusted rate to be paid to the MCO. The rates shall not be subject to negotiation or dispute resolution. The rate is intended to cover all benefits and management services outlined in this RFP.

2.2.4. Management services include but are not limited to:

2.2.4.1. Utilization Management

2.2.4.2. Quality Management and Compliance

2.2.4.3. Prior Authorization

2.2.4.4. Provider Monitoring

2.2.4.5. Member and Provider Services

2.2.4.6. PCP Primary Care Management

2.2.4.7. Fraud and Abuse Monitoring and Compliance

2.2.4.8. Case Management

2.2.4.9. Chronic Care Management

2.2.4.10. Account Management

2.2.4.11. Management of Specialized Behavioral Health Services

2.2.4.12. Integration of Physical and Behavioral Health Services

2.3. General MCO Requirements

2.3.1. As required in 42 CFR §455.104(a), the MCO shall provide DHH with full and complete information on the identity of each person or corporation with an ownership interest of five percent or greater (5%+) in the MCO, or any subcontractor in which the MCO has five percent or greater (5%+) ownership interest. This information shall be provided to DHH on the approved Disclosure Form submitted to DHH with the proposal, annually thereafter, and whenever changes in ownership occur. DHH will review all ownership and control disclosures submitted by the MCO and the MCO's subcontractors.

2.3.2. The MCO 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 MCO.

2.3.3. The MCO's administrative office shall maintain, at a minimum, business hours of 8:00 a.m. to 5:00 p.m. Central Time Monday through Friday, excluding recognized Louisiana state holidays and be operational on all DHH regularly scheduled business days. A listing of state holidays may be found at: http://www.doa.louisiana.gov/osp/aboutus/holidays.htm

2.3.4. The MCO shall maintain appropriate personnel to respond to administrative inquiries from DHH on business days. The MCO must respond to calls within one (1) business day.

2.3.5. The MCO 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 risk-based managed care plans are specified in Section 1903(m) of the Social Security Act and 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 pursuant to Section 23 of this RFP.

2.3.6. The MCO must maintain policy and procedures concerning advance directives with respect to all adult individuals receiving medical services by or through the MCO in accordance with 42 CFR §489.100 and 42 CFR §438.36~~(ii)(1)~~. The written information provided by the MCO must reflect any changes in Louisiana law as soon as possible, but no later than ninety (90) days after the effective date of the change. The MCO shall not condition the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive.

2.3.7. The Louisiana Department of Insurance (DOI) regulates risk-bearing entities providing Louisiana Medicaid services as to their solvency. Therefore, the MCO must comply with all DOI standards applicable to solvency.

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

2.3.9. Mental Health Parity

2.3.9.1. The MCO shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR 146 and 147), which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.

2.3.9.2. The MCO shall develop and maintain internal controls to ensure mental health parity. The health plan's prior authorization policy, procedures, and practices shall comply with The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 and 45 CFR Parts 146 and 147.

2.3.9.3. The MCO shall require that all providers and all subcontractors take such actions as are necessary to permit the MCO to comply with mental health parity requirements listed in this contract. To the extent that the MCO

delegates oversight responsibilities to a third party, the MCO shall require that such third party complies with provisions of this contract relating to mental health parity. The MCO agrees to require, via contract, that such providers comply with regulations and any enforcement actions, including but not limited to termination and restitution. The MCO shall require mental health parity disclosure on provider enrollment forms as mandated by DHH.

2.3.9.4. The MCO shall provide DHH and its designees, which may include auditors and inspectors, with access to MCO service locations, facilities, or installations, including any and all records and files produced, electronic and hardcopy. Access described in this section shall be for the purpose of examining, auditing, or investigating mental health parity.

2.3.9.5. The MCO shall comply with all other applicable state and federal laws and regulations relating to mental health parity and DHH established policies and procedures.

2.3.10. Physical and Specialized Behavioral Health Integration Requirements
To achieve true integration between physical and behavioral health care for members, the following requirements must be met:

2.3.10.1. The MCO must use an integration assessment tool to self-assess annually. The assessment should be inclusive of, but not limited to, such factors as provider locations, integrated or collocated provider numbers, programs focusing on members with both behavioral health and primary care needs, use of multiple treatment plans, and unified systems across behavioral and physical health management. This assessment must be approved by DHH and results reported annually to DHH.

2.3.10.2. Each MCO shall work with DHH to develop a plan for the MCOs to conduct annual assessments of practice integration using the publicly available Integrated Practice Assessment Tool (IPAT) on a statistically valid sampling of providers to include but not be limited to behavioral health providers and primary care providers: internists, family practitioners, pediatrics, OB-GYNs and any other providers that are likely to interface with BH populations. The MCO lead workgroup will identify opportunities to coordinate this effort across MCOs to ensure comparability of results across MCOs and minimize burden on providers. The results of the initial survey must be reported to DHH on or before 11/31/16 and annually thereafter.

2.3.10.3. The MCO shall provide trainings on integrated care including but not limited to the appropriate utilization of basic behavioral health screenings in the primary care setting and basic physical health screenings in the behavioral health setting.

2.3.10.4. The MCO shall identify available opportunities to provide incentives to clinics to employ Licensed Mental Health Professionals (LMHP) in primary care settings and to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.

2.3.10.5. The MCO shall encourage and endorse real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications.

2.3.10.6. The MCO shall have integrated data, quality and claims systems.

2.3.10.7. The MCO shall have a single or integrated clinical documentation system in order to see the whole health of the member.

2.3.10.8. The MCO shall identify "hot spot" sources of high emergency department (ED) referrals and/or inpatient psychiatric hospitalization and provide preemptive care coordination.

2.4. Moral and Religious Objections

2.4.1. If an MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the MCO must furnish information about the core benefits and services that it does not cover, in accordance with §1932(b)(3)(B)(ii) of the Social Security Act and 42 CFR §438.102(b)(1), by notifying:

2.4.1.1. DHH with its proposal, or whenever it adopts the policy during the term of the Contract;

2.4.1.2. Potential enrollees before and during enrollment in the MCO;

2.4.1.3. Enrollees at least thirty (30) ~~within ninety (90)~~ days prior to the effective date of ~~after adopting~~ the policy with respect to any particular service; and

2.4.1.4. Members through the inclusion of the information in the Member's Manual.

2.4.2. If an MCO elects not to provide, reimburse for, or provide coverage of a core benefit or service described in Section 6 of this RFP because of an objection on moral or religious grounds, the monthly capitation payment for that MCO will be adjusted accordingly.

2.4.3. Each proposal must include either:

2.4.3.1. A statement of attestation that the Proposer has no moral or religious objections to providing any core benefits and services described in Section 6 of this RFP; **or**

2.4.3.2. A statement of any moral and religious objections to providing any core benefits and services described in Section 6 of this RFP. The statement must describe, in as much detail as possible, all direct and related services that are objectionable. It must include a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc., and if there are none, it must so state.

2.5. Insurance Requirements

2.5.1. General Insurance Information

2.5.1.1. The MCO shall not commence work under this contract until it has obtained all insurance required herein. Certificates of Insurance, fully executed by officers of the insurance company shall be filed with DHH for approval. The MCO shall be named as the insured on the policy.

2.5.1.2. The MCO shall not allow any subcontractor to commence work on a subcontract until all similar insurance required for the subcontractor has been obtained and approved.

2.5.1.3. If so requested, the MCO shall also submit copies of insurance policies for inspection and approval by DHH before work is commenced.

2.5.1.4. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days' notice in advance to DHH and consented to by DHH in writing and the policies shall so provide.

2.5.2. Workers' Compensation Insurance

2.5.2.1. The MCO shall obtain and maintain during the life of the Contract, Workers' Compensation Insurance for all of the MCO's employees that provide services under the Contract with a minimum limit of $500,000 per accident/per disease/per employee.

2.5.2.2. The MCO shall require that any subcontractor and/or contract providers obtain all similar insurance prior to commencing work.

2.5.2.3. The MCO shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to DHH during the Readiness Review and annually thereafter or upon change in coverage and/or carrier.

2.5.2.4. DHH shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the MCO, subcontractor and/or provider obtaining such insurance.

2.5.2.5. Failure to provide proof of adequate coverage before work is commenced may result in this Contract being terminated.

2.5.3. Commercial Liability Insurance

2.5.3.1. The MCO shall maintain, during the life of the Contract, Commercial General Liability Insurance to protect the MCO, DHH, 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 from claims for property damages, which may arise from operations under the contract, whether such operations be by the MCO 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 DHH.

2.5.3.2. Such insurance shall name DHH as additional insured for claims arising from or as the result of the operations of the MCO or its subcontractors.

2.5.3.3. 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 a minimum limit per occurrence of $1,000,000 and a minimum general aggregate of $2,000,000.

2.5.4. Reinsurance

2.5.4.1. The MCO shall hold a certificate of authority from the Department of Insurance and file with DHH all contracts of reinsurance, or a summary of the plan of self-insurance.

2.5.4.2. All reinsurance agreements or summaries of plans of self-insurance shall be filed with the reinsurance agreements and shall remain in full force and effect for at least thirty (30) calendar days following written notice by registered mail of cancellation by either party to DHH or designee.

2.5.4.3. The MCO shall maintain reinsurance agreements throughout the Contract period, including any extensions(s) or renewal(s). The MCO shall provide prior notification to DHH of its intent to purchase or modify reinsurance protection for certain members enrolled under the MCO.

2.5.4.4. The MCO shall provide to DHH the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance arrangements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related party relationship shall be specifically disclosed.

2.5.5. Errors and Omissions Insurance

2.5.5.1. The MCO shall obtain, pay for, and keep in force for the duration of the Contract period, Errors and Omissions insurance in the amount of at least one million dollars ($1,000,000), per occurrence.

2.5.5.2. Insurance shall be placed with insurers with an A.M. Best's rating of no less than A-:VI. This rating requirement may be waived for Worker's Compensation coverage only.

2.5.6. Licensed and Non-Licensed Motor Vehicles

The MCO shall maintain during the life of the contract, Automobile Liability Insurance in an amount not less than combined single limits of one million dollars ($1,000,000) per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the contract on the site of the work to be performed there under, unless such coverage is included in insurance elsewhere specified. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.

2.5.7. Subcontractor's Insurance

The MCO shall require that any and all subcontractors, which are not protected under the MCO's own insurance policies, take and maintain insurance of the same nature and in the same amounts as required of the MCO.

2.6. Bond Requirements

2.6.1. Performance Bond

2.6.1.1. The MCO shall be required to establish and maintain a performance bond for as long as the MCO has Contract-related liabilities of fifty thousand dollars ($50,000) or more outstanding, or fifteen (15) months following the termination date of this contract, whichever is later, to guarantee: (1) payment of the Contractor's obligations to DHH and (2) performance by the MCO of its obligations under this contract (42 CFR §438.116).

2.6.1.2. The bond must be obtained from an agent appearing on the United States Department of Treasury's list of approved sureties. The bond must be made payable to the state of Louisiana. The contract and dates of performance must be specified in the bond.

2.6.1.3. The initial amount of the bond shall be equal to fifty (50) million dollars. The initial bond must be submitted to DHH within 10 days of contract approval by the Office of Contractual Review.

2.6.1.4. The bond amount shall be reevaluated and adjusted following the annual open enrollment process, which includes the period during which members can change MCOs without cause. The adjusted amount shall be equal to fifty percent (50%) of the total capitation payment, exclusive of maternity kick payments, paid to the Contractor for the month following the end of the process. The adjusted bond must be submitted to DHH within 60 days of notification to the MCO of the adjusted amount.

2.6.1.5. All bonds submitted to DHH must be original and have the raised engraved seal on the bond and on the Power of Attorney page. The MCO must retain a photocopy of the bond.

2.6.1.6. Any performance bond furnished shall be written by a surety or insurance company currently on the U.S. Department of the Treasury Financial Management Service list of approved bonding companies which is published annually in the Federal Register, or by a Louisiana domiciled insurance company with at least an A-rating in the latest printing of the A.M. Best's Key Rating Guide to write individual bonds up to ten (10) percent of policyholders' surplus as shown in the A.M. Best's Key Rating Guide or by an insurance company that is either domiciled in Louisiana or owned by Louisiana residents and is licensed to write surety bonds. No surety or insurance company shall write a performance bond which is in excess of the amount indicated as approved by the U.S. Department of the Treasury Financial Management Service list or by a Louisiana domiciled insurance company with an A-rating by A.M. Best up to a limit of 10 percent of policyholders' surplus as shown by A.M. Best; companies authorized by this Paragraph who are not on the treasury list shall not write a performance bond when the penalty exceeds fifteen (15) percent of its capital and surplus, such capital and surplus being the amount by which the company's assets exceed its liabilities as reflected by the most recent financial statements filed by the company with the Department of Insurance. In addition, any performance bond furnished shall be written by a surety or insurance company that is currently licensed to do business in the state of Louisiana.

2.6.2. Fidelity Bond

2.6.2.1. The MCO shall secure and maintain during the life of the Contract a blanket fidelity bond on all personnel in its employment.

2.6.2.2. The bond shall include but not be limited to coverage for losses sustained through any fraudulent or dishonest act or acts committed by any employees of the MCO and its subcontractors.

INTENTIONALLY LEFT BLANK

3.0 Medicaid Eligibility

3.1 Eligibility Determinations

3.1.1 DHH determines eligibility for Medicaid and Children's Health Insurance Program (CHIP) for all coverage groups with the exception of Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF) (which is known in Louisiana as the Family Independence Temporary Assistance Program (FITAP)) and Foster Care/Children in out of home placement.

3.1.2 The Social Security Administration (SSA) determines eligibility for SSI and the Louisiana Department of Children and Family Services (DCFS) determines eligibility for TANF/FITAP and Foster Care.

3.1.3 Once an applicant is determined eligible for Medicaid or CHIP by DHH, SSA or DCFS, the pertinent eligibility information is entered in the Medicaid Eligibility Determination System (MEDS).

3.2 Duration of Medicaid Eligibility

3.2.1 Children under age 19 enrolled in Medicaid or CHIP receive twelve (12) months continuous eligibility, regardless of changes in income or household size.

3.2.2 Individuals who attain Medicaid eligibility as a pregnant woman are guaranteed eligibility for comprehensive services through the second calendar month following the end of the pregnancy.

3.2.3 Renewals of Medicaid and CHIP eligibility are conducted annually and do not require a face-to-face interview or signed application as DHH may conduct *ex parte* renewals, Express Lane Eligibility (ELE) renewals for children under age 19 receiving Supplemental Nutrition Assistance Program (SNAP) benefits, and telephone renewals.

3.3 Eligibility in Bayou Health

3.3.1 Eligibility for enrollment in the Louisiana Medicaid Bayou Health Program is limited to individuals who are determined eligible for Louisiana Medicaid and Louisiana CHIP Programs and who belong to mandatory or voluntary MCO populations as described below.

3.3.2 Populations covered under Bayou Health include:

3.3.2.1 Mandatory MCO Populations – All Covered Services (Section 3.4)

3.3.2.2 Mandatory MCO Populations – Specialized Behavioral Health and Non-Emergency Ambulance Transportation (Section 3.6)

3.3.2.3 Mandatory MCO Populations – Specialized Behavioral Health and Non-Emergency Transportation (Section 3.7)

3.3.2.4 Voluntary Opt-In Populations (Section 3.5)

3.3.3 Within Bayou Health, there are four (4) broad categories of coverage depending upon which of the above populations a member falls into and whether, if permitted under Section 3.5, they decide to voluntarily opt-in for full coverage. The categories of coverage are as follows:

3.3.3.1 All covered services

3.3.3.2 Specialized Behavioral Health Services and Non-Emergency Ambulance transportation

3.3.3.3 Specialized Behavioral Health and NEMT Services including Non-Emergency Ambulance transportation

3.3.3.4 All covered services except Specialized Behavioral Health and Coordinated System of Care (CSoC) services (CSoC Population). For this population, PRTF, TGH, and Substance Use Disorder (SUD) Residential services (ASAM Levels III.1, III.2D, III.5 and III.7 for children under 21 and Levels III.3 and III.7D for youth aged 21) remain the responsibility of the MCO.

3.4 Mandatory MCO Populations – All Covered Services

Unless otherwise covered in Sections 3.5, 3.6, and 3.7, the following Medicaid populations are automatically enrolled into Bayou Health and are mandated to participate in the program for all services as specified in Section 6.0 (Core Benefits and Services) currently include the following:

3.4.1 Children under nineteen (19) years of age including those who are eligible under Section 1931 poverty-level related groups and optional groups of older children in the following categories:

3.4.1.1 TANF - Individuals and families receiving cash assistance through FITAP, administered by the DCFS;

3.4.1.2 CHAMP-Child Program – Poverty level children up to age nineteen (19) who meet financial and non-financial eligibility criteria. Deprivation or uninsured status is not an eligibility requirement;

3.4.1.3 Deemed Eligible Child Program - Infants born to Medicaid-eligible pregnant women, regardless of whether or not the infant remains with the birth mother, throughout the infant's first year of life;

3.4.1.4 Youth Aging Out of Foster Care (Chafee Option)- Children under age twenty-one (21) who were in foster care (and already covered by Medicaid) on their eighteenth (18th) birthday, but have aged out of foster care;

3.4.1.5 Former Foster Care Children – covers individuals age eighteen (18) through twenty-six (26) who were receiving Medicaid benefits and in foster care at the time that they obtained age eighteen (18.)

3.4.1.6 Regular Medically Needy Program - Individuals and families who have more income than is allowed for regular on-going Medicaid; and

3.4.1.7 LaCHIP Program - Children enrolled in the Title XXI Medicaid expansion and separate CHIP programs for low-income children under age nineteen (19) who do not otherwise qualify for Medicaid.

3.4.1.8 Blind/Disabled Children and Related Populations are beneficiaries, generally under age 19, who are eligible for Medicaid due to blindness or disability

3.4.1.9 Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

3.4.1.10 Children functionally eligible and agrees to participate in the CSoC program (see exceptions to covered services in Section 3.3.3.4.)

3.4.2 Parents and Caretaker Relatives eligible under Section 1931 of the Social Security Act including:

3.4.2.1 Parents and Caretaker Relatives Program

3.4.2.2 TANF (FITAP) Program

3.4.2.3 Regular Medically Needy Program

3.4.3 Pregnant Women - Individuals whose basis of eligibility is pregnancy, who are eligible only for pregnancy related services [42 CFR §440.210(2)] including:

3.4.3.1 LaMOMS (CHAMP-Pregnant Women) - Pregnant women otherwise ineligible who receive coverage for prenatal care, delivery, and care through the second calendar month following the end of pregnancy.

3.4.3.2 LaCHIP Phase IV Program – Separate state CHIP Program for CHIP Unborn Option which covers uninsured pregnant women ineligible for Medicaid until end of pregnancy and completion of administrative determination of continued eligibility in any other Medicaid program.

3.4.4 Breast and Cervical Cancer (BCC) Program - Uninsured women under age sixty-five (65) who are not otherwise eligible for Medicaid and are identified through the Centers for Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer.

3.4.5 Aged, Blind and Disabled Adults – Individuals who do not meet any of the conditions for, mandatory enrollment in the MCO for specialized behavioral health as covered in Sections 3.5, 3.6, and 3.7. These include:

3.4.5.1 Supplemental Security Income (SSI) Program – Individuals nineteen (19) and older who receive cash payments under Title XVI (Supplemental Security Income) administered by the Social Security Administration; and

3.4.5.2 Extended Medicaid Programs - Certain individuals who lose SSI eligibility because of a Social Security cost of living adjustment (COLA) or in some cases entitlement to or an increase in Retirement, Survivors, Disability

Insurance (RSDI) benefits, i.e., Social Security benefits. SSI income standards are used in combination with budgeting rules which allow the exclusion of cost of living adjustments and/or certain benefits. Extended Medicaid consists of the following programs:

- Disabled Adult Children - Individuals over 19 who become blind or disabled before age twenty-two 22 and lost SSI eligibility on or after July 1, 1987, as a result of entitlement to or increase in RSDI Child Insurance Benefits;

- Early Widows/Widowers - Individuals who lose SSI eligibility because of receipt of RSDI early widow/widowers benefits;

- Pickle - Aged, blind, and disabled persons who become ineligible for SSI or MSS as the result of cost of living increase in RSDI or receipt and/or increase of other income including:

    - Group One - Individuals who concurrently received and were eligible to receive both SSI and RSDI in at least one month since April 1, 1977, and lost SSI as the direct result of an RSDI COLA; and

    - Group Two - Individuals who were concurrently eligible for and received both SSI and RSDI in at least one month since April 1, 1977, and lost SSI due to receipt and/or increase of income other than an RSDI COLA, and would again be eligible for SSI except for COLAs received since the loss of SSI.

- Disabled Widows/Widowers and Disabled Surviving Divorced Spouses Unable To Perform Any Substantial Gainful Activity- Widows/Widowers who are not entitled to Part A Medicare who become ineligible for SSI due to receipt of SSA Disabled Widows/Widowers Benefits so long as they were receiving SSI for the month prior to the month they began receiving RSDI, and they would continue to be eligible for SSI if the amount of the RSDI benefit was not counted as income; and

- Blood Product Litigation Program - Individuals who lose SSI eligibility because of settlement payments under the *Susan Walker v. Bayer Corporation* settlement and the Ricky Ray Hemophilia Relief Fund Act of 1998.

3.4.5.3 Medicaid Purchase Plan Program - Working individuals between ages 16 and 65 who have a disability that meets Social Security standards;

3.4.5.4 Provisional Medicaid Program – People with disabilities and aged (65 or older) individuals who meet eligibility requirements of the SSI program as determined by DHH, without having an SSI determination made by SSA; and

3.4.5.5 Aged and related populations are those Medicaid beneficiaries who are age 65 or older and not members of the blind/disabled population or members of the Section 1931 Adult population.

3.4.6 Continued Medicaid Program - Short-term coverage for families who lose Parents and Caretaker Relatives or TANF eligibility because of an increase in earnings or an increase in the hours of employment.

3.4.7 Individuals who have been diagnosed with tuberculosis, or are suspected of having tuberculosis, and are receiving TB related services through the TB Infected Individual Program.

3.4.8 New Adults – Individuals age 19 through 64, not otherwise categorically eligible, with incomes at or below 133% FPL.

3.5 Voluntary Opt-In Populations

3.5.1 for Specialized Behavioral Health and NEMT services and NEMT Services only, and may voluntarily enroll into Bayou Health for other state plan covered services, include:

3.5.1.1 Non-dually eligible individuals receiving services through the following 1915(c) Home and Community-Based (HCBS) Waivers and any HCBS waiver(s) that replaces these current waivers:

- Adult Day Health Care (ADHC) - Direct care in a licensed adult day health care facility for those individuals who would otherwise require nursing facility services;
- New Opportunities Waiver (NOW) – Services to individuals who would otherwise require ICF/DD services;
- Children's Choice (CC) - Supplemental support services to disabled children ~~under age 18~~ on the NOW waiver registry;
- Residential Options Waiver (ROW) – Services to individuals living in the community who would otherwise require ICF/DD services;
- Supports Waiver – Services to individuals 18 years and older with ~~mental retardation or~~ a developmental disability which manifested prior to age 22; and
- Community Choices Waiver (CCW) – Services to persons aged 65 and older or, persons with adult-onset disabilities age 22 or older, who would otherwise require nursing facility services.

3.5.1.2 Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' (OCDD's) Request for Services Registry who are *Chisholm* Class Members.

3.5.2 Voluntary opt-in populations may elect to receive all other state plan services through Bayou Health at any time.

3.5.3 Voluntary opt-in populations may return to Legacy Medicaid for all state plan services other than Specialized Behavioral Health and NEMT at any time effective the earliest possible month that the action can be administratively taken.

3.5.4 Voluntary opt-in populations who have previously returned to Legacy Medicaid for all state plan services other than Specialized Behavioral Health and NEMT may exercise this option to return to Bayou Health for other state plan services only during the annual open enrollment period**.**

3.6 Mandatory MCO Populations – Specialized Behavioral Health and Non-Emergency Ambulance Transportation

The following populations are mandatorily enrolled in Bayou Health for Specialized Behavioral Health Services and Non-Emergency Ambulance Transportation only:

3.6.1 Individuals residing in Nursing Facilities (NF); and

3.6.2 Individuals under the age of 21 residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD).

3.7 Mandatory MCO Populations – Specialized Behavioral Health and NEMT Services

3.7.1 Individuals who receive both Medicaid and Medicare (Medicaid dual eligible) are mandatorily enrolled in Bayou Health for Specialized Behavioral Health Services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified under Section 3.6.

3.7.2 LaHIPP enrollees are mandatorily enrolled in Bayou Health for Specialized Behavioral Health Services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified under Section 3.6.

3.8 Excluded Populations

3.8.1 Medicaid populations that cannot participate in Bayou Health include:

3.8.1.1 Adults (age 21 and older) residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD);

3.8.1.2 Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete “managed care” type benefit combining medical, social and long-term care services;

3.8.1.3 Refugee Cash Assistance;

3.8.1.4 Refugee Medical Assistance;

3.8.1.5 Take Charge Plus;

3.8.1.6 SLMB only;

3.8.1.7 QI 1;

3.8.1.8 LTC Co-Insurance;

3.8.1.9 QDWI;

3.8.1.10 QMB only; and

3.8.1.11 Individuals with a limited eligibility period including:

3.8.1.11.1 Spend-down Medically Needy Program - An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to three (3) months);

3.8.1.11.2 Emergency Services Only - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements; and

3.8.2 DHH may add, delete, or otherwise change mandatory, voluntary opt-out, voluntary opt-in, and excluded population groups. If changed, the Contract shall be amended and the MCO given sixty (60) days advance notice whenever possible.

INTENTIONALLY LEFT BLANK

4.0 STAFF REQUIREMENTS AND SUPPORT SERVICES

4.1. General Staffing Requirements

4.1.1 The MCO shall have in place the organizational, operational, managerial, and administrative systems capable of fulfilling all contract requirements. The MCO shall be staffed by qualified persons in numbers appropriate to the MCO's size of enrollment.

4.1.2 For the purposes of this contract, the MCO 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 MCO must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. The Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, can be accessed at the following url: https://oig.hhs.gov/exclusions/index.asp

4.1.3 The MCO must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The MCO'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 MCO 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 MCO to hire additional staff and application of monetary penalties as specified in Section 20 of this RFP.

4.1.4 The MCO 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.

4.1.5 The MCO 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.

4.1.6 The MCO shall remove or reassign, upon written request from DHH, any MCO employee or subcontractor employee that DHH deems to be unacceptable. The MCO shall hold DHH harmless for actions taken as a result hereto.

4.1.7 The MCO is strongly encouraged to have in place, no later than three (3) months after award of the Contract, a workplace wellness program which encourages

healthy lifestyles, accessible to all employees based within the state of Louisiana.

4.2 Key Staff Positions

4.2.1 Staffing Requirements

4.2.1.1 An individual staff member is limited to occupying a maximum of two of the key staff positions listed below unless prior approval is obtained by DHH or otherwise stated below. Exceptions include the Administrator/CEO, the Medical Director/CMO and the Behavioral Health Medical Director; the individuals holding each shall not hold another position.

4.2.1.2 The MCO may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law.

4.2.1.3 The MCO shall inform DHH in writing when an employee leaves one of the key staff positions listed below (this requirement does not apply to additional required staff, also listed below). The name of the interim contact person should be included with the notification. This notification shall take place within (5) business days of the resignation/termination.

4.2.1.4 The MCO shall replace any of the key staff with a person of equivalent experience, knowledge and talent. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place along with a revised organization chart complete with key staff time allocation.

4.2.1.5 Replacement of the Administrator/CEO, Medical Director/CMO, or Behavioral Health Medical Director shall require prior written approval from DHH which will not be unreasonably withheld provided a suitable candidate is proposed.

4.2.1.6 Annually, the MCO must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key staff. 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].

4.2.1.7 Exception to Staffing Requirements

4.2.1.7.1 Requests for exceptions to mandatory staffing requirements as a result of prevailing best interests must be submitted in writing to DHH for prior approval.

4.2.1.7.2 The MCO should address the reason for the request, the organization's ability to furnish services as contractually required with the exception in place, and duration of exception period requested.

4.2.1.7.3 The MCO shall provide and have approved a Staffing Plan that describes how the MCO will maintain the staffing level to ensure the successful accomplishment of all duties including specialized behavioral health related functions.

4.2.1.7.4 The MCO may propose to DHH a staffing plan that combines positions and functions outlined in the contract for other positions, provided the MCO describes how the Table of Organization and staff roles delineated in the contract will be addressed.

4.2.2 **Administrator/Chief Executive Officer (CEO)** to provide overall direction for the MCO, develop strategies, formulate policies, oversee operations to ensure goals are met. Must serve in a full time (40 hours weekly) position available during DHH working hours to fulfill the responsibilities of the position.

4.2.3 **Medical Director/Chief Medical Officer** who is a physician with a current, unencumbered license through the Louisiana State Board of Medical Examiners. The Medical Director must have at least three (3) years of training in a medical specialty and five (5) years' experience post-training providing clinical services. The Medical Director shall devote full time (minimum 40 hours weekly) to the MCO's operations to ensure timely medical decisions, including after-hours consultation as needed. The physician must have achieved board certification in their specialty. During periods when the Medical Director is not available, the MCO shall have physician staff to provide competent medical direction. The Medical Director shall be actively involved in all major clinical and quality management components of the MCO. The Medical Director shall be responsible for:

- Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the MCO Grievance System;

- Administration of all medical management activities of the MCO;

- Serve as member of and participate in every quarterly and phone meeting of the Medicaid Quality Committee either in person or by phone. Medical Director may designate a representative with a working understanding of the clinical and quality issues impacting Medicaid; and

- Serve as the director of the Utilization Management committee and chairman or co-chairman of the Quality Assessment and Performance Improvement committee.

4.2.4 **Behavioral Health Medical Director** who is a physician with a current, unencumbered Louisiana-license as a physician, board-certified in psychiatry with at least three (3) years of training in a medical specialty. The Behavioral Health Medical Director shall devote full time (minimum 32 hours weekly) to the MCO's operations to ensure timely medical decisions, including after-hours consultation as needed. During periods when the Behavioral Health Medical Director is not available, the MCO shall have physician staff to provide competent medical direction. The Behavioral Health Medical Director will share responsibility to manage the behavioral health services delivery system with the Behavioral Health Coordinator, and shall be actively involved in all major clinical and quality management components of the behavioral health services of the MCO. The Behavioral Health Medical Director shall meet regularly with the Chief

Medical Officer. The Behavioral Health Medical Director's responsibilities shall include, but not be limited to the following:

- Oversee, monitor, and assist with the management of psychopharmacology pharmacy benefit manager (PBM) activities, including the establishment of prior authorization clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age 18;

- Provide clinical case management consultations and clinical guidance for contracted primary care physicians (PCPs) treating behavior health-related concerns not requiring referral to behavior health specialists;

- Work within each plan to develop comprehensive care programs for the management of youth and adult behavioral health concerns typically treated by PCP's, such as ADHD and depression;

- Develop targeted education and training for Bayou Health Plan PCP's related to commonly-encountered behavior health issues frequently treated by PCPs;

- Oversee, monitor and assist with effective implementation of the Quality Management (QM) program;

- Work closely with the Utilization Management (UM) of services and associated appeals related to children and youth and adults with mental illness and/or substance abuse disorders (SUD);

- Share responsibility to manage the behavioral health services delivery system with the Behavioral Health Coordinator; and

- Shall be actively involved in all major clinical and quality management components of the behavioral health services of the MCO.

4.2.5 **Chief Operating Officer (COO)** to manage day to day operations of multiple levels of staff and multiple functions/departments across the MCO to meet performance requirements. Accountable to CEO for operational results. The COO may be designated to serve as the primary point-of-contact for all MCO operational issues.

4.2.6 **Chief Financial Officer/CFO** to oversee the budget, accounting systems, financial reporting, and all audit activities implemented by the MCO;

4.2.7 **Program Integrity Officer** who is qualified by training and experience in health care or risk management, to oversee monitoring and enforcement of the fraud, waste, and abuse compliance program to prevent and detect potential fraud, waste, and abuse activities pursuant to state and federal rules and regulations, and carry out the provisions of the compliance plan, including fraud, waste, and abuse policies and procedures, investigating unusual incidents and implementing any corrective action plans. As a management official, this position shall have the authority to assess records and independently refer suspected member fraud, provider fraud, and member abuse cases to DHH and other duly authorized enforcement agencies. Position must report directly to the CEO.

4.2.8 **Grievance System Manager** who will manage and adjudicate member and provider disputes arising under the Grievance System including **member** grievances, appeals and requests for hearing and provider claim and disputes.

4.2.9 **Business Continuity Planning and Emergency Coordinator** to manage **and** oversee the MCO's emergency management plan during disasters and ensure continuity of core benefits and services for members who may need to be evacuated to other areas of the state or out-of-state.

4.2.10 **Contract Compliance ~~Coordinator~~ Officer** who will serve as the primary point-of-contact for all MCO contract compliance issues, will manage the connection of MCO personnel to LDH business owners, and will develop and implement written policies, procedures, and standards to ensure compliance with the requirements of this contract. These ~~primary~~ functions may include but are not limited to coordinating the tracking and submission of all contract deliverables; fielding and coordinating responses to DHH inquiries, coordinating the preparation and execution of contract requirements, random and periodic audits and *ad hoc* visits. This position shall report directly to the CEO and board of directors in accordance with 42 CFR §438.608(a)(1)(ii).

4.2.11 **Quality Management Coordinator** who is a Louisiana-licensed registered nurse, physician or physician's assistant or is a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers and who is full-time~~.~~ (at least 40 hours per week). Six Sigma or other training in quality management is preferred. The QM Coordinator must have experience in quality management and quality improvement as described in 42 CFR §438.200 – §438.242. The primary functions, including those targeting specialized behavioral health services, of the Quality Management Coordinator position are:

- Ensuring individual and systemic quality of care;
- Integrating quality throughout the organization;
- Implementing process improvement;
- Resolving, tracking and trending quality of care grievances; and
- Ensuring a credentialed provider network.

4.2.12 **Performance/Quality Improvement Coordinator** who has a minimum **qualification** as a certified professional in healthcare quality (CPHQ) or certified in health care quality management (CHCQM) or comparable education and experience in data and outcomes measurement as described in 42 CFR §438.200 – 438.242. The primary functions of the Performance/Quality Improvement Coordinator, including those targeting specialized behavioral health services, are:

- Focusing organizational efforts on improving clinical quality performance measures;

- Developing and implementing performance improvement projects;
- Utilizing data to develop intervention strategies to improve outcome; and
- Reporting quality improvement/performance outcomes.

4.2.13 **Maternal Child Health/EPSDT Coordinator** who is a Louisiana licensed registered nurse, physician, or physician's assistant; or has a Master's degree in **health** services, public health, or health care administration or other related field and/or a CPHQ or CHCQM. Staffing under this position should be sufficient to meet quality and performance measure goals. The primary functions of the MCH/EPSDT Coordinator are:

- Ensuring receipt of EPSDT services;
- Ensuring receipt of maternal and postpartum care;
- Promoting family planning services;
- Promoting preventive health strategies;
- Identifying and coordinating assistance for identified member needs specific to maternal/child health and EPSDT;
- Interfacing with community partners.

4.2.14 **Medical Management Coordinator** who is a Louisiana-licensed registered nurse, physician or physician's assistant if required to make medical **necessity** determinations; or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determinations, to manage all required Medicaid management requirements under DHH policies, rules and the contract. The primary functions of the Medical Management Coordinator are:

- Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;
- Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted;
- Developing, implementing and monitoring the provision of care coordination, disease management and case management functions;
- Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services; and
- Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards.

4.2.15 **Provider Services Manager** to coordinate communications between the MCO and its subcontracted providers.

4.2.16 **Member Services Manager** to coordinate communications between the MCO and its members. There shall be sufficient Member Services staff to enable members to receive prompt resolution of their problems or inquiries and appropriate education about participation in the MCO program.

4.2.17 **Claims Administrator** to develop, implement and administer a comprehensive claims processing system capable of paying claims in accordance with state and federal requirements. The primary functions of the Claims Administrator are:

- Developing and implementing claims processing systems capable of paying claims in accordance with state and federal requirements and the terms of the Contract;
- Developing processes for cost avoidance;
- Ensuring minimization of claims recoupments;
- Meeting claims processing timelines; and
- Meeting DHH encounter reporting requirements.

4.2.18 **Provider Claims Educator** must be full-time (forty [40] hours per week) employee for an MCO with over one hundred thousand (100,000) members statewide. This position is fully integrated with the MCO's grievance, claims processing, and provider relations systems and facilitates the exchange of information between these systems and providers, with a minimum of five (5) years management and supervisory experience in the health care field. The primary functions of the Provider Claims Educator are:

- Educating in-network and out-of-network providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available MCO resources such as provider manuals, websites, fee schedules, etc.;
- Interfacing with the MCO's call center to compile, analyze, and disseminate information from provider calls;
- Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction; and
- Frequently communicating (i.e., telephonic and on-site) with providers to ensure the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.

4.2.19 **Case Management Administrator/Manager** to oversee the case management functions and who shall have the qualifications of a case manager (See definitions) and a minimum of five (5) years of management/supervisory experience in the health care field.

4.2.20 **Information Management and Systems Director** who is trained and experienced in information systems, data processing and data reporting to oversee all MCO information systems functions including, but not limited to, establishing and maintaining connectivity with DHH information systems and providing necessary and timely reports to DHH.

4.2.21 **Encounter Data Quality Coordinator** to organize and coordinate services and communication between MCO administration and DHH for the purpose of identifying, resolving, and monitoring encounter and data validation/management issues. Serves as the MCO's encounter expert to answer questions, provide recommendations, and participate in problem solving and decision making related to encounter data, submissions, and processing. Analyzes activities related to the processing of encounter data and data validation studies to enhance accuracy and throughput.

4.2.22 **Behavioral Health Coordinator** shall meet the requirements for a LMHP and have at least seven (7) years' experience in managing behavioral healthcare operations. The Behavioral Health Coordinator shall have responsibility for clinical program development and oversight of staff and services related to the delivery of covered mental health and addiction services to children/youth, adults with serious mental illness and/or with substance use disorders in compliance with federal and state laws and the requirements set forth in this contract, including all documents incorporated by reference. The Behavioral Health Coordinator will share responsibility to manage the specialized behavioral health services delivery system with the Behavioral Health Medical Director. The Behavioral Health Coordinator shall regularly review integration performance, performance improvement projects, and surveys related to integration and shall work closely with the Performance/Quality Improvement Coordinator and Quality Management Coordinator and Behavioral Health Quality Management Coordinator.

4.2.23 **Behavioral Health Children's System Administrator** must meet the requirements for a LMHP and have at least seven (7) years' experience and expertise in the special behavioral health needs of children with severe behavioral health challenges and their families. Prior experience working with other child serving systems is preferred. The ideal candidate will have at least three (3) years' experience with delivering or managing Evidenced Based Practices (EBPs) and best practices for children and youth, including experience within system of care and wraparound environments. The Children's System Administrator shall work closely with the CSoC Governance Board as needed and DHH.

4.2.24 **Addictionologist or an Addiction Services Manager (ASM)** who must meet the requirements of a licensed addiction counselor (LAC) or LMHP with at least seven (7) years of clinical experience with addiction treatment of adults and children experiencing substance use problems and disorders. The ASM shall be responsible for oversight and compliance with the addiction principles of care and application of American Society of Addiction Medicine (ASAM) placement criteria for all addiction program development. The ASM will work closely with the COO, the Behavioral Health Coordinator, the Quality Management Coordinator, and the Behavioral Health Medical Director in assuring quality,

appropriate utilization management, and adequacy of the addiction provider network.

4.2.25 **Behavioral Health Case Management Supervisor** for specialized behavioral health services is a Louisiana-licensed psychiatrist or a Louisiana-licensed Mental Health Practitioner (i.e., Medical Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marital and Family Therapist, Licensed Addictions Counselor, or Advanced Practice Registered Nurse, who is a nurse practitioner specialist in Adult Psychiatric and Mental Health, family Psychiatric and Mental Health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health). A Case Management Supervisor for medical services is a Louisiana-licensed registered nurse. The Case Management Supervisor shall be responsible for all staff and activities related to the case management program, and shall be responsible for ensuring the functioning of case management activities across the continuum of care.

4.3 Additional Required Staff

The MCO shall have sufficient number of qualified staff with sufficient experience and expertise to meet both physical health services and behavioral health services responsibilities, providing dedicated staff where necessary to meet this obligation including all required timeframes and geographic coverage outlined in this contract.

4.3.1 **Prior Authorization Staff** to authorize health care 24 hours per day, 7 days per week. This staff shall include a Louisiana licensed registered nurse, physician or physician's assistant. The staff will work under the direction of a Louisiana-licensed registered nurse, physician or physician's assistant.

4.3.1.1 The MCO shall have a sufficient number of LMHPs, including licensed addiction counselors (LACs), as well as a board-certified psychiatrist and a board-certified addictionologist. If an addictionologist cannot be retained full-time due to limited availability, the MCO shall contract with a qualified consultant. With the exception of the addictionologist who shall be available at least 10 hours per week, the other LMHPs shall be available 24 hours per day/7 days per week. The MCO shall provide UM staff, both experienced and specifically assigned to children, youth, adults, and older adults, and PSH.

4.3.2 **Concurrent Review Staff** to conduct inpatient concurrent review. This staff shall include of a Louisiana licensed nurse, physician, or physician's assistant. The staff will work under the direction of a Louisiana licensed registered nurse, physician or physician's assistant.

4.3.2.1 The MCO shall have a sufficient number of LMHPs, including licensed addiction counselors (LACs), as well as a board-certified psychiatrist and a board-certified addictionologist. If an addictionologist cannot be retained full-time due to limited availability, the MCO shall contract with a qualified consultant. With the exception of the addictionologist who shall be available at least 10 hours per week, the other LMHPs shall be available 24 hours per day/7 days per week. The MCO shall provide UM staff, both experienced and specifically assigned to children, youth, adults, and older adults, and PSH.

4.3.3 **Clerical and Support Staff** to ensure proper functioning of the MCO's operation.

4.3.4 **Provider Services Staff** to enable providers to receive prompt responses and assistance and handle provider grievances and disputes. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution of their problems and inquiries and appropriate education about participation in the MCO program and to maintain a sufficient provider network.

4.3.5 **Member Services Staff** to enable members to receive prompt responses and assistance. There shall be sufficient Member Services staff to enable members and potential members to receive prompt resolution of their problems or inquiries.

4.3.6 **Claims Processing Staff** to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.

4.3.7 **Encounter Processing Staff** to ensure the timely and accurate processing and submission to DHH of encounter data and reports.

4.3.8 **Case Management Staff** to assess, plan, facilitate and advocate options and services to meet the enrollees' health needs through communication and available resources to promote quality cost-effective outcomes. The MCO shall provide and maintain in Louisiana, appropriate levels of case management staff necessary to assure adequate local geographic coverage for in field face to face contact with physicians and members as appropriate and may include additional out of state staff providing phone consultation and support.

4.3.8.1 An adequate number of case management staff necessary to support members in need of specialized behavioral health services shall be certified in treatment planning through the completion of specialized training in the Treatment Planning Philosophy,

4.3.8.2 For the population receiving specialized behavioral health services, the MCO shall have integrated care management centers/case management staff that physically co-locate with care management staff. The MCO shall employ care managers to coordinate follow-up to specialty behavioral health providers and follow-up with patients to improve overall health care.

4.3.9 **Fraud, Waste, and Abuse Investigators** are responsible for all fraud, waste, and abuse detection activities, including the fraud and abuse compliance plan, MCO employee training and monitoring, sampling investigation of paid claim discrepancies, and day-to-day provider investigation related inquiries.

4.3.10 **Licensed Mental Health Professionals (LMHP)** to perform evaluations for adult mental health rehabilitation services. Whether through subcontract or direct employment, the MCO shall maintain appropriate levels of LMHP staff to assure adequate local geographic coverage for in field face-to-face contact with members. LMHP staff must be trained to determine the medical necessity criteria as established by the State. LMHPs shall be certified in administering the Level of Care Utilization System (LOCUS).

4.3.11 **LMHPs to perform PASRR Level II evaluations** upon referrals from OBH to assess the appropriateness of nursing facility placement and the need for and facilitation of behavioral health services. PASRR Level II evaluations must be performed by an LMHP independent of OBH and not delegated to a nursing facility or an entity that has a direct or indirect affiliation or relationship with a nursing facility as per 42 CFR 483.106. Whether through subcontract or direct employment, the MCO shall maintain appropriate levels of LMHP staff to assure adequate local geographic coverage for in field face-to-face contact with members in need of such evaluations. These staff must be administratively separate from staff performing utilization review but may be the same staff as listed under 4.3.10.

4.3.12 **Behavioral Health Liaisons and Coordination with Partner Agencies** — the MCO shall have staff identified to provide liaison activities for the following entities. The liaison shall be available for response to inquiries within one business day of inquiry. Any change in liaison personnel shall be sent to respective entity within 48 hours of notice to the MCO.

4.3.12.1 A liaison dedicated solely to LDOE, DCFS and OJJ. This liaison shall also be responsible for outreach, education and community involvement for the court systems, education systems and law enforcement. This staff position must be located in Louisiana. The designated liaison must attend all CSoC Governance Board meetings. The liaison shall have experience in child welfare and delinquency. The liaison shall also outreach to local school systems to educate on the services available. The liaison shall be knowledgeable and provide education on the entire behavioral health service array including, CSoC, crisis services and process for obtaining services and out of home placements and process for placement.

4.3.12.2 A single point of contact dedicated to liaising with the judicial system. Functions include serving as a point of contact for judges, court personnel and appearing in court when requested by the court system or DHH. This contact shall also serve as a point of contact for DHH legal and staff working with DHH custody cases. This person shall have familiarity with drug court, juvenile court, family court and criminal court processes and issues. This person shall provide continuous outreach and education to the judicial system on access to services. This staff person may also serve the function listed above as the DCFS/OJJ point of contact, however, if DHH determines the case load to be too voluminous, DHH may request an additional staff person be hired.

4.3.12.3 LGE liaison who shall serve as a point of contact for inquiries, barriers and resolution for LGEs. The liaison shall have experience with the LGE structure, services provided, members served and responsibilities. This liaison may be required to attend Human Services Interagency Council (HSIC) meetings if requested by DHH. The liaison shall have knowledge of the non-Medicaid uninsured system.

4.3.12.4 Tribal liaison that is the single point of contact regarding delivery of covered services to Native Americans;

4.3.12.5 Behavioral health consumer and family organizations liaison for children, youth and adults. This person shall be a peer, former consumer of services

and/or in recovery. This liaison shall be engaged with the advocacy community.

4.3.12.6 A Permanent Supportive Housing (PSH) program liaison, to be approved by DHH, to work with DHH PSH program staff to assure effective implementation of PSH program deliverables as outlined in Section 6.4.5.

4.3.12.7 An Intellectual/Developmental Disability (I/DD) liaison to work with OCDD staff regarding I/DD medical and behavioral health issues.

4.4 In-State Staff Positions

The MCO is responsible for maintaining least fifty (50) percent of staff within the state of Louisiana. Positions at a minimum that must be located in Louisiana are the following:

4.4.1 Administrator/Chief Executive Officer

4.4.2 Chief Operating Officer/COO

4.4.3 Medical Director/CMO

4.4.4 Behavioral Health Medical Director

4.4.5 Program Integrity Officer

4.4.6 Grievance System Manager

4.4.7 Contract Compliance Coordinator

4.4.8 Quality Management Coordinator

4.4.9 Maternal Health/EPSDT (Child Health) Coordinator

4.4.10 Medical Management Manager

4.4.11 Member Services Manager

4.4.12 Provider Services Manager

4.4.13 Provider Claims Educator (if applicable)

4.4.14 Encounter Data Quality Coordinator

4.4.15 Case Management Staff

4.4.16 Fraud, Waste, and Abuse Investigators (at a rate of one per ~~one hundred~~ fifty thousand and fraction thereof (1:~~10~~50,000) members, subject to the provisions in Section 15.1.14

4.4.17 Behavioral Health Liaisons

4.4.18 Behavioral Health Coordinator

4.4.19 Behavioral Health Children's System Administrator

4.4.20 Addictionologist or Addiction Services Manager

4.4.21 Behavioral Health Case Management Supervisor

4.5 Written Policies, Procedures, and Job Descriptions

4.5.1 The MCO shall develop and maintain written policies, procedures and job descriptions for each functional area, including for specialized behavioral health services, consistent in format and style. The MCO 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 MCO's written policies reflect current practices. Reviewed policies shall be dated and signed by the MCO'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 medical and quality management policies must be approved and signed by the MCO's Medical Director. All behavioral health policies must be approved and signed by the MCO's Behavioral Health Medical Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements.

4.5.2 Based on provider or member feedback, if DHH deems an MCO policy or process to be inefficient and/or places an unnecessary burden on the members or providers, the MCO will be required to work with DHH to change the policy or procedure within a time period specified by DHH.

4.6 Staff Training and Meeting Attendance

4.6.1 The MCO shall ensure that all staff members including sub-contractors have appropriate training, education, experience and orientation to fulfill their requirements of the position. DHH may require additional staffing for an MCO that has substantially failed to maintain compliance with any provision of the contract and/or DHH policies.

4.6.2 The MCO must provide initial and ongoing staff training that includes an overview of DHH, DHH Policy and Procedure Manuals, and Contract and state and federal requirements specific to individual job functions. The MCO 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.

4.6.3 The MCO shall educate all staff members about the MCO's policies and procedures on advance directives.

~~**4.6.3**~~**4.6.4** New and existing transportation, prior authorization, provider services and member services representatives must be trained in the geography of Louisiana as well as culture and correct pronunciation of cities, towns, and surnames. They must have access to GPS or mapping search engines for the purposes of authorizing services in; recommending providers and transporting members to the most geographically appropriate location.

~~4.6.4~~4.6.5 The MCO 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.

~~4.6.5~~4.6.6 DHH reserves the right to attend any and all training programs and seminars conducted by the MCO. The MCO shall provide DHH a list of any marketing training dates (See Section 12 Marketing and Member Materials), time and location, at least fourteen (14) calendar days prior to the actual date of training. The MCO shall provide documentation of meetings and trainings (including staff and provider trainings) upon request. Meeting minutes, agendas, invited attendee lists and sign-in sheets along with action items must be provided upon request.

~~4.6.6~~4.6.7 DHH reserves the right to assign mandatory training for key staff, staff members, and subcontractors. Failure to comply places DHH at risk of receiving audit findings and/or financial penalties from state and federal auditing agencies. The MCO may be required to submit documentation that all staff have completed DHH assigned mandatory training, education, professional experience, orientation, and credentialing, as applicable, to perform assigned job duties.

~~4.6.7~~4.6.8 Additional key staff training requirements, with inclusion of specialized behavioral health services, shall include but not be limited to:

~~4.6.7.1~~4.6.8.1 For staff, including newly hired case managers and case management supervisors:

~~4.6.7.1.1~~4.6.8.1.1 Specialized behavioral health policy and procedure manuals issued and maintained by OBH;

~~4.6.7.1.2~~4.6.8.1.2 OJJ system, population, and processes;

~~4.6.7.1.3~~4.6.8.1.3 DCFS system, population, and processes;

~~4.6.7.1.4~~4.6.8.1.4 Contract requirements;

~~4.6.7.1.5~~4.6.8.1.5 Currently approved CMS authorities for specialized behavioral health (waivers and State Plan);

~~4.6.7.1.6~~4.6.8.1.6 Specialized behavioral health services for members residing in a nursing facility;

~~4.6.7.1.7~~4.6.8.1.7 Pre-admission screening and resident review (PASRR);

~~4.6.7.1.8~~4.6.8.1.8 Current and applicable evidence based practices offered by the MCO, CSoC program; and

~~4.6.7.1.9~~4.6.8.1.9 Behavioral health services available through other funding sources, including Medicare.

~~4.6.7.2~~4.6.8.2 For staff members having contact with members or providers – initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.

~~4.6.7.3~~4.6.8.3 For staff members working directly with members – Crisis intervention training.

~~4.6.7.4~~4.6.8.4 The MCO shall participate in all PSH trainings required by DHH and shall, at the request of DHH, require that relevant subcontractors to the MCO participate as well.

INTENTIONALLY LEFT BLANK

5.0 MCO REIMBURSEMENT

5.1. Capitated Payments

5.1.1. DHH shall make monthly capitated payments for each member enrolled into the MCO.

5.1.2. The monthly capitated payment shall be based on member enrollment for the month. Member enrollment for the month is determined by the total number of Medicaid eligibles assigned to the MCO as of the last working day of the previous month. For age group assignment purposes, age will be defined as of the beginning of the month for which the payment is intended.

5.2. Maternity Kick Payments

5.2.1. DHH shall provide MCOs a one-time supplemental lump sum payment for each obstetrical delivery. This kick payment is intended to cover the cost of prenatal care, the delivery event, and post-partum care and normal newborn hospital costs.

5.2.2. Only one maternity kick payment will be made per delivery event. Multiple births during the same delivery will result in one maternity kick payment being paid. The maternity kick payment will be paid for both live and still births. A kick payment will not be reimbursed for abortions or spontaneous abortions (spontaneous abortions as defined in state statute). The amount of the kick payment will be determined by DHH's actuary.

5.2.3. The kick payment will be paid to the MCO upon submission of satisfactory evidence of the occurrence of a delivery.

5.2.4. For deliveries occurring before 39 weeks without a medical indication, the amount of the kick payment will be determined by DHH's actuary in accordance with DHH policy.

5.3. MCO Payment Schedule

5.3.1. Capitated payments and maternity kick payments shall be made in accordance with the payment schedule established by DHH and published on the Fiscal Intermediary website.

5.3.2. DHH reserves the right to defer remittance of the monthly capitated payment scheduled for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.

5.4. Withhold of Capitated Payment

5.4.1. Through January 31, 2018, a withhold of the monthly capitated payment shall be applied to provide an incentive for MCO compliance with the requirements of this Contract.

5.4.1.1. The withhold amount will be equivalent to two percent (2%) of the monthly capitated payment for physical and basic behavioral health for all MCO

enrollees, exclusive of maternity kick payments and the Full Medicaid Payment (FMP) component of the monthly capitated payment.

5.4.1.2. If DHH has not identified any MCO deficiencies, DHH will pay to the MCO the amount of the MCO's capitated payments withheld in the month subsequent to the withhold.

5.4.1.3. If DHH has determined the MCO is not in compliance with a requirement of this Contract in any given month, DHH may issue a written notice of action and DHH may retain the amount withheld for the month prior to DHH identifying the compliance deficiencies.

5.4.1.4. Monthly retention of the withhold amount may continue for each subsequent month so long as the identified deficiencies have not been corrected.

5.4.1.5. If the same or similar deficiency(s) continues beyond timeframes specified for correction in the written notice of action, which shall be considered the cure period, DHH may permanently retain the amount withheld for the period of non-compliance consistent with the monetary penalty, sanctions, and liquidated damages provisions of this Contract.

5.4.1.6. Amounts withheld for MCO Incentive Based Performance Measure outcomes, as defined in Section 14.2.5, may be permanently retained upon validation of calculated rate by DHH's contracted external quality review organization.

5.4.2. Effective February 1, 2018, a withhold of the monthly capitated payment shall be applied to incentivize quality, health outcomes, and value-based payments.

The withhold amount will be equal to two percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments and the FMP component of the monthly capitated payment.

5.4.2.1. Quality and Health Outcomes

5.4.2.1.1. Half of the total withhold amount, equal to one percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments and the FMP component of the monthly capitated payment, shall be applied to incentivize quality and health outcomes.

5.4.2.1.2. For each measurement year ending on or after December 31, 2018, the MCO may earn back the quality withhold for the measurement year based on its performance relative to incentive-based measures and targets as established by LDH.

5.4.2.1.3. Measure descriptions and targets for incentive-based measures will be specified in Appendix J prior to the start of the measurement year. Incentive-Based (IB) measures are identified in Appendix J annotated with "$$."

5.4.2.1.4. Targets for Healthcare Effectiveness Data and Information Set (HEDIS®) incentive-based measure scores will be equal to National Committee for Quality Assurance (NCQA) Quality Compass Medicaid National 50th percentile [All Lines of Business (LOBs) (Excluding Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs))] values for the prior measurement year.

~~5.4.1.6.1.~~**5.4.2.1.5.** If NCQA makes changes to any of the measures selected by LDH, such that valid comparison to prior years will not be possible, LDH, at its sole discretion, may elect to eliminate the measure from incentive eligibility, change the affected measure to be reporting only, or replace it with another measure.

5.4.2.1.6. Targets for non-HEDIS incentive-based measures will be equal to the best performance reported to LDH by any MCO for the prior measurement year.

5.4.2.1.7. LDH shall determine the amount of the quality withhold earned back by the MCO based on the MCO's performance.

~~5.4.1.6.2.~~**5.4.2.1.8.** All incentive-based measures shall be weighted equally for purposes of earning back the quality withhold.

5.4.2.1.8.1. To earn back the full withhold amount associated with each incentive-based measure, MCO performance must either meet the target for that measure or improve over the MCO's performance for that measure for the prior measurement year by at least 2 points (2.0 without any rounding). If the MCO did not report data for a particular measure in accordance with LDH requirements for the prior measurement year, the MCO must meet the target to earn the withhold for this measure.

5.4.2.1.8.2. If the MCO submits its HEDIS results to NCQA per the timelines and specifications as required in Section 14.2.5.9, along with proof of submission to LDH, LDH will refund any amounts withheld for quality and health outcomes for the measurement year for which the results are reported. (For example: For HEDIS results reported in July 2019, amounts withheld for quality and health outcomes from monthly capitation payments for February through July 2018 member months will be released.)

~~5.4.1.6.3.~~**5.4.2.1.9.** Non-HEDIS incentive-based measure scores will be calculated by LDH and compared to targets established by LDH.

~~5.4.1.6.4.~~**5.4.2.1.10.** For all measures, the MCO's results will be validated by LDH's contracted External Quality Review Organization.

5.4.2.1.11. No later than the end of the calendar year of the reporting year, LDH will notify the MCO of the amount of its quality withhold earned back and refund the amount within 30 days of such notice.

5.4.2.1.12. LDH shall retain the amount of the quality withhold not earned back by the MCO.

5.4.2.2. Value-Based Payments

5.4.2.2.1. Half of the total withhold amount, equal to one percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments and the FMP component of the monthly capitated payment, shall be applied to incentivize Value-Based Payments (VBP).

5.4.2.2.2. The MCO may earn back the VBP withhold amount for increasing its use of Alternative Payment Models consistent with categories 2A, 2C, 3 and 4 of the Learning Action Network (LAN) Alternative Payment Models Framework and aligned with the incentive-based measures specified in Appendix J (hereafter collectively referred to as "APM").

5.4.2.2.3. To earn back the full withhold amount in CY2018, the MCO shall:

5.4.2.2.3.1. By February 15, 2018, submit to LDH a baseline report on its FY2017 APM use as specified in Attachment L. The calculated rate of baseline APM use shall be reviewed by LDH. If the MCO APM report is complete and consistent with specifications as determined by LDH, LDH will reduce the amount of the VBP withhold for the remainder of CY2018 to 0.80% of the monthly capitation rate. The withhold shall not be reduced for late submissions.

5.4.2.2.3.2. By August 15, 2018, submit to LDH for approval, in accordance with Attachment L, a strategic plan to increase its APM use above its FY2017 baseline, including specific strategies, milestones, targets, and deliverables. If the MCO strategic plan is complete and consistent with specifications as determined by LDH, LDH will reduce the VBP withhold for the remainder of CY2018 to 0.40% of the monthly capitation rate and refund any amounts withheld for VBP through July 2018. The withhold shall not be reduced or refunded for late submissions.

~~5.4.1.6.4.1.~~**5.4.2.2.3.3.** LDH shall provide feedback to the MCO on its strategic plan within 30 days of submission. Within 30 days of LDH feedback, the MCO shall submit a final strategic plan inclusive of LDH feedback. Upon receipt of the final strategic plan, LDH will eliminate the MCO's VBP withhold for the remainder of CY2018 and refund any amounts withheld for VBP during CY2018.

5.4.2.2.4. To earn back the full VBP withhold amount in CY2019, the MCO shall:

5.4.2.2.4.1. By August 15, 2019, submit to LDH a report on its FY2019 APM use as specified in Attachment L. The calculated rate of APM use shall be reviewed by LDH. If the MCO APM report is complete and consistent with specifications as determined

by LDH, LDH will reduce the VBP withhold for the remainder of CY2019 to 0.50% of the monthly capitation rate and refund any amounts withheld for VBP through July 2019. The withhold shall not be reduced or refunded for late submissions.

~~5.4.1.6.4.2.~~5.4.2.2.4.2. By December 1, 2019, submit to LDH a written update on the implementation and status of its APM strategic plan that demonstrates that the MCO met its specific strategies, milestones, targets, and deliverables for FY2019 identified in the MCO's APM strategic plan as approved by LDH. If the MCO did not meet criteria established in the strategic plan, the MCO shall describe why the criteria were not met.

5.4.2.2.4.3. If the MCO FY2019 APM strategic plan update is deemed ~~to~~by LDH to meet the milestones, targets, and deliverables for FY2019 as identified in the MCO's APM strategic plan as approved by LDH, LDH will refund any amounts withheld for VBP during CY2019.

5.4.2.2.5. LDH shall retain the amount withheld from any MCO for any unearned VBP incentive.

~~5.4.1.7.~~5.4.2.3. If, in the final determination of MCO performance relative to Quality and Health Outcomes and Value Based Payment incentives, the MCO's unearned withhold amount exceeds its withhold balance held in escrow by LDH, the MCO is responsible for remitting payment for the balance to LDH within thirty (30) calendar days following notification to the MCO by LDH unless otherwise authorized in writing by LDH. LDH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to LDH to future payments.

5.4.3. All MCOs contracted with LDH shall collectively agree on a common format and frequency for provider-specific profile reports on the incentive-based quality measures identified in Appendix J and submit the agreed-upon format for approval by LDH no later than October 1, 2018. The profile format shall be reviewed annually by the MCOs. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.

5.4.4. The MCO shall distribute provider-specific profile reports to providers using the LDH-approved common format and frequency effective the first quarter of calendar year 2019.

~~5.4.2.~~5.4.5. No interest shall be due to the MCO on any sums withheld or retained under this Section.

~~5.4.3.~~5.4.6. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract.

5.5. Payment Adjustments

5.5.1. In the event that an erroneous payment is made to the MCO, DHH shall reconcile the error by adjusting the MCO's next monthly capitation payment or future capitation payments on a schedule determined by DHH in consultation with the Fiscal Intermediary.

5.5.2. Retrospective adjustments to prior capitation payments may occur when it is determined that a member's aid category and/or type case was changed and the member remains MCO eligible.

5.5.3. If the member's aid category and/or type case changed from MCO eligible to MCO excluded, previous capitation payments for excluded months will be recouped from the MCO. The MCO shall initiate recoupments of payments to providers within 60 days of the date DHH notifies the MCO of the change. The MCO shall instruct the provider to resubmit the claim(s) to the Medicaid fee-for-service program (if applicable).

5.5.4. In cases of a retroactive effective date for Medicare enrollment of a member, the MCO will recoup payments made to the providers. The MCO shall initiate recoupments within 60 days of the date DHH notifies the MCO of Medicare enrollment. The MCO shall instruct the provider to resubmit the claim(s) to Medicare and the payer with financial responsibility for the claim(s) (if applicable).

5.5.5. The MCO will refund payments received from DHH for a deceased member after the month of death and an incarcerated member the month after entering involuntary custody. DHH will recoup the payment as specified in the contract.

5.5.6. The entire monthly capitation payment will be paid during the month of birth and month of death and month entry into involuntary custody. Payments shall not be pro-rated to adjust for partial month eligibility as this has been factored into the actuarial rates.

5.6. Risk Sharing

5.6.1. The MCO shall agree to accept, as payment in full, the actuarially sound rate and maternity kick payment established by DHH pursuant to the contract, and shall not seek additional payment from a member, or DHH, for any unpaid cost.

5.6.2. The MCO shall assume one hundred percent (100%) liability for any expenditure above the monthly capitated rate and maternity kick payment.

5.7. Determination of MCO Rates

5.7.1. DHH will develop cost-effective and actuarially sound rates according to all applicable CMS rules and regulations. DHH will not use a competitive bidding process to develop the MCO capitation. DHH will develop monthly capitation rates that will be offered to MCOs on a "take it or leave it" basis.

5.7.2. Rates will be set using fee-for-service claims data, Bayou Health Shared Savings claims experience, Bayou Health MCO encounter data, LBHP encounter data, and financial data and supplemental ad hoc data and analyses appropriate for determining actuarially sound rates. Fiscal periods of the base data will be

determined based upon the data sources, rate periods and purposes for which the data is used with appropriate adjustments which include the following:

5.7.2.1. Utilization trend and the expected impact of managed care on the utilization of the various types of services applied to varying sources of data, including managed care savings assumptions and managed care efficiency adjustments;

5.7.2.2. Unit cost trend and assumptions regarding managed care pricing and payments;

5.7.2.3. Third Party Liability recoveries; and

5.7.2.4. The expected cost of MCO administration and overhead, including but not limited to premium taxes and the Section 1202 Health Insurer Fee.

5.7.3. DHH reserves the right to adjust the rate in the following instances:

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

5.7.3.2. Changes to Medicaid population groups eligible to enroll in an MCO;

5.7.3.3. Legislative appropriations and budgetary constraints; or

5.7.3.4. Changes in federal requirements.

5.7.4. Any adjusted rate must continue to be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c), and will require an amendment to the Contract that is mutually agreed upon by both parties.

5.7.5. Additional factors determining the rate for an individual member may include: 1) age; 2) gender; 3) Medicaid category of assistance; 4) the geographic location of the member's residence; and 5) Medicare enrollment.

5.7.6. As the MCO Program matures and FFS data and Shared Savings data are no longer available, there will be increasing reliance on encounter data and/or financial data to set future rates, subject to comparable adjustments.

5.7.7. The MCO shall be paid in accordance with the monthly capitated rates specified in Contract Attachment D – Mercer Certification, Rate Development Methodology and Rates of this Contract.

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

5.7.9. The MCO shall provide in writing any information requested by DHH to assist in the determination of MCO rates. DHH will give the MCO reasonable time to respond to the request and full cooperation by the MCO is required. DHH will make the final determination as to what is considered reasonable.

5.8. Risk Adjustment

5.8.1. Capitated payments for physical and basic behavioral health shall be risk-adjusted.

5.8.1.1. DHH will analyze the risk profile of members enrolled in each MCO using a national risk adjustment model specified by the State.

5.8.1.2. Each member will be assigned to risk categories based on their age, sex and classified disease conditions. This information and the relative cost associated with each risk category reflects the anticipated utilization of health care services relative to the overall population.

5.8.1.2.1. The relative costs will be developed using Louisiana specific historical data from Medicaid fee-for-service claims, Shared Savings claims, and MCO encounter data as determined appropriate.

5.8.1.3. Each MCO's proposed base capitation rates will be risk adjusted based on the MCO's risk score that reflects the expected health care expenditures associated with its enrolled members relative to the applicable total Medicaid population.

5.8.1.4. Risk adjustment scores will be updated following the full annual open process, which includes the period during which members can change MCOs without cause. The updated score will be effective for the month following the end of the process and reviewed semi-annually. Risk adjustment may be completed more than semi-annually if determined warranted by DHH.

5.8.1.5. DHH will provide the MCO with three (3) months advance notice of any major revision to the risk-adjustment methodology. The MCO will be given fourteen (14) calendar days to provide input on the proposed changes. DHH will consider the feedback from the MCOs in the changes to the risk adjustment methodology.

5.8.2. Other capitated payments shall not be risk-adjusted.

5.9. Medical Loss Ratio

5.9.1. In accordance with the MCO Financial Reporting Guide published by DHH, the MCO shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year.

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

5.9.1.1.1. If the aggregate MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the MCO shall refund DHH the difference. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher.

5.9.1.2. DHH may request MLR reporting that distinguishes physical and basic behavioral health from specialized behavioral health.

5.9.1.2.1. Neither the minimum MLR standard (85%) nor the refund applicable to the aggregate MLR shall apply to distinct MLRs reported.

5.10. Return of Funds

5.10.1. All amounts owed by the MCO to DHH, as identified through routine or investigative reviews of records or audits conducted by DHH or other state or federal agency, are due no later than thirty (30) calendar days following notification to the MCO 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. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher.

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

5.11. Other Payment Terms

5.11.1. The MCO shall make payments to its providers as stipulated in the contract.

5.11.2. The MCO shall not assign its right to receive payment to any other entity.

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

5.11.4. The MCO 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 MCO.

5.12. Cost Sharing

5.12.1. The MCO and its subcontractors are not required to impose any copay or cost sharing requirements on their members.

5.12.2. The MCO and its subcontractors may impose cost sharing on Medicaid members in accordance with 42 CFR §447.50 - §447.57 provided, however, that it does not exceed cost sharing amounts in the Louisiana Medicaid State Plan.

5.12.3. DHH reserves the right to amend cost sharing requirements

5.12.4. An MCO or its subcontractors may not:

5.12.4.1. Deny services to an individual who is eligible for services because of the individual's inability to pay the cost sharing;

5.12.4.2. Restrict its members' access to needed drugs and related pharmaceutical products by requiring that members use mail-order pharmacy providers; or

5.12.4.3. Impose copayments for the following:

- Family planning services and supplies;
- Emergency services;
- Aspirin 81mg: women ages 12-79 and men ages 45-79;
- Folic Acid 0.4 and 0.8mg: women ages 12-54;
- Vitamin D 400 IU: women and men ages 65 and older;
- Services provided to:
    - Individuals younger than 21 years old;
    - Pregnant women;
    - Individuals who are inpatients in long-term care facilities or other institutions;
    - Native Americans; and
    - Alaskan Eskimos
    - Enrollees of an Home and Community Based Waiver;
    - Women whose basis of Medicaid eligibility is Breast or Cervical Cancer; and
    - Enrollees receiving hospice services.

5.13. Third Party Liability (TPL)

5.13.1. General TPL Information

5.13.1.1. 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 (TPL) resources must meet their legal obligation to pay claims before the MCO pays for the care of an individual eligible for Medicaid.

5.13.1.2. The MCO shall take reasonable measures to determine TPL.

5.13.1.3. The MCO shall coordinate benefits in accordance with 42 CFR §433.135, et seq. and La. R.S. 46:460.71, so that costs for services otherwise payable by the MCO are cost avoided or recovered from a liable party. The two methods

used are cost avoidance and post-payment recovery. The MCO shall use these methods as described in federal and state law.

5.13.1.4. Establishing TPL takes place when the MCO receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or services delivered to a member.

5.13.1.5. If the probable existence of TPL cannot be established the MCO must adjudicate the claim. The MCO must then utilize post-payment recovery if TPL is later determined to exist which is described in further detail below.

5.13.1.6. The term "state" shall be interpreted to mean "MCO" for purposes of complying with the federal regulations referenced above. The MCO may utilize subcontractors to comply with coordination of benefit efforts for services provided pursuant to this contract.

5.13.1.7. For the eligible Medicaid population that is dually enrolled in Medicare, Medicaid-covered specialized behavioral health services that are not covered by Medicare shall be paid by the MCO. For dually eligible individuals, Medicare "crossover" claims (claims for services that are covered by Medicare as the primary payer) are excluded from coverage under the capitated rates. These services will be administered separately by the Fiscal Intermediary from the services covered under the capitation rates effective under this contract. In the event that a dually eligible individual's Medicare benefits have been exhausted as of the date of service on which a Medicare covered behavioral health service was provided, Medicaid will be considered primary. Claims for those services will no longer be considered "crossover" claims, and the MCO shall be responsible for payment. Specific payment mechanisms surrounding these populations shall be determined by DHH in the MCO Systems Companion Guide.

5.13.1.8. MCO must update its system with daily TPL records sent from LDH's Fiscal Intermediary (FI) within one (1) business day of receipt. MCO must reconcile its system with weekly TPL reconciliation files sent from LDH's FI within one (1) business day of receipt. If a P enrolled member is unable to access services or treatment until an update is made, the MCO must verify and update its system within four (4) business hours of receipt of an update request. P enrolled members are members enrolled with the MCO for Medical, Behavioral Health, Pharmacy and Transportation services.. This includes updates on coverage, including removal of coverage that existed prior to the members linkage to the MCO that impacts current provider adjudication or member service access (i.e. pharmacy awaiting TPL update to fulfill prescription). Such updates must be submitted to LDH Third Party Liability contractor on the Louisiana Department of Health Medicaid Recipient Insurance Information Update Form the same day the update is made in the MCO system.

5.13.1.9. Third Party Liability (TPL) Data Exchange

5.13.1.9.1. The MCO must:

- Receive, process and update TPL files sent by DHH or its contractor;

- Update its TPL databases within twenty-four (24) business hours of receipt of said files; and

- Transmit to DHH or its contractor in the formats and methods specified by DHH TPL files it or its TPL contractor discovers for each member that has not otherwise been provided by DHH or its contractor.

5.13.1.9.2. If a P enrolled member is unable to have a prescription filled or unable to access immediate care because of incorrect third party insurance coverage, the MCO must verify and update its system within four (4) business hours of receipt of an update request. P enrolled members are members enrolled with the MCO for Medical, Behavioral Health, Pharmacy and Transportation services. This includes updates on coverage, including removal of coverage that existed prior to the member's linkage to the MCO that impacts current provider adjudication or member service access. Such updates must be submitted to DHH Third Party Liability contractor on the Louisiana Department of Health Medicaid Recipient Insurance Information Update Form (found here: http://www.lamedicaid.com/ProvWeb1/ProviderTraining/Packets/2008ProviderTrainingMaterials/Recipient_Insurance_Update.pdf) the same day the update is effectuated in the MCO system.

5.13.2. Cost Avoidance and Pay and Chase

5.13.2.1. The MCO shall cost-avoid a claim if it establishes the probable existence of other health insurance at the time the claim is filed, except for the "pay and chase" claims identified in 5.13.2.2.

5.13.2.2. The MCO shall "pay and chase" the full amount allowed under the MCO payment schedule for the claim and then seek reimbursement from the TPL insurer (within sixty days after the end of the month in which the payment was made) for any liable TPL of legal liability if:

- The claim is for prenatal care for pregnant women as defined by HPA 16-17;

- The claim is for preventive pediatric services as defined by HPA 16-17; or

- The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency.

5.13.2.3. TPL Payment Calculation

If a TPL insurer requires the member to pay any co-payment, coinsurance or deductible, the MCO is responsible for making these payments under the

method described below, even if the services are provided outside of the MCO network.

Scenario 1 Professional Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
99212	55.00	0.00	24.10	36.00 (Ded)	24.10
83655-QW	30.00	0.00	11.37	28.20 (Ded)	11.37
Totals	85.00	0.00	35.47	64.20 (Ded)	35.47

The Medicaid allowed amount minus the TPL paid amount is LESS than the patient responsibility; therefore, the Medicaid allowed amount is the payment.)

Scenario 2 Outpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
HR270	99.25	74.44	22.04	0.00	0.00
HR450	316.25	137.19	70.24	100.00	0.00
Total	415.50	211.63	92.28	100.00	0.00

(Medicaid “zero pays” the claim. When cost-compared, the private insurance paid more than Medicaid allowed amount for the procedure. When compared, the lesser of the Medicaid allowed amount minus the TPL payment AND the patient responsibility is the former; thus, no further payment is made by Medicaid. The claim is paid in full.)

Scenario 3 Inpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
Multiple HR	12,253.00	2,450.00	5,052.00	300.00	300.00

(The Medicaid allowed amount minus the TPL payment is greater than the patient responsibility; thus, the patient responsibility is paid on this covered service.)

Scenario 4: FQHC/RHC/American Indian Clinic

Provider’s PPS Rate (Medicaid allowable)	Procedure Code	Billed Charge	TPL Paid Amount	Patient Responsibility Amount	Medicaid Payment
150.00	T1015	150.00	50.00	40.00 (Ded)	100.00

Provider’s PPS rate is $150.00. The third party paid $50.00. Medicaid pays the difference from the PPS rate and third party payment making the provider whole.

MCOs may not establish a cost-sharing payment methodology for members with third party liability for FQHC, RHC and American Indian Clinic services at less than

the Medicaid state plan rate (PPS). MCOs must pay the difference between the third party payment and the Medicaid state plan rate (PPS) for the service.

MCO payment = Medicaid PPS Rate - TPL paid amount

Scenario 5 Outpatient Pharmacy Claim

Amount Billed	TPL Paid Amount	Medicaid Maximum Allowable	Patient Responsibility Amount from Primary	Medicaid Pharmacy Co-Pay	Medicaid Payment
55.00	10.00	24.10	26.00 (Ded)	1.00	13.10
30.00	0.00	11.37	28.20 (Ded)	1.00	10.37
85.00	0.00	35.47	64.20 (Ded)	2.00	33.47

If third party liability (TPL) is involved, the MCO as the secondary payer may not deny the claim for a high dollar amount billed for claims less than $1,500. If the TPL pays $0.00 or denies the claim, then the pharmacy claims should be treated as a straight Medicaid pharmacy claim.
there is other third party liability (TPL) payment greater than $0.00, the MCO should electronically bypass prior authorization requirements and Point of Sale edits that would not be necessary as the secondary payer.

Scenario 6: LaHIPP member claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
99213	70.00	40.00	36.13	10.00	10.00

Because this is a LAHIPP recipient, Medicaid pays the co-pay even though the private insurance payment is more than the Medicaid allowable. Medicaid pays the patient responsibility on Medicaid covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.

5.13.3. Post-payment Recoveries

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

5.13.3.2. The MCO must:

- Initiate recovery of reimbursement within 60 days after the end of the month it learns of the existence of liable third parties after a claim is paid.

- Not perform post payment recoupments for TPL from providers for claims with dates of service (DOS) older than ten (10) months, except when the primary carrier is traditional Medicare, Tricare, or Champus.

- Allow providers sixty (60) days from the date stamp of the recovery letter to refute the recovery with a one-time thirty (30) day extension at the provider's request.

- Refer pay and chase claims directly to the liable third parties.

- Refer Point of Sale pharmacy (POS) claims directly to the carrier."

- Inform providers they should not send a refund check or initiate a void or adjustment request on post payment recovery claims; MCO shall initiate an automatic recoupment at the expiration of the 60 day time period if an extension request is not received from the provider and at the expiration of the 90 day time period if an extension is requested by the provider. The MCO must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the MCO must submit adjusted encounters for the claims.

- If the liable third party is traditional Medicare, Tricare or Champus VA, and more than 10 months have passed since the DOS, the MCO shall recover from the provider.

5.13.3.3. The MCO must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the MCO must submit adjusted encounters for the claims.

5.13.3.4. The MCO shall identify the existence of potential TPL to pay for core benefits and services through the use of trauma code edits in accordance with 42 CFR §433.138(e).

5.13.3.5. The MCO 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 are less than five hundred dollars ($500).

5.13.3.6. The amount of any recoveries collected by the MCO outside of the claims processing system shall be treated by the MCO as offsets to medical expenses for the purposes of reporting.

5.13.3.7. Prior to accepting a TPL settlement on accident/trauma-related claims equal to or greater than twenty-five thousand dollars ($25,000), the MCO shall obtain approval from DHH.

5.13.3.7.1. The MCO, upon receipt of a subpoena duces tecum, shall produce documents responsive to said subpoena by the date of return indicated therein (or shall contact the party who caused issuance of the subpoena, in order to request additional time to respond) if the production is authorized under La. R.S. 13:3715.1. Upon receipt of a request for records not sent via subpoena, the MCO shall release PHI

(private health information) or a response explaining why PHI cannot be released to the individual or entity making the request, within fifteen (15) calendar days of receipt of the request and a written authorization, as set forth in La. R.S. 40:1165.1 (A)(2)(c). The MCO is solely responsible for any sanctions and costs imposed by a court for competent jurisdiction for failure to comply with the requirements of La. R.S. 40:1165.1(A)(2)(c) or for failure to respond timely to a subpoena duces tecum. Additionally, DHH may impose sanctions against the MCO for failure to properly or timely respond to requests for PHI.

5.13.3.7.2. All records requests received by the MCO shall be investigated by the MCO (or its vendor) for possible TPL recoveries, resulting in issuance of a lien statement (or notice of lack thereof) to the requesting party, as provided for in La. R.S. 46:446.

5.13.3.8. When the MCO has actual knowledge that an insurer or other risk bearing entity of one of its members has filed for bankruptcy and the provider files a claim for reimbursement with the MCO with dates of service prior to the date the an insurer or other risk bearing entity filed bankruptcy, the MCO must reimburse the provider with Medicaid as the primary insurer, only if the member was enrolled with the MCO at the time the service was provided and for which the provider has not been paid. The MCO would need to seek reimbursement as a creditor in the bankruptcy proceedings or from a liable third party. If the provider files a claim for reimbursement with the MCO with dates of service after the date the insurer or other risk bearing entity filed for Chapter 11 bankruptcy, the insurer or other risk bearing entity would continue to be the primary insurer. If the provider files a claim for reimbursement with the MCO with dates of service after the date the insurer or other risk bearing entity filed for Chapter 7 bankruptcy, Medicaid will be the primary insurer.

5.13.4. Distribution of TPL Recoveries

5.13.4.1. The MCO may retain up to 100% of its TPL collections if all of the following conditions exist:

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

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

5.13.4.1.3. Such recovery is not prohibited by state or federal law; and

5.13.4.1.4. DHH will utilize the data in calculating future capitation rates.

5.13.5. TPL Reporting Requirements

5.13.5.1. The MCO shall provide DHH TPL 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.

5.13.5.2. The MCO shall be required to include the collections and claims information in the encounter data submitted to DHH, including any retrospective findings via encounter adjustments.

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

5.13.5.4. Upon the request of DHH, the MCO shall demonstrate that reasonable effort has been made to seek, collect and/or report TPL 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.

5.13.5.5. The MCO is required to 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.

5.13.6. DHH Right to Conduct Identification and Pursuit of TPL

5.13.6.1. DHH may invoke its right to pursue recovery if the MCO fails to recover reimbursement from the third party to the limit of legal liability within three hundred sixty-five (365) days from date of service of the claims(s).

5.13.6.2. If DHH determines that the MCO is not actively engaged in cost avoidance activities the MCO shall be subject to monetary penalties in an amount not less than three times the amount that could have been cost avoided.

5.14. Coordination of Benefits

5.14.1. Other Coverage Information

The MCO shall provide TPL information it or its contractor discovers for each member that is not included in the weekly reconciliation files received from LDH's FI. The MCO shall submit a daily file reporting additions and updates of TPL information in a format and medium specified by LDH. The MCO shall review daily response files from LDH's FI and correct and resubmit rejected records until the record is correctly reported on weekly TPL reconciliation files received from LDH's FI.

5.14.2. Reporting and Tracking

The MCO'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.

5.15. Financial Disclosures for Pharmacy Services

The MCO must disclose all financial terms and arrangements for remuneration of any kind that apply between the MCO or the MCO's PBM subcontractor and any

prescription drug wholesaler, manufacturer or labeler, including, without limitation, formulary management, educational support, claims processing, pharmacy network fees, drug product sales or pricing agreements, data sales fees, and any other fees. Section 16 of this contract provides that DHH or state auditors may audit such information at any time. DHH agrees to maintain the confidentiality of information disclosed by the MCO pursuant to the contract, to the extent that such information is confidential under Louisiana or federal law.

5.16. Health Insurance Provider Fee (HIPF) Reimbursement

If the MCO is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee ("Annual Fee") whose final calculation includes an applicable portion of the MCO's net premiums written from DHH's Medicaid/CHIP lines of business, DHH shall, upon the MCO satisfying completion of the requirements below, make an annual payment to the MCO in each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by DHH (and its contracted actuary) as an adjustment to each MCO's capitation rates, in accordance with the MCO Financial Reporting Guide, for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.

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

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

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

5.16.1.3. If the MCO's Louisiana-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, provide with its Form 8963 a supplemental delineation of Louisiana-specific Medicaid/CHIP premium revenue that was listed on the MCO's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the MCO pursuant to this Contract) was determined. The MCO will indicate for DHH the portion of the Louisiana-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, if applicable, beginning with Data Year 2014.

5.16.1.3.1. The MCO shall also submit a certification regarding the supplemental delineation consistent with 42 CFR 438.604 and 42 CFR 438.606.

5.16.1.3.2. If a portion of the Louisiana-specific Medicaid/CHIP premiums were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, the MCO shall submit the calculations and methodology for the amount excluded.

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

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

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

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

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

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

5.16.5. The MCO shall advise DHH if payment of the final fee payment is less than the amount invoiced by the IRS.

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

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

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

The obligation outlined in this section shall survive the termination of the contract

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

5.17.1. The CSoC Contractor shall be responsible for payment to enrolled providers for the provision of specialized behavioral health services, with the exception of Psychiatric Residential Treatment Facility, Therapeutic Group Home, and SUD Residential treatment services (ASAM Levels III.1, III.2D, III.5 and III.7 for children under 21 and Levels III.3 and III.7D for youth aged 21), for each month during which the recipient has a 1915(c) / 1915(b)(3) segment on the eligibility file with a begin date on or earlier than the first day of that month, or in the event that a recipient transfers between waivers during the month, but the previous segment began on or earlier than the first day of that month.

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

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

5.17.4. The MCO shall be responsible for payment of all PRTF, TGH, and SUD Residential treatment services (ASAM Levels III.1, III.2D, III.5 and III.7 for children under 21 and Levels III.3 and III.7D for youth aged 21) for CSoC enrolled youth.

INTENTIONALLY LEFT BLANK

6.0 CORE BENEFITS AND SERVICES

6.1. General Provisions

6.1.1. The MCO shall have available for members, at a minimum, those core benefits and services and any other services specified in the Contract and as defined in the Louisiana Medicaid State Plan, administrative rules and DHH policy and procedure manuals. The MCO shall possess the expertise and resources to ensure the delivery of quality health care services to MCO members in accordance with Louisiana Medicaid program standards and the prevailing medical community and national standards.

6.1.2. The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services, including but not limited to non-emergent use of hospital Emergency Departments. 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 eligibles under fee-for-service Medicaid, as specified in 42 CFR §438.210(a). Upward variances of amount, duration and scope of these services are allowed.

6.1.3. Although the MCO shall provide the full range of required core benefits and services listed below in Section 6.1.4, they may choose to provide value-added benefits and services as described in 6.26 and cost-effective alternative services as described in 6.27.~~over and above those specified when it is cost effective to do so or in the best medical interest of their members. The MCO may offer additional benefits that are outside the scope of core 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. The following departmental priorities may be addressed through value-added services:~~

- ~~Reduction in Emergency Department (ED) use for non-emergent care through increased access to after-hours care, same-day appointments, data sharing with physicians or hospitals, member education, and/or other interventions identified by the proposer.~~
- ~~Improved birth outcomes through prenatal, postnatal, and inter-pregnancy care, reduction in early elective deliveries and Cesarean sections, promotion of vaginal birth after Cesarean section (VBAC), and/or other interventions identified by the proposer.~~
- ~~Improved access to long-acting reversible contraceptives.~~
- ~~Reduction in childhood obesity through partnerships with pediatricians, education providers, or nutrition specialists, and/or other interventions identified by the proposer.~~
- ~~Reduction in health disparities among racial groups in the areas of birth weight, sexually transmitted infections (STIs), and other conditions identified by the proposer through increased access to primary care and/or other interventions identified by the proposer.~~

- ~~Improved screening for and plans for treatment of communicable diseases including HIV, syphilis and Hepatitis C in appropriate populations.~~

- ~~Improved outcomes for adult members with sickle cell disease including payment for sickle cell day hospitals or pain management clinics and/or other interventions identified by the proposer.~~

- ~~Dental care, eye glasses, and/or vaccinations for adults.~~

- ~~Use of behavioral health peer operated warmlines and use of peer support specialist.~~

~~**6.1.3.1.** Examples of value-added benefits include but are not limited to:~~

- ~~Medical services not included in the Louisiana Medicaid State Plan or approved Medicaid Waiver;~~

- ~~Medical services that are beyond the amount, duration and scope in the Louisiana Medicaid State Plan to members, and the actuarial value of the services provided; or~~

- ~~Health, safety, or hygiene related member incentives for accessing preventive services or participate in programs to enhance their general health and well-being.~~

- ~~Value-added services are not Medicaid-funded and, as such, are not subject to appeal and fair hearing rights. A denial of these services will not be considered an action for purposes of grievances and appeals. The MCO shall send the member a notification letter if a value-added service is not approved.~~

~~**6.1.3.2.** The proposed monetary value of these benefits will be considered a binding contract deliverable. If for some reason, including but not limited to lack of member participation, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.~~

6.1.4. The MCO shall provide core benefits and services to Medicaid members. The core benefits and services that shall be provided to members are:

- Audiology Services
- Inpatient Hospital Services
- Outpatient Hospital Services
- Ambulatory Surgical Services
- Ancillary Medical Services
- Lab and X-ray Services
- Surgical Dental Services
- Diagnostic Services

- Organ Transplant and Related Services
- Family Planning Services (not applicable to MCO operating under Section 2.4 of this RFP)
- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (excluding Applied Behavior Analysis (ABA) and dental services)
- Emergency Medical Services
- Communicable Disease Services
- Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies
- Emergency Dental Services
- Emergency and Non-Emergency Medical Transportation
- Home Health Services
- Personal Care Services (Age 0-20)
- Hospice Services
- Basic Behavioral Health Services
- Specialized Behavioral Health Services including rehabilitative and Licensed Mental Health Professional Services (including Advanced Practice Registered Nurse (APRN) services)
- Clinic Services
- Physician Services
- Pregnancy-Related Services
- Nurse Midwife Services
- Pediatric and Family Nurse Practitioner Services
- Advance Practice Registered Nursing Services
- Chiropractic Services (Age 0-20)
- Federally Qualified Health Center (FQHC) Services
- Rural Health Clinic Services
- Immunizations (Children and Adults)
- End Stage Renal Disease Services
- Home Health-Extended Services (Age 0-20)
- Optometrist Services (Age 21 & Older, non-EPSDT)
- Personal Care Services (Age 0-20)
- Podiatry Services
- Therapy Services (Physical, Occupational, Speech)
- Respiratory Services
- Pharmacy Services (Outpatient prescription medicines dispensed).
- Pediatric Day Healthcare Services

- Applied Behavior Analysis
- Other benefits and services in the Alternative Benefit Plan approved by CMS.

6.1.5. The MCO 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.

6.1.6. The MCO 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.

6.1.7. The MCO may place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity or best practices; ~~or~~ (b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose; (c) for the purpose of utilization control, provided the services support members with ongoing or chronic conditions in a manner that reflects the member's ongoing need for such services and supports; or (d) provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.

6.1.8. The MCO may exceed the service limits as specified in the Louisiana Medicaid State Plan provided those service limits can be exceeded, with authorization, in fee-for-service. No medical service limitation can be more restrictive than those that currently exist under the Louisiana Medicaid State Plan including quantitative and non-quantitative treatment limits.

6.1.9. The MCO shall cover medically necessary services that address:

6.1.9.1. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability;

6.1.9.2. The ability for an member to achieve age-appropriate growth and development; and

6.1.9.3. The ability for member to attain, maintain, or regain functional capacity.

~~**6.1.9.**~~**6.1.10.** The MCO may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care.

~~**6.1.9.1.**~~**6.1.10.1.** See definition of "medically necessary services" in the Glossary. The Medicaid Director in consultation with the Medicaid Medical Director and Medicaid Behavioral Health Medical Director will make the final interpretation of any disputes about the medical necessity and continuation of core benefits and services under this RFP based on whether or not the Medicaid fee-for-service program would have provided the service.

~~**6.1.10.**~~**6.1.11.** The MCO shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes but is not limited to prenatal care, delivery, postpartum care, and family planning services for pregnant women in accordance with 42 CFR Part 440, Subpart B.

6.1.12. The MCO may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR Part 438, Subpart K.

~~6.1.11.~~**6.1.13.** The MCO shall not portray core benefits or services as a~~n expanded health~~ value-added benefit or service.

~~6.1.12.~~**6.1.14.** Responsibilities with respect to *Chisholm vs. Kliebert* class

The MCO must maintain an outreach and referral system to direct class members with an Autism Spectrum Disorder diagnosis to qualified healthcare professionals, who can provide Comprehensive Diagnostic Evaluations required to establish medical necessity for Applied Behavior Analysis services.

In addition, the court settlement applies to and ensures necessary psychological and behavioral services described in 42 U.S.C. § 1396d(a), including diagnostic services and treatment, to correct or ameliorate defects and physical and mental illnesses and conditions must be provided by the state to those members of the *Chisholm* class, who meet the criteria listed in the stipulation.

6.2. Eye Care and Vision Services

The MCO shall provide coverage of vision services that are performed by a licensed ophthalmologist or optometrist, conform to accepted methods of screening, diagnosis and treatment of eye ailments or visual impairments/conditions for members. Medicaid covered eye wear services provided by opticians are available to enrollees who are under the age of 21. The MCO shall not require a referral for in-network providers. The MCO's requirements for provision and authorization of services within the scope of licensure for optometrists cannot be more stringent than those requirements for participating ophthalmologists.

6.3. Pharmacy Services

6.3.1. Covered Services

6.3.1.1. According to 42 CFR §438.3, the MCO must cover all outpatient drugs where the manufacturer has entered into the Federal rebate agreement and meet the standards in Section 1927 of the Social Security Act. The MCO may manage coverage and utilization of drugs through the formation of a Preferred Drug List (PDL), excluding the Common PDL. Procedures used to manage utilization may include, but are not limited to, prior authorization, utilization edits and clinical edits. Self-administered drugs dispensed by a pharmacy, including specialty pharmacies, shall be covered as a pharmacy benefit unless otherwise approved by DHH Pharmacy staff. Physician administered drugs that are not listed on the FFS fee schedule but the manufacturer has signed the federal rebate agreement, should be covered as a pharmacy benefit. Prior authorization and/or other safety edits are allowed on physician administered drugs.

6.3.1.2. The MCO shall provide coverage for all drugs deemed medically necessary for members under the age of twenty-one (21).

6.3.1.3. The MCO is not required to follow the LDH monthly prescription limits. However, it may not enact prescription quantity limits more stringent than the Medicaid State Plan. If prescription limits are adopted, the MCO monthly prescription limits must have Point of Sale (POS) override capabilities when a greater number of prescriptions per month are determined to be medically necessary by the prescriber. MCO monthly prescription limits must have Point of Sale (POS) override capabilities when a greater quantity is determined to be medically necessary by the prescriber and MCO.

6.3.1.4. The "Covered Drug List" is all drugs included in the federal rebate agreement. A subset of the Covered Drug List shall be the "Preferred Drug List (PDL)" listing all preferred agents. The "Common PDL" (list of drugs common to all MCOs without prior authorization) shall be maintained and updated upon DHH request, as well as posted.

6.3.2. Covered Drug List

The Covered Drug List shall include all outpatient drugs where the manufacturer has entered into the Federal rebate agreement and met the standards in Section 1927 of the Social Security Act.

6.3.2.1. The MCO shall expand its Covered Drug List, as needed, to include newly FDA-approved drugs subject to Section 1927(d) of the Social Security Act, which are deemed to be appropriate, safe, and efficacious in the medical management of members.

6.3.2.2. The Covered Drug List may only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the MCO may include in its Covered Drug List any FDA approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition.

6.3.2.3. The Formulary shall be reviewed in its entirety and updated at least semi-annually and upon DHH request.

6.3.2.4. Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.

6.3.2.5. The MCO Covered Drug list should be updated at least weekly from a national drug database.

6.3.3. Preferred Drug List

6.3.3.1. The PDL is a subset of drug products on the Covered Drug List, and an up-to-date version shall be available to all providers and members through the MCO web site and electronic prescribing tools. The PDL must be available in electronic format and easily searchable by brand or generic name. The PDL should also be available in a searchable PDF file document listed by therapeutic classes. Any edits on preferred products such as quantity limits, step therapy, or prior authorization should be noted on the PDF file document.

6.3.3.2. Drugs that are on the Covered Drug List, but not on the PDL must be available to members through a prior authorization process. Pharmacy prior authorizations must be resolved (approved or denied) within 24 hours of the request, seven (7) days a week. A 72 hour supply of the requested medication must be available to recipients in emergency situations.

6.3.3.3. The PDL shall be reviewed by the MCO in its entirety and updated at least annually and upon DHH request but no more frequently than quarterly with 60 days' notice.

6.3.3.4. The MCO shall limit negative changes to the PDL (e.g., remove a drug, impose step therapy, etc.) to four times a year, unless urgent circumstances require more timely action, such as drug manufacturer's removal of a drug from the market due to patient safety concerns. The addition of a newly approved generic and removal of the brand equivalent does not constitute a negative PDL change.

6.3.3.5. The PDL and any revision thereto, shall be reviewed and approved by DHH prior to implementation. Any changes to the PDL, including but not limited to any/all prior authorization, fail first, step therapy requirements or prescription quantity limits, shall be submitted to DHH at least 30 days prior to implementation. The MCO shall not replace an approved preferred drug on the PDL without prior approval of DHH.

6.3.3.6. The selection of drugs included on the PDL shall be sufficient to ensure enough provider choice and include FDA approved drugs to serve the medical needs of all enrollees, including those with special needs.

6.3.3.7. The MCO shall have at least two "preferred" oral behavioral health drugs in each therapeutic class available at a retail pharmacy without prior authorization.

6.3.3.8. The MCO shall have at least two "preferred" drugs in each therapeutic class and at least one injectable drug in each class that has an injectable product for behavioral health drugs.

6.3.3.9. Common PDL

The "Common PDL" (list of drugs common to all MCOs without prior authorization) shall be maintained and updated upon DHH request.

6.3.3.9.1. A separate "Common PDL" document should be posted with the other PDL documents.

6.3.3.9.2. The Common PDL should be reviewed at least annually and upon DHH request.

6.3.4. Prior Authorization for Pharmacy Benefits

6.3.4.1. Prior authorization must comply with 42 CFR § 438.3(s)(6) and may be used for drug products only under the following conditions:

6.3.4.1.1. When prescribed drugs included in the federal rebate program have clinical criteria;

6.3.4.1.2. To determine when prescribed drugs are medically necessary;

6.3.4.1.3. When prescribed drugs are inconsistent with FDA-approved labeling, including behavioral health drugs or when prescribed drugs are inconsistent with nationally accepted guidelines;

6.3.4.1.4. When prescribed brand name medications has an A-rated generic equivalents. The MCO can encourage a prescriber to complete the FDA Medwatch form, but this should not be required or considered in the approval/denial determination process. If the drug has a narrow therapeutic index and the prior authorization for the brand drug is denied, then DHH pharmacy staff must be notified within 24 hours or the next working day of the denial. All details of the claim and prior authorization must be included. (All drugs listed in the Common PDL are exempt from PA requirements);

6.3.4.1.5. To minimize potential drug over-utilization;

6.3.4.1.6. To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy; and/or

6.3.4.1.7. Under other conditions with DHH Pharmacy approval.

6.3.4.1.8. Prior authorization shall not require more than two failures of preferred products.

6.3.4.2. The MCO shall override prior authorization for selected drug products or devices at DHH's discretion.

6.3.4.3. The MCO shall not require prior authorization for a dosage change for any medications (including long-acting injectable antipsychotics) and other medication assisted treatment (including dosages of buprenorphine or buprenorphine/naloxone) that have been previously authorized and/or approved by the MCO, as long as the newly prescribed dose is within established FDA guidelines for that medication.

6.3.4.4. The MCO must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber.

6.3.4.5. The MCO must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests by phone, fax or automated process. If the MCO or its pharmacy benefit manager operates a separate call center for prior authorization requests, it will be subject to the provider call center standards set forth in Section 12 of this Contract and monetary penalties set forth in Section 20 of this Contract.

6.3.4.6. The MCO shall not penalize the prescriber or member, financially or otherwise, for prior authorization requests or other inquiries regarding prescribed medications.

6.3.4.7. Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and member in writing.

6.3.4.8. A member receiving a prescription drug that was on the MCO's PDL and subsequently removed or changed, shall be permitted to continue to receive that prescription drug if determined to be medically necessary for at least sixty (60) days. Medical necessity must be determined in consultation with the prescriber.

6.3.4.9. If a pharmacy prior authorization is under review, the MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable but the MCO is only required to pay one dispensing fee. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.

6.3.4.10. Pharmacy prior authorization denials may be appealed in accordance with Section 13 of this Contract.

6.3.4.11. Step Therapy and/or Fail First Protocols

The MCO may implement step therapy or fail first protocols to drive utilization toward the most efficacious, cost-effective and safest drug therapy. These protocols may be applied to either individual drugs or classes of drugs. However, the MCO must provide a clear process for a provider to request an override of such restrictions. An override shall meet the requirements of R.S. 46:460.34.

6.3.4.11.1. Step therapy and/or fail first protocols shall not require more than two failures of preferred products.

6.3.4.12. Submission and Publication of the Covered Drug List, PDL, and Common PDL

6.3.4.12.1. The MCO shall publish and make available to members and providers upon request a hard copy of the most current Covered Drug List, PDL and Common PDL. All of the above documents shall be posted together on the MCO web page. Updates to the PDL shall be made available to the provider and DHH thirty (30) days before the effective date of the change.

6.3.4.12.2. The MCO shall submit an electronic version of its PDL to DHH at least quarterly within 30 days of the P&T meeting and 30 days prior to implementation of any changes. The PDL must be provided in a format approved by DHH.

6.3.5. Pharmaceutical and Therapeutics (P&T) Committee

6.3.5.1. The MCO shall establish a Pharmaceutical and Therapeutics (P&T) Committee, or similar entity, for the development of the PDL. The Committee shall represent the needs of all its members including enrollees with special needs. Louisiana network physicians, pharmacists, and specialists, including but not limited to a behavioral health specialist, shall have the opportunity to participate in the development of prior authorization criteria and clinical drug policies. The P&T Committee shall consist of at least six members including 3 non-employee Louisiana providers (either Physicians or Pharmacists) that are not employees of the MCO or PBM. The MCO Medical Director and MCO Behavioral Health Medical Director should participate in all P&T meetings. Changes to prior authorization criteria, clinical drug policies, or PDL, must be submitted to DHH for approval at least 30 days prior to implementation. DHH will consider and comment on proposed changes.

6.3.5.2. The P&T committee shall meet at least quarterly in Baton Rouge, Louisiana to consider products in categories recommended for consideration for inclusion/exclusion on the MCO's PDL. The P&T Committee shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product.

6.3.5.3. The MCO shall develop policies governing the conduct of P&T committee meetings, including procedures by which it makes its PDL recommendations. P&T Committee meetings shall be open to the public and shall allow for public comment prior to voting by the committee on any change in the preferred drug list. The MCO must keep written minutes of the P&T committee meetings. The MCO shall not prohibit any member of the public from attending the P&T committee meetings.

6.3.5.4. The MCO shall notify the Department when the P&T committee meeting has been scheduled. Official public notification of the P&T meeting shall be made on the MCO provider website and through other applicable avenues such as provider training and/or newsletters. The committee shall include a nonvoting representative from DHH that is provided all documents received by committee members.

6.3.6. Behavioral Health Specific Pharmacy Policies and Procedures

The MCO shall develop DHH approved policies and procedures that meet or exceed the following requirements:

6.3.6.1. The MCO or its subcontractor(s) shall contract with the psychiatric facilities and residential substance use facilities so that the plans are notified upon patient admission and upon patient planned discharge from the psychiatric facility or residential substance use facilities. Prior to discharge the MCO shall be informed of the recipient's discharge medications. The MCO will then be responsible to override or allow all behavioral health discharge medications to be dispensed by overriding prior authorization restrictions for a ninety (90) day period. This includes, but is not limited to, naloxone, Suboxone, and long-acting injectable anti-psychotics.

If the MCO is not notified prior to the discharged and the member presents at the pharmacy with a medication issued at the time of discharge, the MCO will provide a prior authorization override for a ninety (90) day period from the date of discharge as long as the member presents the prescription within ninety (90) days of being discharged from a psychiatric and/or residential substance use facility.

6.3.6.2. The MCO shall have a specific Suboxone, Subutex and methadone management program and approach, which shall be approved by DHH. The policy and procedure must be in accordance with current state and federal statutes in collaboration with the State Opioid Treatment Authority/DHH. The MCO shall submit the policy for DHH approval no later than January 1, 2016.

6.3.6.3. The MCO shall have a DHH approved pharmacy management program and approach to stimulant prescribing for children under age 6, and persons age 18 or older.

6.3.6.4. The MCO shall have a DHH approved program and approach for the prescribing of antipsychotic medications to persons under 18 years of age.

6.3.6.5. The MCO shall use encounter, beneficiary, and prescription data to compare Medicaid physician, medical psychologist or psychiatric specialist APRN's prescribing practices to nationally recognized, standardized guidelines, including but not limited to, American Psychiatric Association Guidelines, American Academy of Pediatrics Guidelines, American Academy of Child, and Adolescent Psychiatry Practice Parameters.

6.3.6.6. Prescription Monitoring Program. The MCO shall require network prescribers to utilize and conduct patient specific queries in the Prescription Monitoring Program (PMP) for behavioral health patients upon writing the first prescription for a controlled substance, then annually. The physician shall print the PMP query and file it as part of the recipient's record. The MCO shall conduct sample audits to verify compliance. Additional PMP queries should be encouraged to be conducted at the prescriber's discretion.

6.3.7. Drug Utilization Review (DUR) Program

The MCO shall maintain a DUR program to assure that outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results in accordance with Section 1927(g) of SSA. DUR (prospective, retrospective and educational) standards established by the MCO shall be consistent with those same standards established by DHH.

6.3.7.1. The MCO shall include review of Mental Health/Substance Abuse (MH/SA) drugs in its prospective, retrospective and educational DUR program.

6.3.7.2. DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud and abuse, and take into consideration both the quality and cost of the pharmacy benefit.

6.3.7.3. The MCO shall provide for a DUR program that contains the following components:

• Prospective DUR program

• Retrospective DUR program

• Educational DUR program

6.3.7.3.1. Prospective DUR Program

6.3.7.3.1.1. The MCO shall provide for a review of drug therapy at Point of Sale (POS) before each prescription is given to the recipient. Screening should be performed for potential drug problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, duration of therapy, and clinical misuse. The following parameters should be screened at POS. Inappropriate therapy should trigger edits and each edit should have its own separate denial code and description including, but not limited to: early refill, duration of therapy, therapeutic duplication, pregnancy precaution, quantity limit (excluding opioids), quantity limit for long-acting opioids, quantity limit for short-acting opioids, diagnosis code required on selected agents, drug interactions, age limit, and dose limits. Reporting capabilities shall exist for these denial codes. The MCOs will need to report data on edits to the Department on a semi-annual basis prior to the submission date requirement of the DUR Annual Report.

6.3.7.3.1.2. Pharmacy claims processing shall be capable of capturing diagnosis codes at the POS and utilizing codes in the adjudication process at POS. Denial of pharmacy claims could be triggered by an inappropriate diagnosis code or the absence of a diagnosis code.

6.3.7.3.1.3. The MCO should assure the pharmacist offers to counsel the patient or caregiver. A log of receipt of prescription and the offer to counsel by the pharmacist shall be incorporated into MCO policy.

6.3.7.3.2. Retrospective DUR Program

6.3.7.3.2.1. The MCO shall provide for the ongoing periodic examination of claims data to identify patterns of gross overuse, abuse, potential fraud, and inappropriate or medically unnecessary care among prescribers, pharmacists, or recipients.

6.3.7.3.2.2. Claims review must be assessed against predetermined standards while monitoring for therapeutic appropriateness. Prescribers and pharmacists should be contacted via an electronic portal or other electronic means if possible. Facsimile and mail will suffice in some instances. At a minimum, the MCO shall incorporate all of DHH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by DHH pharmacy.

6.3.7.3.3. Educational DUR Program

6.3.7.3.3.1. The MCO shall provide active and ongoing educational outreach programs to educate and inform prescribers and pharmacists on common drug therapy programs with the aim of improving prescribing and/or dispensing practices. The frequency of patterns of abuse and gross overutilization or inappropriate or unnecessary care among prescribers, pharmacists and recipients should be identified.

6.3.7.3.3.2. MCOs should educate prescribers, pharmacists and recipients on therapeutic appropriateness when overutilization or underutilization occurs. DHH expects the MCOs to use current clinical guidelines and national recommendations to alert prescribers and pharmacists of pertinent clinical data. Clinical outcomes shall be monitored by the MCO and reported to DHH on a periodic basis established by the Department.

6.3.7.4. DHH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. At a minimum, the DUR program must include all DHH DUR initiatives and submit new initiatives to DHH for prior approval at least forty-five (45) days in advance of the proposed effective date.

6.3.7.5. The MCO must provide a detailed description of its DUR program annually to DHH to mimic the FFS DUR annual report to CMS. The annual report shall ensure the requirements of 1927(g) of the Act are being met by the MCO DUR program. The annual report to the state will be due 4 months preceding the CMS deadline.

6.3.7.6. The MCOs shall recommend one Louisiana MCO Medical Director and one Louisiana MCO Pharmacy director to represent all Louisiana MCOs as voting members on the Medicaid DUR Board. The MCO representatives may not be employed by the same MCO plan.

6.4. Behavioral Health Services

6.4.1. For the purposes of this RFP, behavioral health services are divided into two levels: basic and specialized.

6.4.1.1. Basic behavioral health services shall include, but are not limited to, screening, prevention, early intervention, medication management, treatment and referral services provided in the primary care setting and as defined in the Medicaid State Plan. Basic behavioral health services may further be defined as those provided in the member's PCP or medical office by the member's (non-specialist) physician (i.e., DO, MD, APRN) as part of routine physician evaluation and management activities. These services shall be covered by the MCO for members with both physical health and behavioral health coverage.

6.4.1.2. Specialized behavioral health services shall include, but are not limited to services specifically defined in the Medicaid State Plan. Specialized behavioral health services shall also include any other behavioral health service subsequently amended into the Medicaid state plan or waivers. Effective December 1, 2015, these services are covered by the MCO for all covered populations except for specialized behavioral health services covered by the Coordinated System of Care contractor for youth enrolled with the CSoC contractor as per 5.17.

6.4.2. The MCO shall screen members to determine level of need for the purpose of service authorization based on medical necessity. Based on this medical necessity determination, the MCO shall authorize Medicaid State Plan services as appropriate.

6.4.3. Services shall be managed to promote utilization of best, evidence-based and informed practices and to improve access and deliver efficient, high quality services.

6.4.4. Specialized Behavioral Health Covered Services:

- Psychiatrist (all ages)
- Licensed Mental Health Professionals (LMHP)
  - Medical Psychologists
  - Licensed Psychologists
  - Licensed Clinical Social Workers (LCSW)
  - Licensed Professional Counselors (LPC)
  - Licensed Marriage and Family therapists (LMFT)
  - Licensed Addiction Counselors (LAC)
  - Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & mental Health, Family Psychiatric & Mental health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric & Mental Health, Child Adolescent Mental Health)
- Mental Health Rehabilitation Services
  - Community Psychiatric Support and Treatment (CPST)
  - Community Psychiatric Support and Treatment (CPST), specialized for high-risk populations. This includes:
    - Multi-Systemic Therapy (MST) (under age 21)
    - Functional Family Therapy (FFT) (under age 21)
    - Homebuilders (under age 21)
    - Assertive Community Treatment (limited to 18 years and older)
  - Psychosocial Rehabilitation (PSR)
  - Crisis Intervention

- Therapeutic Group Homes (under age 21): Therapeutic Group Homes have a non-Medicaid funded room and board component that must be addressed prior to placement.
- Crisis Stabilization (under age 21)

- Psychiatric Residential Treatment Facilities (under age 21)
- Inpatient hospitalization (age 21 and under; 65 and older) for Behavioral Health Services
- Outpatient and Residential Substance Use Disorder Services in accordance with the American Society of Addiction Medicine (ASAM) levels of care
- Screening for services, including the Coordinated System of Care, may take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care. ~~Screening may also take~~The MCO shall ensure (either using MCO care management protocols or by ensuring appropriate, proactive discharge planning by MCO contracted providers) the screening takes place while a youth resides in an out-of-home level of care (such as inpatient, PRTF, SUD residential treatment or TGH) and is prepared~~ing~~ for discharge to a home and community-based setting. ~~Screening~~For settings such as PRTF and TGH with lengths of stay allowing sufficient time for comprehensive and deliberate discharge and aftercare planning, the MCO shall ensure that screening for CSoC takes place at least 30 days and up to 90 days prior to the anticipated discharge date. If CSoC screening shows appropriateness, referral to CSoC~~,~~ up to 90 days prior to discharge from a residential setting ~~is encouraged~~shall occur, as it is expected to assist in comprehensive discharge and treatment planning, prevent disruption, and improve stabilization upon reentry to a home and community environment.
- Pending CMS approval for the coverage of Methadone to treat opiate addiction, the MCOs shall contract with the Opioid Treatment Programs (OTP) for the administration of Methadone and clinical treatment services for members in accordance with state and federal regulations. These services may also be provided via an in lieu of service for other members at the discretion of the MCOs.

6.4.5. Permanent Supportive Housing

6.4.5.1. DHH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Bayou Health members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH http://new.dhh.louisiana.gov/index.cfm/page/1732/n/388. Overall management of the PSH program is centralized within DHH and final approval for members to participate in PSH is made by the DHH PSH program staff. For the Louisiana PSH program, the MCO shall:

6.4.5.1.1. Provide outreach to qualified members with a potential need for PSH;

6.4.5.1.2. Assist members in completing the PSH program application;

6.4.5.1.3. Within one (1) working day of request by designated DHH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;

6.4.5.1.4. Assure timely prior authorization for PSH tenancy and pre-tenancy supports as applicable;

6.4.5.1.5. Assure timely provider referral for members who are approved by DHH for PSH program participation and are authorized for tenancy or pre-tenancy supports;

6.4.5.1.6. Assure PSH tenancy supports are delivered in a timely and effective manner in accordance with an appropriate plan of care;

6.4.5.1.7. Respond to service problems identified by PSH program management, including but not limited to those that place a member's/tenant's housing or PSH services at risk;

6.4.5.1.8. Report on PSH outreach monthly and quarterly using a format to be provided by the DHH PSH program manager; and

6.4.5.1.9. Work with PSH program management to assure an optimal network of qualified service providers trained by the DHH PSH program staff or designee to provide tenancy supports across disability groups and certified to deliver services as defined in the PSH Provider Certification Requirements.

6.4.5.2. To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:

6.4.5.2.1. Identify a PSH program liaison, to be approved by DHH, to work with DHH PSH program staff to assure effective performance of MCO responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise.

6.4.5.2.2. Assist with statewide targeted outreach to members/households who could benefit from PSH, including those members least likely to apply. The MCO shall assure participation of MCO staff appropriate and sufficient for effective representation on DHH-convened PSH outreach committee(s).

6.4.5.2.3. Develop for approval by DHH PSH program staff all required and/or requested written policies and procedures necessary to implement the PSH-related requirements of this RFP. Initial versions of PSH policies and procedures shall be submitted prior to readiness review. PSH program staff will work with the MCO to assure consistent policies and procedures across Bayou Health plans.

6.4.6. Criteria for screening protocols and determining whether an individual meets the criteria for specialized behavioral health services may be determined by DHH and are based on factors relating to age, diagnosis, disability (acuity) and duration of the behavioral health condition.

6.4.7. In recognizing that at least 70 percent of behavioral health can be and is treated in the PCP setting, the MCO shall be responsible for the management and provision of all basic behavioral health services including but not limited to those with mild, moderate depression, ADHD, generalized anxiety, etc. that can be appropriately screened, diagnosed or treated in a primary care setting. MCO support shall include but not be limited to assistance which will align their practices with best practice standards, such as those developed by the American Academy of Pediatrics, for the assessment, diagnosis, and treatment of ADHD, such as increasing the accuracy of ADHD diagnosis, increasing screening for other behavioral health concerns, and increasing the use of behavioral therapy as first-line treatment for children under age 6.

6.4.8. The MCO is responsible for the provision of screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (The EPSDT benefit guarantees coverage of "screening services" which must, at a minimum, include "a comprehensive health and developmental history – including assessment of both physical and mental health.) Section 1905(r)(1)(B)(i) of the Social Security Act, 42 U.S.C. §1396d(r)(1)(B)(i))

6.4.9. The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting.

6.4.9.1. The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards. The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care. The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.

6.4.10. Develop crisis intervention and stabilization services to better manage behavioral health issues in the community. The MCO shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. Regional crisis community collaborations consist of an array of public and private partners such as law enforcement, emergency department directors, psychiatric acute unit directors,

coroners, behavioral health advocates, and peer supports. The MCO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.

6.4.11. Coordinated System of Care (CSoC) Implementation Plan Development

In anticipation of the potential for inclusion of CSoC services within Bayou Health, the MCO shall develop a plan of implementation to be submitted to DHH no later than July 1, 2016. Elements to be addressed in the plan include but are not limited to:

6.4.11.1. Demonstration of the MCOs knowledge on System of Care values and Wraparound Process;

6.4.11.2. Processes and protocols for screening and referral;

6.4.11.3. Network Development for services and supports;

6.4.11.4. Technical assistance and training for the CSoC providers inclusive of the WAAs, the Family Support Organization (FSO) and other contracted providers;

6.4.11.5. Coordination and communications with key agencies, i.e. OJJ, DCFS, OBH, etc.;

6.4.11.6. Transition and coordination of care out of CSoC level of care.

6.4.11.7. Program monitoring and quality improvement; and

6.4.11.8. Timelines required for implementation.

6.5. Laboratory and Radiological Services

6.5.1. The MCO shall provide inpatient and outpatient diagnostic laboratory testing, therapeutic radiology, and radiological services ordered and/or performed by all network providers.

6.5.2. For excluded services such as dental, the MCO is responsible for laboratory or radiological services that may be required to treat an emergency or provide surgical services.

6.5.3. The MCO shall provide for clinical lab services and portable (mobile) x-rays for members who are unable to leave their place of residence without special transportation or assistance to obtain PCP ordered laboratory services and x-rays.

6.5.4. The MCO may require service authorization for diagnostic testing and radiological services ordered or performed by any provider for their members.

6.6. EPSDT Well Child Visits

6.6.1. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is a comprehensive and preventive child health program for individuals under the

age of 21.The EPSDT statute and federal Medicaid regulations require that states cover all services within the scope of the federal Medicaid program, including services outside the Medicaid State Plan, if necessary to correct or ameliorate a known medical condition (42 U.S.C. §1396d(r)(5) and the CMS Medicaid State Manual). The program consists of two mutually supportive, operational components: (1) ensuring the availability and accessibility of required healthcare services; and (2) helping Medicaid members and their parents or guardians effectively use these resources. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

6.6.2. The MCO shall have written procedures for EPSDT services in compliance with 42 CFR Part 441 Subpart B-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), as well as be in compliance with the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, Part 5 – EPSDT. These articles outline the requirements for EPSDT, including assurance that all EPSDT eligible members are notified of EPSDT available services; that necessary screening, diagnostic, and treatment services are available and provided; and tracking or follow-up occurs to ensure all necessary services were provided to all of the MCO's eligible Medicaid children and young adults.

6.6.3. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandates **that all medically necessary services** listed in Section 1905(a) of the Social Security Act be covered under Medicaid for the EPSDT program provided for Medicaid eligible individuals under the age of 21 (42 CFR 441, Subpart B). The MCO is responsible to provide **all medically necessary services whether specified in the core benefits and services and Louisiana Medicaid State Plan or not**, except those services (carved out/excluded/prohibited services) that have been identified in this RFP and the Contract.

6.6.4. The MCO is required to fulfill the medical, vision, and hearing screening components and immunizations as specified in the DHH periodicity schedule.

6.6.5. The MCO shall accurately report, via encounter data submissions all EPSDT and well-child services, blood lead screening access to preventive services, and any other services as required for DHH to comply with federally mandated CMS 416 reporting requirements (Appendix HH – **EPSDT Reporting**). Instructions on how to complete the CMS 416 report may be found on CMS's website at: http://www.medicaid.gov/Medicaid-CHIProgram-Information/By-Topics/Benefits/Downloads/CMS-416-instructions.pdf

See ***MCO Systems Companion Guide*** for format and timetable for reporting of EPSDT data.

6.6.6. DHH shall use encounter data submissions to determine the MCO's compliance with the state's established EPSDT goals of ensuring:

6.6.6.1. Seventy-five (75) percent of eligible members under the age of twenty-one (21) are receiving EPSDT well child visits in accordance with the periodicity schedule for FFY 2015

6.6.6.2. Seventy-eight (78) percent of eligible members under the age of twenty-one (21) are receiving EPSDT well-child visits in accordance with the periodicity schedule for FFY 2016

6.6.6.3. Eighty (80) percent of eligible members under the age of twenty-one (21) are receiving EPSDT well-child visits in accordance with the periodicity schedule for FFY 2017 and all following FFYs.

6.6.7. Some EPSDT preventive screening claims should be submitted sooner than within twelve (12) months from date of service due to the fact that the screenings periodicity can range from every two months and up. See periodicity schedule at: http://www.lamedicaid.com/provweb1/ProviderTraining/packets/2013ProviderTraining/Periodicity%20Schedule_2013_R.pdf

6.7. Immunizations

6.7.1. The MCO shall provide all members with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

6.7.2. The MCO shall ensure that all Providers use vaccines available without charge under the Vaccine for Children (VFC) Program for Medicaid children eighteen (18) years old and younger. Immunizations shall be given in conjunction with EPSDT/Well Child visits or when other appropriate opportunities exist.

6.7.3. DHH will provide the MCO with immunization data for Medicaid MCO members through the month of their twenty-first (21st) birthday, who are enrolled in the MCO.

6.7.4. The MCO's providers shall report the required immunization data into the Louisiana Immunization Network for Kids (LINKS) administered by the DHH/Office of Public Health.

6.7.5. The MCO shall provide all members twenty-one (21) years of age and older with all vaccines and immunizations in accordance with State Plan services as identified at: http://www.lamedicaid.com/provweb1/fee_schedules/Immune_FS_Adults_6.pdf

6.8. Emergency Medical Services and Post Stabilization Services

6.8.1. Emergency Medical Services

6.8.1.1. The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.

6.8.1.2. The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.

6.8.1.3. The MCO shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.

6.8.1.4. The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR §438.114(a), nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.

6.8.1.5. The attending emergency physician, Licensed Mental Health Provider (LMHP), or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO for coverage and payment.

6.8.1.6. If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending *emergency* physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission *once the member is stabilized*.

6.8.1.7. The MCO will include in the proposal a plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.

6.8.1.8. The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.

6.8.1.9. The MCO shall monitor emergency services utilization by provider and member and shall have routine means for redressing inappropriate emergency department utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.

6.8.1.10. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

6.8.2. Post Stabilization Services

6.8.2.1. As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:

6.8.2.1.1. Pre-approved by a network provider or other MCO representative; or

6.8.2.1.2. Not preapproved by a network provider or other MCO representative, but:

6.8.2.1.2.1. Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services or

6.8.2.1.2.2. Administered to maintain, improve or resolve the member's stabilized condition if the MCO:

- Does not respond to a request for pre-approval within one (1) hour;
- Cannot be contacted; or
- MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.

6.8.2.2. The MCO's financial responsibility for post-stabilization care services that it has not pre-approved ends when:

6.8.2.2.1. A network physician with privileges at the treating hospital assumes responsibility for the member's care;

6.8.2.2.2. A network physician assumes responsibility for the member's care through transfer;

6.8.2.2.3. A representative of the MCO and the treating physician reach an agreement concerning the member's care; or

6.8.2.2.4. The member is discharged.

6.9. Emergency Ancillary Services Provided at the Hospital

Emergency ancillary services which are provided in a hospital include, but are not limited to, radiology, laboratory, emergency medicine and anesthesiology. The MCO shall reimburse the professional component of these services at a rate equal to or greater than the published Medicaid fee-for-service rate in effect on the date of service to in-network providers when an MCO provider authorizes these services (either in-patient or out-patient). Emergency ancillary services rendered by non-network providers in a hospital setting shall be reimbursed at the published Medicaid fee schedule in effect on the date of service.

6.10. Sexually Transmitted Infection (STI) Prevention

The MCO shall address high STI prevalence by incentivizing providers to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations.

6.11. Prenatal Care Services

6.11.1. The MCO shall ensure Medicaid members under its care who are pregnant, begin receiving care within the first trimester or within seven (7) days after enrolling in the MCO. (See Appendix J **Performance Measures**) The MCO shall provide available, accessible, and adequate numbers of PCPs and OB/GYN physicians to provide prenatal services, including specialized behavioral health services that are incidental to a pregnancy (in accordance with 42 CFR Part 440 Subpart B,) to all members. As noted in the Women's Health Services subsection, the pregnant member shall be assured direct access within the MCO's provider network to routine OB/GYN services, and the OB/GYN shall notify the PCP of his/her provision of such care and shall coordinate that care with the PCP.

6.11.2. The MCO shall develop an outreach program to encourage women to seek prenatal services during the first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include issuance of brochures and/or periodic articles emphasizing the importance of such care to all members.

6.11.3. The MCO shall perform or require health providers to perform a risk assessment on all obstetrical patients including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The MCO shall provide case management for high-risk obstetrical patients including, but not limited to, patients with a history of prior preterm birth.

6.11.4. The MCO shall ensure that the PCP or the OB provides prenatal care in accordance with the guidelines of the American College of Obstetricians and Gynecologists. The MCO shall ensure that the PCP or the OB counsels the pregnant member about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child once the child is added to the MCO as well as appropriate referrals to the WIC program for nutritional assistance. (See Appendix K – **WIC Referral Form**).

6.11.5. The MCO shall develop and promote patient engagement tools including mobile applications and smartphone-based support to supplement existing pregnancy services. ~~To that end the MCO~~ The MCO shall provide details of its plan in the MCO Marketing and Outreach Plan submitted to DHH for approval. Some goals of this program would be to:

6.11.5.1. Improve overall engagement in the maternity population and help women keep appointments and educate them about needed health screenings throughout pregnancy;

6.11.5.2. Increase the appropriate identification and triage of high-risk pregnancies to evidence-based actions, including connection to maternity case managers or other public health resources; and

6.11.5.3. Improve health decisions across the pregnant population based on available State-based and MCO-based programs and services.

6.12. Maternity Services

Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both mother and newborn child. All medically necessary procedures listed on the claim are the responsibility of the MCO regardless of primary or secondary mental health diagnosis appearing on the claim.

6.13. Perinatal Services

6.13.1. MCO will include in the proposal a plan to address prematurity prevention and improved perinatal outcomes. The plan may include but not be limited to the following:

6.13.1.1. Routine cervical length assessments for pregnant women;

6.13.1.2. Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy. The MCO shall not require prior authorization of progesterone for the prevention of premature birth unless written approval from the Medicaid Medical Director is obtained. The MCO will provide progesterone access to eligible members in a timely fashion.

6.13.1.3. Incentives for vaginal birth after cesarean (VBAC);

6.13.1.4. Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery;

6.13.1.5. Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and

6.13.1.6. Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age.

6.13.2. The MCO shall provide case management services to women postpartum who were identified as high risk during the pregnancy or who have had an adverse pregnancy outcome during the pregnancy including preterm birth less than 37 weeks. Case management services shall include referral to safety net services for inter-pregnancy care and breastfeeding support (if indicated).

6.14. Family Planning Services

6.14.1. Family planning services and supplies are available to help prevent unintended pregnancies. Family Planning shall be provided to MCO members as defined in the emergency rule published in the June 20, 2014 *Louisiana Register*. The MCO shall provide coverage for the following family planning services included here, but not limited to:

6.14.1.1. Comprehensive medical history and physical exam in a frequency per year that meets or exceeds Medicaid limits, this visit includes anticipatory guidance and education related to members' reproductive health/needs;

6.14.1.2. Contraceptive counseling to assist members in reaching an informed decision (including natural family planning, education follow-up visits, and referrals);

6.14.1.3. Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health;

6.14.1.4. Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered;

6.14.1.5. Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration;

6.14.1.6. Male and female sterilization procedures provided in accordance with 42 CFR Part 441, Subpart F;

6.14.1.7. Treatment of major complications from certain family planning procedures such as: treatment of perforated uterus due to intrauterine device insertion; treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring dilation and curettage; and treatment of surgical or anesthesia-related complications during a sterilization procedure; and

6.14.1.8. Transportation services to and from family planning appointments provided all other criteria for NEMT are met.

6.14.2. Services shall include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection or treatment of STIs, and age-appropriate vaccination for the prevention of HPV and cervical cancer. Prior authorization shall not be required for treatment of STIs.

6.14.3. MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2).

6.14.4. The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the fee-for-service rate in effect on the date of service.

6.14.5. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.

6.14.6. The MCO shall encourage family planning providers to communicate with PCP's once any form of medical treatment in undertaken.

6.14.7. The MCO shall maintain accessibility for family planning services through promptness in scheduling appointments (appointments available within one (1) week.

6.14.8. The MCO shall make certain that payments from DHH are not utilized for the services for the treatment of infertility.

6.15. Hysterectomies

6.15.1. The MCO shall cover the cost of medically necessary hysterectomies as provided in 42 CFR §441.255.

6.15.2. Non-elective, medically necessary hysterectomies provided by the MCO shall follow Medicaid policy and meet the following requirements:

6.15.2.1. The individual or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing;

6.15.2.2. The individual or her representative, if any, must sign and date the **Acknowledgment of Receipt of Hysterectomy Information** form (See Appendix L) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

6.15.2.2.1. The **Acknowledgment of Receipt of Hysterectomy Information** form is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.

6.15.2.2.2. The **Acknowledgment of Receipt of Hysterectomy Information** form is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required.

6.15.3. Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

6.15.4. Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

6.16. Sterilization

6.16.1. Sterilization is defined as any medical treatment or procedure that renders an individual permanently incapable of reproducing.

6.16.2. Sterilization must be conducted in accordance with Louisiana R.S. 40:1299.51, state Medicaid policy, federal regulations contained in 42 CFR §441.250 - 441.259. All procedures must be documented with a completed **Sterilization Consent Form OMB 0937-0166.**

6.17. Limitations on Abortions

6.17.1. Abortions must be prior approved before the service is rendered to ensure compliance with federal and state regulations.

6.17.2. The MCO shall provide for abortions in accordance with 42 CFR Part 441, Subpart E, and the requirements of the Hyde Amendment (currently found in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2014, Public Law 113-76, Division H, Title V, §506 and §507) and only if:

6.17.2.1. A woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician place the woman in danger of death unless an abortion is performed; or

6.17.2.2. The pregnancy is the result of an act of rape or incest.

6.17.3. For abortion services performed because of Section 6.16.2.1, a physician must certify in their handwriting, that on the basis of their professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term. The provider shall:

6.17.3.1. Attach the certification statement to the claim form that shall be retained by the MCO. The certification statement shall contain the name and address of the patient. The diagnosis or medical condition which makes the pregnancy life endangering shall be specified on the claim.

6.17.4. For abortion services performed as the result of an act of rape or incest the following requirements shall be met:

6.17.4.1. The member shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest;

6.17.4.2. The report of the act of rape or incest to law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest shall be submitted to the MCO along with the treating physician's claim for reimbursement for performing an abortion;

6.17.4.3. The member shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician; and

6.17.4.4. The **Certification of Informed Consent--Abortion**, which must be obtained from the Louisiana Office of Public Health (Appendix N) shall be witnessed by the treating physician. Providers shall attach a copy of the **Certification of Informed Consent--Abortion** form to their claim form.

6.17.4.5. All claim forms and attachments shall be retained by the MCO. The MCO shall forward a copy of the claim and its accompanying documentation to DHH.

6.17.5. No other abortions, regardless of funding, can be provided as a benefit under this Contract.

6.17.6. The MCO shall not make payment for any core benefit or service under the Contract to a network or non-network provider if any abortion performed hereunder violates federal regulations (Hyde Amendment).

6.18. Institutional Long-Term Care Facilities/Nursing Homes

6.18.1. The MCO is responsible for all core benefits and services as long as a member is enrolled in the MCO, including periods in which the member is admitted to a long-term care facility/nursing home for rehabilitative purposes and prior to the time the member is disenrolled from the MCO.

6.19. Services for Special Populations

6.19.1. Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. ~~For the behavioral health population, i~~Individuals with special health care needs include:

6.19.1.1. Individuals with co-occurring mental health and substance use disorders;

6.19.1.2. Individuals with intravenous drug use;

6.19.1.3. Pregnant women with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS) or fetal alcohol syndrome;

6.19.1.4. ~~Substance using women~~ Individuals with substance use disorders who have ~~with~~ dependent children;

6.19.1.5. Children with behavioral health needs in contact with other child serving systems ~~who are not eligible for CSoC~~including OJJ, DCFS, or the judicial system, and not enrolled in CSoC;

6.19.1.6. Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination; ~~and~~

6.19.1.7. Adults, ~~21~~ 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed ~~by the CSoC program contractor~~ and have declined to enter or are transitioning out of the CSoC program;

6.19.1.8. Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months;

6.19.1.9. Individuals with co-occurring behavioral health and developmental disabilities;

6.19.1.10. Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis;

6.19.1.11. Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and

~~6.19.1.7.~~**6.19.1.12.** Persons living with or at high risk for HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services.

6.19.2. The MCO shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). DHH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members within ninety (90) days of identification, with the exception of individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38.5.4. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.

6.19.3. The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows:

6.19.3.1. The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet MCO, DHH approved, guidelines for SHCN criteria.

6.19.3.2. MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria.

6.19.3.3. Members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. The Enrollment Broker will provide notification to the MCO of members who indicate they have special health care needs.

6.19.3.4. Members may be identified by DHH, including DHH program offices, and that information shall be provided to the MCO.

6.19.4. Individualized Treatment Plans and Care Plans

All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan developed by the treating provider(s) and a person-centered plan of care developed by the MCO care manager.

The individualized treatment plans must be:

6.19.4.1. Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment~~.~~;

6.19.4.2. In compliance with applicable quality assurance and utilization management standards~~.~~; and

6.19.4.3. Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member.

6.19.4.4. A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.
~~SHCN members identified in 6.19.1.6 and 6.19.1.7 must have a **person-centered plan of care** that includes all medically necessary services including specializaed behavioral health services identified in the member's treatment plan.~~

6.20. DME, Prosthetics, Orthotics, and Certain Supplies (DMEPOS)

The MCO shall provide coverage of and be financially responsible for medically necessary durable medical equipment, prosthetics, orthotics, certain supplies, appliances, and assistive devices including, but not limited to, hearing aids for members under the age of 21. DME for those under 21 includes disposable incontinence supplies and enteral formula.

6.21. Women, Infant, and Children (WIC) Program Referral

The MCO shall be responsible for ensuring that coordination exists between the WIC Program and MCO providers. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program. The DHH Office of Public Health administers the WIC Program. A sample referral/release of information form is found in Appendix K.

6.22. Preventative and Safety Educational Programs/Activities

The MCO may provide healthy lifestyle educational programs/activities for the whole family which may include, for example, a discount to a local fitness facility, web access to a healthy cooking website, weight management program participation and/or a

smoking cessation program. The MCO shall obtain approval from DHH prior to implementation of any such program.

6.23. Medical Transportation Services

6.23.1. The MCO shall provide emergency and non-emergency medical transportation for its members.

~~**6.23.2.** Non-Emergency Transportation (NEMT) including both ambulance and non-ambulance~~

6.23.2. The MCO's Transportation Broker shall establish and maintain a call center. The call center shall be responsible for scheduling all Non-Emergency Medical Transportation (NEMT) reservations and dispatching of trips during the business hours of 7:00am to 7:00pm Monday through Friday, with the exception of recognized state holidays. The call center shall adhere to the call center performance standards specified in Section 12.

6.23.3. NEMT shall be provided to and from all medically necessary Medicaid state plan services (including carved out services) for those members who lack viable alternate means of transportation. NEMT to non-Medicaid covered services is not a core benefit; it may be considered a cost-effective alternative service if so approved by LDH per Section 6.27.6.

6.23.3.1. NEMT transportation includes the following, when necessary to ensure the delivery of necessary medical services:

- Transportation for the member and one attendant, by ~~ambulance, taxicab, airplane, bus, or other appropriate~~ any means permitted by law, including but not limited to the requirements of La. R.S. 40:1203.1 et seq.;
- The use of any service that utilizes drivers that have not met the requirements of La. R.S. 40:1203.1 et seq. is strictly prohibited; and
- For trips requiring long distance travel, in accordance with Section 6.23.3.2~~3~~, the cost of meals and lodging and other related travel expenses determined to be necessary to secure medical examinations and treatment for a member.

6.23.3.2. The MCO must have an established process for coordinating medically necessary long distance travel for members who require covered Medicaid state plan services out of state. This may include air travel, lodging, and reimbursement for meals, as supported by medical necessity.

6.23.3.2.1. Coverage and reimbursement for meals and lodging for both the member and one attendant, shall be included when treatment requires more than twelve (12) hours of total travel. "Total travel" includes the duration of the health care appointment and travel to and from that appointment.

6.23.3.2.2. MCO must allow for meals and lodging, for each trip that are not otherwise covered in the inpatient per diem, primary insurance, or other payer source.

6.23.3.2.3. If the MCO denies meals and lodging services to a member who requests these services, the member must receive a written notice of denial explaining the reason for denial and the member's right to an appeal.

6.23.3.3. Other primary private insurance coverage must not impede a member's ability to receive transportation benefits to and from services covered by Medicaid as a secondary payer. If the private insurer has approved out-of-state services that are covered by Medicaid, the MCO must provide transportation, meals and lodging as specified in this section.

6.23.3.4. The MCO may require prior authorization and/or scheduling of NEMT and may require documentation to verify coverage of medical services by the primary insurer prior to approval. ~~The MCO cannot deny NEMT because of medical necessity for the service, nor because of the medical provider's location or network status. NEMT to non-Medicaid covered services may be denied.~~

6.23.3.4.1. For all NEMT services requiring scheduling and/or prior authorization, the MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of the request for services. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service or no less than 24 hours prior to the date of service, unless the request is received less than 48 hours prior to service.

6.23.3.4.2. In cases where the request is made less than 48 hours in advance of needed transportation, the MCO shall make reasonable efforts to schedule transportation and provide notice in advance of the scheduled appointment.

6.23.3.4.3. Expedited service authorizations for services that are deemed urgent but not emergent, shall be determined as expeditiously as the member's health condition requires. For NEMT ambulance services the timeframe for approval must allow ambulance providers to comply with any local ordinances governing their response times.

6.23.4. The MCO may establish its own policy for medical transportation services as long as the MCO ensures members' access to care and the MCO's policy is in accordance with current Louisiana Medicaid guidelines for non-emergency and emergency medical transportation (such as whether the member owns a vehicle or can access transportation by friends, relatives or public transit).

6.23.5. MCO Transportation Broker

6.23.5.1. The MCO may elect to contract with a transportation broker. Whether provided directly or through such broker, the MCO shall ensure:

6.23.5.1.1. Transportation providers are selected to ensure proximity to the member to the maximum extent reasonable given all other contractual, legal, and regulatory requirements;

6.23.5.1.2. Transportation does not exceed the MCO's geographic access requirements established in Section 7;

6.23.5.1.3. Maintenance, by the MCO or its transportation broker, in an electronic format, of all records necessary to establish and validate NEMT claims, including but not limited to:

6.23.5.1.3.1. Authorization data, including all member, provider, pick-up, drop-off, and mileage information necessary to establish a claim or as requested by LDH;

6.23.5.1.3.2. Trip dispatch and passenger records, including logs and driver and passenger transportation verifications; and

6.23.5.1.3.3. Vehicle and driver compliance records, including all required licensure and credentialing;

6.23.5.1.4. All NEMT service claims are reviewed against physical claims for potential abuse and affirmatively reported to LDH upon reasonable suspicion of impropriety;

6.23.5.1.5. LDH is able, without additional expense to LDH, within three (3) business days of a written request by LDH, to inspect, audit, and copy all records maintained by the MCO or its transportation broker in compliance with this agreement.

6.24. Excluded Services

6.24.1. Excluded services shall be defined as those services that members may obtain under the Louisiana State Plan or applicable waivers, and for which the MCO is not financially responsible. However the MCO is responsible for informing members on how to access excluded services, providing all required referrals and assisting in the coordination of scheduling such services. These services shall be paid for by DHH on a fee-for-service basis or other basis. Services include the following:

~~1. Applied Behavior Analysis;~~

6.24.1.1. Dental services with the exception of varnish provided in a primary care setting, surgical dental services, and emergency dental services;

6.24.1.2. ICF/DD Services;

6.24.1.3. Personal Care Services for those ages 21 and older;

6.24.1.4. Nursing Facility Services;

6.24.1.5. Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by OPH certified school-based health clinics);

6.24.1.6. All Home & Community-Based Waiver Services,

6.24.1.7. Targeted Case Management Services; and

6.24.1.8. Services provided through DHH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services).

6.25. Prohibited Services

6.25.1. Elective abortions (those not covered in Section 6.14) and related services;

6.25.2. Experimental/investigational drugs, procedures or equipment, unless approved by the Secretary of DHH;

6.25.3. Elective cosmetic surgery, and

6.25.4. Services for treatment of infertility.

6.26. Value-Added Benefits and Services

6.26.1. As permitted under 42 CFR §438.3(e), the MCO may offer value-added benefits and services to members in addition to the core benefits and services specified in this RFP.

6.26.2. Value-added benefits and services are those optional benefits and services offered by the MCO, including those proposed in the MCO's RFP response, that are not:

6.26.2.1. Core benefits and services as defined in Section 6.1.4; and

6.26.2.2. Cost-effective alternatives as defined in Section 6.27.

6.26.3. Value-added benefits and services are provided at the MCO's expense, are not included in the capitation rate, and shall be identified as value-added benefits or services in encounter data.

6.26.4. Value-added benefits and services may include health 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.

6.26.5. Value-added benefits and services shall be specifically defined by the MCO in regard to amount, duration, and scope.

6.26.6. Transportation to the value-added benefit or service is the responsibility of the member and/or MCO, at the discretion of the MCO.

6.26.7. Value-added benefits and services are not Medicaid-funded and, as such, are not subject to appeal and state fair hearing rights. A denial of these benefits will not be considered an adverse benefit determination for purposes of grievances and appeals. The MCO shall send the member a notification letter if a value-added benefit or service is not approved.

6.26.8. The MCO shall provide LDH a description of the value-added benefits and services to be offered by the MCO for approval. Additions, deletions or modifications to value-added benefits or services made during the contract period shall be submitted to LDH for approval ninety (90) calendar days in advance of the proposed change.

6.26.9. The proposed monetary value of these value-added benefits and services shall be considered a binding contract deliverable.

6.26.9.1. For each value-added benefit or service proposed, the MCO shall:

- Define and describe the benefit or service;
- Identify the category or group of members eligible to receive the benefit or service if it is not appropriate for all members;
- Note any limitations or restrictions that apply to the benefit or service;
- Identify the types of providers responsible for providing the benefit or service, including any limitations on provider capacity if applicable;
- Propose how and when providers and members will be notified about the availability of such benefits or services;
- Describe how a member may obtain or access the benefit or service; and
- Describe how the benefit or service will be identified in administrative data or encounter data.

6.26.9.2. For the thirty-six (36) month term of the initial contract, the MCO shall:

6.26.9.2.1. Indicate the PMPM actuarial value of benefits or services assuming enrollment of 200,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information; and

6.26.9.2.2. Include a statement of commitment to provide the benefits or services for the entire thirty-six (36) month term of the initial contract.

6.26.9.3. For the twenty-three (23) month term of the contract extension, the MCO shall:

6.26.9.3.1. Include a statement of commitment to provide the benefits or services for the entire twenty-three (23) month term of the contract extension. The value of the commitment for the contract extension term shall be no less than the aggregated annual value of all the benefits or services on a PMPM basis included in the statement of commitment for the initial contract term; and

6.26.9.3.2. The MCO may honor each benefit or service commitment made during the initial contract term. For the contract extension term, the MCO shall seek to align its benefits or services commitments with LDH priorities and the MCO's APM Strategic Plan consistent with the requirements of 6.26.8.

6.26.9.4. The department will work with its contract actuary to independently review any statements of actuarial value.

6.26.9.5. If for some reason, including but not limited to lack of member participation, the aggregated annual PMPM proposed is not expended, the Department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

6.27. Cost-Effective Alternative Services

6.27.1. Cost-effective alternative services are services or settings the MCO proposes as cost-effective alternatives to core benefits and services and LDH, in consultation with its actuary, determines to be permissible "in lieu of" services or settings to those included in the State Plan. The utilization and costs of these services are included in the capitation rate.

6.27.2. When the MCO chooses to adopt or discontinue a cost-effective alternative service, LDH shall be notified sixty (60) calendar days in advance of the change.

6.27.3. The MCO may offer additional benefits that are outside the scope of core 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.

6.27.4. Members are not entitled to receive these services. Cost-effective alternative services may be provided because they are either:

6.27.4.1. Alternatives to covered services that, in the MCO's judgement, are cost-effective; or

6.27.4.2. Preventative in nature and offered to avoid the development of conditions that, in the MCO's judgement, would require more costly treatment in the future.

6.27.5. Cost-effective alternative services are not required to be determined medically necessary except to the extent that they are provided as an alternative to covered services as defined in this RFP. Even if medically necessary, cost-effective alternative services are not covered services and are provided only at the MCO's discretion. The member is not required to use the cost-effective alternative service.

6.27.6. LDH shall maintain a list of pre-approved cost-effective alternative services that may include, for example, use of nursing facilities as step down alternatives to acute care hospitalization. Services not included on the list shall be approved in writing by LDH.

6.27.7. The MCO may identify cost-effective alternative services in encounter data submissions as specified by LDH.

~~**1. Expanded Services/Benefits**~~

~~1. As permitted under 42 CFR §438.6(e),the MCO may offer expanded services and benefits to enrolled Medicaid MCO members in addition to those core benefits and services specified in this RFP.~~

~~2. These expanded services may include health 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 MCO in regard to amount, duration and scope. DHH will not provide any additional reimbursement for these services/benefits.~~

~~4. Transportation for these services/benefits is the responsibility of the member and/or MCO, at the discretion of the MCO.~~

~~5. The MCO shall provide DHH a description of the expanded services/benefits to be offered by the MCO for approval. Additions, deletions or modifications to expanded services/benefits made during the contract period must be submitted to DHH, for approval.~~

~~6. Examples of expanded services/benefits include, but are not limited to:~~

~~1. Tooth extractions or dental services;~~

~~2. Eyeglasses for adults;~~

~~3. Pain management services;~~

~~4. Community health workers; and~~

~~5. Sickle cell day hospitals.~~

~~7. DHH may expand, eliminate, or otherwise change core benefits and services. If changed, the Contract shall be amended and the MCO given sixty (60) days advance notice whenever possible.~~

~~6.26.~~6.28. Care Management

~~6.26.1.~~6.28.1. Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.

~~6.26.2.~~6.28.2. The MCO shall be responsible for ensuring:

~~6.26.2.1.~~6.28.2.1. Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider

~~6.26.2.2.~~6.28.2.2. Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k)

which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and

~~6.26.2.3.~~6.28.2.3. Care coordination and referral activities~~, in person or telephonically depending on member's acuity,~~ incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services.

~~6.26.2.4.~~6.28.2.4. Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff.

~~6.27.~~6.29. Referral System for Specialty Healthcare

~~6.27.1.~~6.29.1. The MCO shall have a referral system for MCO members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care. The MCO shall provide the coordination necessary for referral of MCO members to specialty providers. The MCO shall assist the provider or member in determining the need for services outside the MCO network and refer the member to the appropriate service provider. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services (*e.g.*, medications prescribed, treatment received, recommendations for care), and follow up are included in the PCP's member medical record.

~~6.27.2.~~6.29.2. The MCO shall submit referral system policies and procedures for review and approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements:

~~6.27.2.1.~~6.29.2.1. When a referral from the member's PCP is and is not required (See Section 8.5.1.6 Exceptions to Service Authorization and/or Referral Requirements);

~~6.27.2.2.~~6.29.2.2. Process for member referral to an out-of-network provider when there is no provider within the MCO's provider network who has the appropriate training or expertise to meet the particular health needs of the member;

~~6.27.2.3.~~6.29.2.3. Process for providing a standing referral when a member with a condition requires on-going care from a specialist;

~~6.27.2.4.~~6.29.2.4. Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;

~~6.27.2.5.~~6.29.2.5. Process for member referral for case management;

~~6.27.2.6.~~6.29.2.6. Process for member referral for chronic care management;

~~6.27.2.7.~~6.29.2.7. Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.

~~6.27.2.8.~~6.29.2.8. Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's member medical record.

~~6.27.2.9.~~6.29.2.9. There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider; and

~~6.27.2.10.~~6.29.2.10. Process for referral of members for Medicaid State Plan services that are excluded from MCO core benefits and services and that will continue to be provided through fee-for-service Medicaid.

~~6.27.2.11.~~6.29.2.11. The MCO shall develop electronic, web-based referral processes and systems.

~~6.28.~~6.30. Care Coordination, Continuity of Care, and Care Transition

The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by DHH, ~~or~~provided by DHH's dental benefit program manager, or provided by community and social support providers. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. These MCO activities and processes shall be demonstrated via workflows with specific decision points and provided to DHH by January 11, 2016.

Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that an MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by DHH.

~~6.28.1.~~6.30.1. The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.

~~6.28.2.~~6.30.2. The MCO shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:

6.30.2.1. Ensure a best effort is made to conduct an initial screening of the member's needs within ninety (90) days of their enrollment date for all new members. If the initial attempt is unsuccessful, subsequent attempts shall be made within the ninety (90) day time period;

~~6.28.2.1.~~**6.30.2.2.** Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;

6.30.2.3. Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses;

~~6.28.2.2.~~**6.30.2.4.** Coordinate care between network PCPs and specialists, including specialized behavioral health providers;

~~6.28.2.3.~~**6.30.2.5.** Coordinate care for out-of-network services, including specialty care services;

~~6.28.2.4.~~**6.30.2.6.** Coordinate MCO provided services with services the member may receive from other health care providers;

~~6.28.2.5.~~**6.30.2.7.** Upon request, share with LDH or other health care entities serving the member ~~with special health care needs~~ the results and identification and assessment of that member's needs to prevent duplication of those activities;

6.30.2.8. Ensure that each provider furnishing services to the member maintains and shares the member's health record in accordance with professional standards;

~~6.28.2.6.~~**6.30.2.9.** Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, and other applicable state or federal laws;

~~6.28.2.7.~~**6.30.2.10.** Maintain and operate a formalized hospital and/or institutional discharge planning program;

~~6.28.2.8.~~**6.30.2.11.** Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:

~~6.28.2.8.1.~~**6.30.2.11.1.** Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).

~~6.28.2.8.2.~~**6.30.2.11.2.** Care managers follow-up with members with a behavioral health-related diagnosis within 72 hours following discharge.

~~6.28.2.8.3.~~**6.30.2.11.3.** Coordination with DHH and other state agencies following an inpatient, PRTF, or other residential stay for members with a

primary behavioral health diagnosis occurs timely when the member is not to return home.

~~6.28.2.8.4.~~6.30.2.11.4. Members approaching the end of medical necessity/continued stay for PRTF or TGH have concrete and proactive discharge plans in place, including linkage with aftercare providers to address the member's treatment needs in the member's next recommended level of care or living situation. Concrete and proactive discharge plans, including linkage with aftercare providers in the member's next LOC or living situation, should be in place thirty (30) calendar days prior to discharge from a PRTF or TGH. The MCO shall follow up and coordinate with the discharging PRTF or TGH, receiving provider(s), and the member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers as per the member's discharge plan.

~~6.28.2.9.~~6.30.2.12. Document authorized referrals in its utilization management system; ~~and~~

~~6.28.2.10.~~6.30.2.13. Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less;~~.~~

~~6.28.2.11.~~6.30.2.14. Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of DHH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffings; and~~.~~

6.30.2.15. For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility~~.~~;

6.30.3. The MCO shall not deny continuation of residential treatment (e.g., TGH or PRTF) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care.

~~6.29.~~6.31. Referrals for Tobacco Cessation and Problem Gaming

6.30.1 MCO Care Managers shall screen for problem gaming and tobacco usage of each member during the initial individual needs assessment. The CM shall be responsible for advising members that screen positive to quit and will refer the member to appropriate network providers offering tobacco cessation treatment and/or problem gaming services.

6.30.2 Information regarding treatment services and/or referral to care shall be entered into the MCO's systems for the purpose of tracking and reporting according to various demographics (e.g., age, race, gender, behavioral health diagnosis, etc.). Tobacco cessation and problem gaming reports shall be made available upon DHH request in a format and frequency as determined by DHH.

6.30.3 The MCO shall collect and report the information associated with tobacco cessation and/or problem gaming screening, treatment and referral information as appropriate and as specified in the Behavioral Health Companion Guide.

~~6.30.~~6.32. Continuity of Care for Pregnant Women

~~6.30.1.~~6.32.1. In the event a member entering the MCO is receiving medically necessary covered services in addition to, or other than, prenatal services (see below for new enrollees receiving only prenatal services) the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days, however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

~~6.30.2.~~6.32.2. In the event a member entering the MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the MCO can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

~~6.30.3.~~6.32.3. In the event a member entering the MCO is in her second or third trimester of pregnancy and is receiving medically-necessary covered prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) for sixty (60) days post-partum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period.

~~6.30.4.~~6.32.4. The contract shall ensure that the member is held harmless by the provider for the costs of medically necessary core benefits and services.

~~6.31.~~6.33. Preconception/Inter-conception Care

For fertile women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care, with special counseling on pregnancy prevention options for adolescent patients. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient in achieving her plan with optimization of health status in the interim. Use of long acting reversible contraceptives should be encouraged and barriers such as prior authorization shall not be required for approval.

~~6.32.~~6.34. Continuity of Care for Individuals with Special Health Care Needs

In the event a Medicaid or CHIP eligible entering the MCO is receiving medically necessary covered services, the day before MCO enrollment, the MCO shall provide

continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days; however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

~~6.33.~~6.35. Continuity of Care for Pharmacy Services

~~6.33.1.~~6.35.1. The MCO must submit for approval, a transition of care program that ensures members can continue treatment of maintenance medications for at least 60 days after launch of pharmacy services, enrollment into the MCO's plan, or switching from one plan to another. The MCO shall continue any treatment of antidepressants and antipsychotics for at least 90 days after enrollment into the MCO's plan. Additionally, an enrollee that is, at the time of enrollment into the MCO, receiving a prescription drug that is not on the MCO's Formulary or PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least 60 days.

~~6.33.2.~~6.35.2. The MCO shall continue the behavioral health therapeutic classes (including long-acting injectable antipsychotics), and other medication assisted treatment (including Suboxone and naloxone) prescribed to the enrollee in a state mental health treatment facility for at least 90 days after the facility discharges the enrollee, unless the MCO's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are:

- Not medically necessary; or
- Potentially harmful to the enrollee.

~~6.34.~~6.36. Continuity for Behavioral Health Care

~~6.34.1.~~6.36.1. The PCP shall provide basic behavioral health services (as described previously in this Section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

~~6.34.2.~~6.36.2. The MCO shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs.

Principles that guide care integration are as follows:

- Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings;
- Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions;
- The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It

will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement;

- It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

~~6.34.3.~~6.36.3. In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.

~~6.34.4.~~6.36.4. The MCO shall comply with all post-stabilization care service requirements found at 42 CFR §422.113.

~~6.34.5.~~6.36.5. The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.

~~6.34.6.~~6.36.6. The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.

~~6.34.7.~~6.36.7. These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.

~~6.34.8.~~6.36.8. The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.

~~6.34.9.~~6.36.9. The MCO shall work to strongly support the integration of both physical and behavioral health services through:

~~6.34.9.1.~~6.36.9.1. Enhanced detection and treatment of behavioral health disorders in primary care settings;

~~6.34.9.2.~~6.36.9.2. Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co-existing medical-behavioral health disorders;

~~6.34.9.3.~~6.36.9.3. Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder;

~~6.34.9.4.~~6.36.9.4. Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co-management.

~~6.34.9.5.~~6.36.9.5. Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.

~~6.34.9.6.~~6.36.9.6. Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.

~~6.34.9.7.~~6.36.9.7. Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;

~~6.34.9.8.~~6.36.9.8. Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;

~~6.34.9.9.~~6.36.9.9. Ensuring continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.

~~6.34.9.10.~~6.36.9.10. Documenting authorized referrals in the MCO's clinical management system;

~~6.34.9.11.~~6.36.9.11. Developing capacity for enhanced rates or incentives for integrated care by providers;

~~6.34.9.12.~~6.36.9.12. Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;

~~6.34.9.13.~~6.36.9.13. Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and

~~6.34.9.14.~~6.36.9.14. Participating in regular collaborative meetings at least yearly or as needed, with DHH representatives for the purpose of coordination and communication.

~~6.35.~~6.37. Continuity for DME, Prosthetics, Orthotics, and Certain Supplies

In the event a Medicaid member entering the MCO is receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services the day before MCO enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, the MCO shall be responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services for up to ninety (90) calendar days **or** until the

member may be reasonably transferred (within timeframe specified in this RFP) without disruption, whichever is less. The MCO must also honor any prior authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the member was enrolled in another MCO or the Medicaid fee-for-service program for a period of ninety (90) calendar days after the member's enrollment in the MCO.

~~6.36.~~6.38. Care Transition

~~6.36.1.~~6.38.1. The MCO shall provide active assistance to members when transitioning to another MCO or to Medicaid FFS.

~~6.36.2.~~6.38.2. The receiving MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving MCO unless the member has been identified as an individual with special health care needs (See Section 6.32 for exceptions for individuals with Special Health Care Needs.) During this transition period, the receiving MCO shall be responsible for, but not limited to, notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.

~~6.36.3.~~6.38.3. If a member is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the member is discharged. The receiving MCO is responsible for all other care.

~~6.36.3.1.~~6.38.3.1. In the event that the relinquishing MCO's contract is terminated prior to the member's discharge, responsibility for the remainder of the hospitalization charges shall revert to the receiving MCO, effective at 12:01am on the day after the prior MCO's contract ends.

~~6.36.4.~~6.38.4. Upon notification of the member's transfer, the receiving MCO shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving MCO access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving MCO shall be the responsibility of the relinquishing MCO. A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing MCO's PCP within ten (10) business days of the receiving MCO's PCP's request.

~~6.36.4.1.~~6.38.4.1. The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.

~~6.36.4.2.~~6.38.4.2. During transition the MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.

~~6.36.5.~~6.38.5. Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.

~~6.36.6.~~6.38.6. Special consideration shall be given to, but not limited to, the following:

~~6.36.6.1.~~6.38.6.1. Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;

~~6.36.6.2.~~6.38.6.2. Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;

~~6.36.6.3.~~6.38.6.3. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth; and

~~6.36.6.4.~~6.38.6.4. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization.~~;~~

~~6.36.7.~~6.38.7. When relinquishing members, the MCO is responsible for timely notification to the receiving MCO regarding pertinent information related to any special needs of transitioning members. The MCO, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor so services are not interrupted, and for providing the new member with MCO and service information, emergency numbers and instructions on how to obtain services.

~~6.36.8.~~6.38.8. Transition of Care for Integration of Specialized Behavioral Health

~~6.36.8.1.~~6.38.8.1. For the period December 1, 2015 through February 29, 2016 the MCO shall honor all Magellan authorization decisions for outpatient services at the level of service and duration approved prior to December 1, 2015. The MCO must continue to honor existing Magellan authorizations beyond February 29, 2016 until such time as a determination for continued services is complete and the member and provider have been timely notified. These requirements apply to all prior approvals regardless of the provider's status as a contracted or non-contracted provider.

~~6.37.~~6.39. Case Management

~~6.37.1.~~6.39.1. The MCO shall develop and implement a case management program through a process which provides ~~that~~ appropriate and~~,~~ medically-related services, social services, and basic and specialized behavioral health services that are identified, planned, obtained and monitored for identified members who

are in the special healthcare needs (SHCN) population and identified members who have high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate plan that meets the medical, functional, social and behavioral health needs of the member. The MCO shall submit case management program policies and procedures to DHH for approval within thirty (30) days following the date the contract is signed, ~~and~~ annually thereafter, and thirty (30) days prior to implementation of any revision.

~~6.37.2.~~6.39.2. Case management program functions shall include but not be limited to the following, all of which shall be addressed in the MCO's case management policies and procedures:

6.39.2.1. Identification criteria, process, and triggers for referral and admission into case management, including a process to offer voluntary participation in case management to members;

6.39.2.2. Identification criteria, process, and tracking mechanisms for members receiving services in or referred to a nursing facility;

6.39.2.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, reproductive aged women with a history of prior poor birth outcomes and high risk pregnant women;

~~6.37.2.1.~~6.39.2.4. Early identification, through active outreach, of members who have or may have special healthcare needs;

~~6.37.2.2.~~6.39.2.5. Assessment of a member's risk factors, current health status, current service utilization, gaps in care, and medication review initially and on an ongoing basis to ensure member health and safety;

~~6.37.2.3.~~6.39.2.6. Education regarding patient-centered medical home and referral to a medical home when appropriate;

6.39.2.7. Development of an individualized ~~treatment~~ comprehensive plan of care, ~~in accordance with Section 6.19.4~~which is based on the results of the member's individual needs assessment. The plan of care shall be developed and implemented through a person-centered process in which the member has a primary role and which is based on the principles of self-determination and recovery. The plan of care shall include the following elements at a minimum:~~;~~

6.39.2.7.1. Member demographics;

6.39.2.7.2. Identification of the member's treating providers and Interdisciplinary Team if applicable;

6.39.2.7.3. Member's past and present primary care and behavioral health concerns, relevant treatment history including gaps in care, significant medical history, and present health status;

6.39.2.7.4. Member's goals;

6.39.2.7.5. Identified strengths and needs;

6.39.2.7.6. Identified barriers to the care plan goals;

6.39.2.7.7. Documentation that freedom of choice of services and providers were offered to the member and/or his/her caregiver;

6.39.2.7.8. Supports and services needed to meet the member's needs;

6.39.2.7.9. Resources and settings of care recommended to the member's providers, including responsible party and target date for completion;

6.39.2.7.10. Strategies to improve care coordination;

6.39.2.7.11. Strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication management. Each follow-up item includes an identified responsible party(ies); and

~~6.37.2.3.1.~~**6.39.2.7.12.** Plan for addressing crisis to prevent unnecessary hospitalization or institutionalization for members with a behavioral health diagnosis who may experience crisis. The crisis plan shall identify resources and contact information.

6.39.2.8. Documentation of a schedule for following-up with the member's providers and convening plan of care reviews at intervals consistent with the identified member care needs and to ensure progress and safety;

6.39.2.9. A process for updating the plan of care based on the member's changing needs, progress, and outcomes;

6.39.2.10. Facilitation of a service authorization for those services identified in the plan of care;

~~6.37.2.4.~~**6.39.2.11.** Referrals and assistance to ensure timely access to providers;

6.39.2.12. Continuity of care for identified Special Health Care Needs populations including managing transitions between pediatric and adult health care providers;

~~6.37.2.5.~~**6.39.2.13.** ~~Care coordination that a~~Actively ~~ly~~ linking of the member to providers and coordination with~~,~~ medical services, residential, social, community and other support services where needed;

6.39.2.13.1. For members who have DD eligibility, verification of the Statement of Approval and collaboration with Local Governing Entities (LGEs) and Support Coordination Agencies.

6.39.2.14. Identification of barriers to adequate healthcare and assisting with timely resolution;

6.39.2.15. A process for monitoring to identify early changes in the health status of members, ensuring members are receiving needed services and supports, and ensuring member safety and progress;

6.39.2.16. A process for providing high-touch, face-to-face engagement for high-risk members, including those who have complex care needs, are difficult to engage through telephonic care management, are residing in or transitioning from an institution, access care primarily through emergency services, or are frequently admitted to inpatient settings;

6.39.2.17. A process for continuity of care, including managing transitions between levels of care. Services shall be of sufficient intensity to ensure case managers are able to identify and coordinate services and supports to prevent institutionalization and assist the member with maintaining community placement;

6.39.2.18. A process for offering or arranging self-management training and health education to members and caregivers regarding conditions;

6.39.2.19. A process for conducting case management rounds for CSoC enrolled youth at least monthly with the CSoC Contractor; and

- ~~Monitoring;~~
- ~~Continuity of care; and~~

~~6.37.2.6.~~**6.39.2.20.** Follow-up and documentation.

~~6.37.3.~~**6.39.3.** Additional Case Management Requirements for the SHCN populations with behavioral health needs as defined in 6.19.

A Plan of Care shall be developed by the MCO for this population annually at a minimum and as needed. The plan of care shall list all services and intensity of those services appropriate for the individual. The POC shall be integrated and shall identify both physical and behavioral service needs. Additionally, the POC shall include natural supports needed and referrals to other services.

~~6.37.3.1.~~**6.39.3.1.** The MCO shall:

- Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately;
- Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment;
- Ensure members are referred to service providers in accordance with freedom of choice requirement;
- Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and
- Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.

~~6.37.4.~~6.39.4. Assessments for Mental Health Rehabilitation Services for adults:

~~6.37.4.1.~~6.39.4.1. The MCO shall be responsible for conducting or subcontracting to conduct assessments as per the requirements in the State Plan. DHH will establish process measures to monitor access to timely assessments.

~~6.37.4.2.~~6.39.4.2. Assessment for eligibility shall be completed within fourteen (14) calendar days of referral.

~~6.37.4.3.~~6.39.4.3. Annual recertification for services will be completed within 365 days of most recent certification in order to assure that there is no lapse in service authorization or services to members who remain qualified.

~~6.37.5.~~6.39.5. Independent Evaluations for PASRR Level II

~~6.37.5.1.~~6.39.5.1. The MCO shall be responsible for conducting or subcontracting to conduct PASRR Level II evaluations of members upon referral from OBH. Referrals will be based upon the need for an independent evaluation to determine the need for nursing facility services and/ or the need for specialized services to address mental health issues while the member is in a nursing facility.

~~6.37.5.2.~~6.39.5.2. In conducting the evaluation, the MCO shall follow the criteria set forth in 42 CFR §483.128 and shall utilize the PASRR Level II standardized evaluation form provided by DHH.

~~6.37.5.3.~~6.39.5.3. Evaluators may use relevant evaluative data, obtained prior to initiation of PASRR, if the data are considered valid and accurate and reflect the current functional status of the individual. However, if necessary to supplement and verify the currency and accuracy of existing data, the evaluator shall gather additional information necessary to assess proper placement and treatment.

~~6.37.5.4.~~6.39.5.4. In order to comply with federally mandated timelines, the MCO shall submit the completed Level II evaluation report to OBH within four (4) working days of receipt of the referral from OBH.

~~6.37.5.5.~~6.39.5.5. Level II evaluation recommendations shall focus on ensuring the least restrictive setting appropriate with the appropriate services.

~~6.37.5.6.~~6.39.5.6. When OBH determines that nursing facility services are not appropriate, the MCO shall assist eligible members to obtain appropriate alternative behavioral health services available under this contract.

~~6.37.5.7.~~6.39.5.7. If at any time the MCO should become aware that a member residing in a nursing home who has an SMI has not received a Level II determination, the MCO shall notify OBH.

~~6.37.5.8.~~6.39.5.8. The MCO shall notify OBH as per the Behavioral Health Companion Guide of any problems or issues with the PASRR process.

~~6.37.6.~~6.39.6. Case Management for Members Receiving Nursing Facility Care

~~6.37.6.1.~~6.39.6.1. The MCO shall ensure that members who are identified by OBH as needing specialized services for behavioral health while in a nursing facility have access to such services as required under 42 CFR §483.120 and determined by OBH. For individuals denied nursing facility placement, the MCO shall ensure members have access to medically necessary covered services needed to maintain them in the community.

~~6.37.6.2.~~6.39.6.2. ~~The MCO shall have a person centered plan of care completed within 30 days from the OBH PASRR Level II determination or admission to the nursing facility, whichever is later.~~ Service authorizations for specialized behavioral health services must be in place within 15 days following the receipt ~~completion~~ of the ~~plan of care~~specialized behavioral health service recommendations as a result of the PASRR Level II determination or admission to the nursing facility, whichever is later.

~~6.37.6.3.~~6.39.6.3. The MCO shall inform OBH of any changes in condition of members residing in a nursing facility that would require a resident review as noted in Section 1919(e)(7)(B)(iii) of the Social Security Act.

~~6.37.7.~~6.39.7. PASRR Tracking

~~6.37.7.1.~~6.39.7.1. The MCO shall utilize the Behavioral Health Companion Guide to report utilization of the PASRR process.

~~6.37.7.2.~~6.39.7.2. The MCO is responsible for tracking for members residing in a nursing facility who went through the PASRR process, those identified with SMI and those receiving specialized services as per 42 CFR §483.130.

~~6.37.7.3.~~6.39.7.3. The MCO shall track and report quarterly to OBH the delivery of all PASRR specialized behavioral health services as defined and required under 42 CFR §483.120.

~~6.37.7.4.~~6.39.7.4. The MCO shall advise OBH and Medicaid on any barriers to completing the PASRR evaluations or tracking process.

~~6.37.7.5.~~6.39.7.5. Records shall be retained for 5 years in order to support OBH determinations, and to protect the individual's appeal rights as per 42 CFR §483.130.

~~6.37.8.~~6.39.8. The MCOs shall adhere to the requirements and procedures as set forth in the Justice-Involved Pre-release Enrollment Program Manual.

~~6.38.~~6.40. Case Management Policies and Procedures

The MCO shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:

~~6.38.1.~~6.40.1. A process to offer voluntary participation in the Case Management Program to eligible members;

~~6.38.2.~~6.40.2. Identification criteria, process, and triggers for referral and admission into the Case Management Program;

~~6.38.3.~~6.40.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following:

~~6.38.3.1.~~6.40.3.1. Reproductive aged women with a history of prior poor birth outcomes; and

~~6.38.3.2.~~6.40.3.2. High risk pregnant women.

~~6.38.4.~~6.40.4. The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers;

~~6.38.5.~~6.40.5. A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;

~~6.38.6.~~6.40.6. Procedures and criteria for making referrals to specialists and subspecialists

~~6.38.7.~~6.40.7. Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and

~~6.38.8.~~6.40.8. Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.

~~6.39.~~6.41. Case Management Reporting Requirements

The MCO shall submit case management reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:

~~6.39.1.~~6.41.1. Number of members identified with potential special healthcare needs utilizing historical claims data;

~~6.39.2.~~6.41.2. Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;

~~6.39.3.~~6.41.3. Number of members identified with potential special healthcare needs that self-refer;

~~6.39.4.~~6.41.4. Number of members with potential special healthcare needs identified by the MCO;

~~6.39.5.~~6.41.5. Number of members in the lock-in program (see section 6.40.1);

~~6.39.6.~~6.41.6. Number of members identified with special healthcare needs by the PASRR Level II authority;

~~6.39.7.~~6.41.7. Number of members with assessments completed, and

~~6.39.8.~~6.41.8. Number of members with assessments resulting in a referral for Case Management.

~~6.40.~~6.42. Chronic Care Management Program (CCMP)

~~6.40.1.~~6.42.1. The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions:

~~6.40.1.1.~~6.42.1.1. Asthma;

~~6.40.1.2.~~6.42.1.2. Congestive heart failure;

~~6.40.1.3.~~6.42.1.3. Diabetes;

~~6.40.1.4.~~6.42.1.4. HIV;

~~6.40.1.5.~~6.42.1.5. Hepatitis C;

~~6.40.1.6.~~6.42.1.6. Obesity; and

~~6.40.1.7.~~6.42.1.7. Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.

~~6.40.2.~~6.42.2. The program shall include information on work the plan has conducted in other states, if applicable; a measure of success; any state models planned for implementation in Louisiana; and a plan for partnering with national, state, or community foundations to support the work.

~~6.40.3.~~6.42.3. The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.

~~6.40.4.~~6.42.4. The MCO shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that:

~~6.40.4.1.~~6.42.4.1. Include the definition of the target population;

~~6.40.4.2.~~6.42.4.2. Include member identification strategies, i.e., through encounter data;

~~6.40.4.3.~~6.42.4.3. Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;

~~6.40.4.4.~~6.42.4.4. Include guidelines for treatment plan development, as described in National Committee for Quality Assurance (NCQA) Disease Management program content, that provide the outline for all program activities and interventions;

~~6.40.4.5.~~6.42.4.5. Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;

~~6.40.4.6.~~6.42.4.6. Include methods for informing and educating members and providers;

~~6.40.4.7.~~6.42.4.7. Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;

~~6.40.4.8.~~6.42.4.8. Address co-morbidities through a whole-person approach;

~~6.40.4.9.~~6.42.4.9. Identify members who require in-person case management services and a plan to meet this need;

~~6.40.4.10.~~6.42.4.10. Coordinate CCMP activities for members also identified in the Case Management Program; and

~~6.40.4.11.~~6.42.4.11. Include Program Evaluation requirements.

~~6.41.~~6.43. **Predictive Modeling**

~~6.41.1.~~6.43.1. The MCO shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.

~~6.41.2.~~6.43.2. The MCO shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines within thirty (30) days of signing the Contract and annually thereafter and prior to any changes. These specifications shall include but are not limited to:

~~6.41.2.1.~~6.43.2.1. A brief history of the tool's development and historical and current uses;

~~6.41.2.2.~~6.43.2.2. Medicaid data elements to be used for predictors and dependent measure(s);

~~6.41.2.3.~~6.43.2.3. Assessments of data reliability and model validity;

~~6.41.2.4.~~6.43.2.4. A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and

~~6.41.2.5.~~6.43.2.5. A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population.

~~6.42.~~6.44. CCMP Reporting Requirements

~~6.42.1.~~6.44.1. The MCO shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.

~~6.42.2.~~6.44.2. The CCMP reports shall contain at a minimum:

~~6.42.2.1.~~6.44.2.1. Total number of members;

~~6.42.2.2.~~6.44.2.2. Number of members in each stratification level for each chronic condition; and

~~6.42.2.3.~~6.44.2.3. Number of members who were disenrolled from program and explanation as to why they were disenrolled.

~~6.42.3.~~6.44.3. The MCO shall submit the following report annually:

~~6.42.3.1.~~6.44.3.1. Chronic Care Management Program evaluation

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

~~6.42.4.~~6.45.1. The MCO shall create a framework for delivery of services, staff development, and policies and procedures for providing effective care for members with co-occurring behavioral health and developmental disabilities. This population should have the same reasonable access to behavioral health services as someone without a co-occurring behavioral health and developmental disability. If a member qualifies for services through OCDD, the MCO shall coordinate with OCDD, LGEs, and support coordinators concerning the care of the member. A Statement of Approval from OCDD shall not preclude services from the MCO.

6.46. Applied Behavior Analysis (ABA)

6.46.1. Effective February 1, 2018, the MCO shall cover Applied Behavior Analysis (ABA) services.

6.46.2. The MCO shall coordinate and ensure continuity of care between behavioral health specialists, primary care physicians, and other health care specialists, including but not limited to providers qualified to perform Comprehensive Diagnostic Evaluations (CDE), occupational therapists, physical therapists, and speech therapists as indicated and based on medical necessity criteria for such services.

6.46.3. The MCO shall ensure member and provider call center staff and utilization management staff are knowledgeable in ABA services. Staff shall be capable of providing an explanation of ABA services, a list of ABA providers, and information regarding the prior authorization process to members or providers seeking information.

6.46.4. ABA service shall not be denied solely because a member does not have an ASD diagnosis.

6.47. Care Management Evaluation

6.47.1. The MCO shall participate in LDH-directed activities to evaluate the effectiveness of MCO care management, care coordination, and case management operations, identify evidence-based practices, and develop and implement interventions to increase effectiveness.

INTENTIONALLY LEFT BLANK

7.0 PROVIDER NETWORK REQUIREMENTS

7.1. General Provider Network Requirements

7.1.1. The MCO shall maintain and monitor a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered under this contract for all members, including those with limited English proficiency or physical or mental disabilities.

~~7.1.1.~~**7.1.2.** The MCO must maintain a network that ensures, at minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]

~~7.1.2.~~**7.1.3.** All services covered under this contract shall be accessible to MCO members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area.

~~7.1.3.~~**7.1.4.** Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section, Appendix UU – **Provider Network – Geographic and Capacity Standards**, and in Appendix SS **– Provider Network – Appointment Availability Standards**. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.

~~7.1.4.~~**7.1.5.** If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].

7.1.6. The MCO's network providers shall comply with all requirements set forth in this RFP.

~~7.1.5.~~**7.1.7.** The MCO's network providers shall ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.

7.1.8. At the request of the member, the MCO shall provide for a second opinion from a network provider, or arrange for the member to obtain one outside the network, at no cost to the member.

~~7.1.6.~~**7.1.9.** The MCO and its providers 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, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by:

- Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required);
- Assessing the cultural competency of the providers on an ongoing basis, at least annually;
- Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.;
- Assessing provider satisfaction of the services provided by the MCO at least annually; and
- Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.

7.1.10. The MCO shall ensure parity in determining access to out of network providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in accordance with 42 CFR §438.910(d)(3).

7.2. Appointment Availability Access Standards

7.2.1. The following appointment availability standards have been established as minimum requirements to ensure that members' needs are sufficiently met. DHH will monitor the MCO's compliance with these standards through regular reporting as shown in Appendix UU **– Provider Network – Geographic and Capacity Standards**. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:

7.2.1.1. Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request;

7.2.1.2. Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request;

7.2.1.3. Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;

7.2.1.4. Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;

7.2.1.5. Specialty care consultation within 1 month of referral or as clinically indicated;

7.2.1.6. Lab and X-ray services (usual and customary) not to exceed three weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and

7.2.1.7. Maternity Care

Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing member or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy.

- Within their first trimester within 14 days;
- Within the second trimester within 7 days;
- Within their third trimester within 3 days;
- High risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;

7.2.1.8. Follow-up to ED visits in accordance with ED attending provider discharge instructions.

7.2.1.9. In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

7.2.1.10. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment.

7.2.1.11. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

7.2.1.12. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

7.3. Geographic Access Requirements

The MCO shall comply with the ~~following~~ maximum travel time and/or distance requirements as specified in Appendix UU.~~, as determined by DHH approved mapping software (*e.g.* GeoAccess).~~ Requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the

findings to LDH as part of its annual Network Provider Development Management Plan.

7.3.1. Primary Care Providers

7.3.1.1. Travel distance for members living in rural parishes shall not exceed 30 miles; and

7.3.1.2. Travel distance for members living in urban parishes shall not exceed 10 miles.

7.3.2. Acute Inpatient Hospitals

7.3.2.1. Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement.

7.3.2.2. Travel distance for members living in urban parishes shall not exceed 10 miles.

7.3.3. Specialists

7.3.3.1. Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and

7.3.3.2. Travel distance shall not exceed 90 miles for all members.

7.3.3.3. Specialists included under this requirement are listed in Appendix TT **– Network Providers by Specialty Type.** DHH reserves the right to add additional specialty types as needed to meet the medical needs of the member population.

7.3.3.4. Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by DHH for this purpose.

7.3.4. Lab and Radiology Services

7.3.4.1. Travel distance shall not exceed 20 miles in urban parishes; and

7.3.4.2. Travel distance shall not exceed 30 miles for rural parishes.

7.3.5. Pharmacies

7.3.5.1. Travel distance shall not exceed 10 miles in urban parishes; and

7.3.5.2. Travel distance shall not exceed 30 miles in rural parishes.

7.3.6. Hemodialysis Centers

7.3.6.1. Travel distance shall not exceed 10 miles in urban areas; and

7.3.6.2. Travel distance shall not exceed 30 miles in rural areas.

7.3.7. Specialized Behavioral Health Providers

7.3.7.1. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or Clinical Nurse Specialist (CNS) in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles or 60 minutes for 90% of such members.

7.3.7.2. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes for 90% of such members.

~~Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 milesfor 90% of adult members, and shall not exceed 60 miles for adolescent members.~~

7.3.7.3. Travel distance to psychiatric inpatient hospital services~~Level III.7 Medically Monitored Intensive Residential co-occurring treatment~~ shall not exceed 90~~60~~ miles or 90 minutes for 90% of ~~adult~~ members. Maximum time for admission shall not exceed 4 hours (emergency involuntary), 24 hours (involuntary), or 24 hours (voluntary).

7.3.7.4. Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days.

~~7.3.7.3.~~**7.3.7.5.** Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.

7.3.7.6. Travel distance to ASAM Level 3.7 co-occurring treatment shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximus time for admission or appointment shall not exceed 10 business days.

~~7.3.7.4.~~**7.3.7.7.** Travel distance to ASAM Level 3.7WM~~III.7D Medically Monitored Residential Detoxification~~ shall not exceed 60 miles ~~for 90% of adult members~~or 90 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days. Withdrawal management shall be available within 24 hours when medically necessary.

~~7.3.7.5.~~**7.3.7.8.** Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles ~~for 90% of members~~or 3.5 hours for ~~9~~100% of members. Maximum time for admission shall not exceed 20 calendar days. Access and adequacy is based on availability of in-state PRTFs unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member.

~~7.3.7.6.~~**7.3.7.9.** Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to DHH for approval.

~~7.3.7.7.~~7.3.7.10. There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.

7.4. Provider to Member Ratios

7.4.1. The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in Appendix UU.

7.5. Monitoring and Reporting on Provider Networks

7.5.1. Appointment Availability Monitoring

7.5.1.1. The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts.

7.5.1.2. The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.

7.5.2. Geographic Availability Monitoring

7.5.2.1. The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in Appendix UU. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them.

7.5.2.2. The data in the quarterly GeoAccess reports shall be current, accurate, and consistent with provider registry data submitted to DHH by the plans as required in the MCO Systems Companion Guide.

7.5.2.3. The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan,

7.5.3. Provider to Member Ratios

7.5.3.1. Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and Appendix UU.

7.5.3.2. Member linkages to Primary Care providers shall be submitted to DHH weekly as described in the MCO Systems Companion Guide.

7.6. Provider Enrollment

7.6.1. Provider Participation

7.6.1.1. In accordance with 42 CFR §438.602(b) and upon LDH implementation of a provider management system, the MCO and its subcontractors shall not enter into a network provider agreement with a provider to provide services to Medicaid beneficiaries when the provider is not otherwise appropriately screened by and enrolled with the State according to the standards under 42 CFR §455 Subparts B and E and upon implementation of appropriate systems. Such enrollment includes providers that order, refer, or furnish services under the State Plan and Waivers. Such enrollment does not obligate providers to participate in the FFS healthcare delivery system.

7.6.1.2. Once providers are screened and enrolled with the State, the MCO may credential providers to verify they are qualified to perform the services they are seeking to provide and execute network provider agreements. The State may implement a NCQA-certified Credentials Verification Organization (CVO), in which case the MCO must participate on the CVO credentialing committee and accept the final credentialing decisions of the CVO.

7.6.1.3. The MCO may execute network provider agreements pending the outcome of the State screening, enrollment, and re-validation process of up to one hundred twenty (120) calendar days, but upon notification from the state that a provider's enrollment has been denied or terminated, or the expiration of the one hundred twenty (120) calendar day period without enrollment of the provider, the MCO shall terminate such network provider immediately and notify affected members that the provider is no longer participating in the network.

7.6.1.4. Prior to contracting with a network provider and/or paying a provider's claim, the MCO shall ensure that the provider has a valid National Provider Identifier (NPI) Number, where applicable, has a valid license or certification to perform services, has not been excluded or barred from participation in Medicare, Medicaid, and/or CHIP, and has obtained a Medicaid provider number from LDH upon implementation of appropriate systems.

~~7.6.1.1.~~**7.6.1.5.** MCO shall comply timely with all sanctions imposed by the State on network providers, including enrollment revocation, termination, and mandatory exclusions.

~~7.6.1.2.~~**7.6.1.6.** The MCO must offer a contract to the following providers:

- Louisiana Office of Public Health (OPH);
- All OPH-certified School Based Health Clinics (SBHCs);
- All small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs) (free-standing and hospital based);
- Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program;

- The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services; and
- All providers approved by the DHH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program.

~~a. The MCO must offer a contract to the following behavioral health provider types for specialized behavioral health services for the first twenty-two (22) months after integration. The time period for extending this requirement shall be decided by DHH:~~

- ~~Rural Health Clinics (RHCs);~~
- Local Governing Entities;
- ~~Federally Qualified health Centers;~~
- Methadone Clinics pending CMS approval;
- Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels 1, 2.1, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4-WM~~I, II.1, II.D, III.1, III.2D, III.3, III.5, III.7, III.7D, IV.D~~);
- Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®;
- Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)];
- All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs);
- ~~Mental Health Rehabilitation (MHR) Agencies;~~
- Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).

~~7.6.1.3.~~7.6.1.7. The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.

~~7.6.1.4.~~7.6.1.8. If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.

~~7.6.1.5.~~7.6.1.9. The provision~~s~~ above ~~(7.6.1.2 and 7.6.1.3)~~ do~~es~~ not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. Th~~is ese~~ provision~~s~~ also do~~es~~ not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from

using reimbursement amounts that are ~~the~~ greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].

~~7.6.1.6.~~7.6.1.10. If the MCO declines requests of individuals or groups of providers to be included in the MCO network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR §438.12(a)(1)].

~~7.6.1.7.~~7.6.1.11. The MCO shall work with DHH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.

~~7.6.1.8.~~7.6.1.12. The MCO shall comply with any additional requirements established by LDH.

7.6.2. Exclusion from Participation

7.6.2.1. The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/ , and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.

7.6.2.2. The MCO shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings:

7.6.2.2.1. Revocation of the provider's home and community-based services license or behavioral health service license;

7.6.2.2.2. Exclusion from the Medicaid program;

7.6.2.2.3. Termination from the Medicaid program;

7.6.2.2.4. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41);

7.6.2.2.5. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or

7.6.2.2.6. The Louisiana Attorney General's Office has seized the assets of the service provider.

7.6.2.3. The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.

7.6.3. Other Enrollment and Disenrollment Requirements

7.6.3.1. The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR §438.12(a)(1) ~~and (2)~~]. The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(2)]. In addition, the MCO shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR §438.214(c)].

7.6.3.2. All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.

7.6.3.3. If the MCO terminates a provider's contract for cause, the MCO shall provide ~~immediate~~ written notice to the provider within one (1) business day of the decision being made. The notice shall be through electronic means followed by a certified letter mailed within one (1) business day. The MCO shall notify DHH ~~of the termination as soon as possible, but no later than seven (7) calendar days, of written~~ through email prior to provider notification ~~of cancelation to the provider~~.

7.6.3.4. If termination affects network adequacy, the MCO shall include in the notification to DHH their plans to notify MCO members of such change and strategy to ensure timely access for MCO members through different in-network and/or out-of-network providers. If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure that will be no stoppage or interruption of services to members.

~~7.6.3.4.~~**7.6.3.5.** The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of issuance of the termination notice, to each MCO 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~~1) within the past two years.

7.7. Mainstreaming

7.7.1. DHH considers mainstreaming of MCO members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.

7.7.2. To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference,

health status, income status, program membership, or physical, ~~or~~ behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

7.7.2.1. Denying or not providing to a member any covered service or availability of a facility.

7.7.2.2. Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.

7.7.2.3. Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, separate physical locations, or preference to private pay or Medicaid fee-for-service patients.

7.7.3. When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify DHH in writing.

7.7.4. The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.

7.8. Primary Care

The PCP shall serve as the member's initial and most important point of interaction with the MCO's provider network. A PCP in the MCO must be a provider who provides or arranges for the delivery of medical services, including case management, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in this Section.

7.8.1. Assignment of Primary Care Providers

7.8.1.1. As part of the financial Medicaid application process, applicants may be given the option to indicate their preferred choice of MCO.

7.8.1.2. If the choice of MCO is not indicated on the new eligible file transmitted by DHH to the Enrollment Broker, the Enrollment Broker shall contact the eligible individual to request their choice of MCO and if available the PCP of choice.

7.8.1.3. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in an MCO.

7.8.1.4. The name of PCP requested by a new enrollee will be included in the Member File from the Enrollment Broker to the MCO.

7.8.1.5. The MCO shall confirm the PCP selection information in a written notice to the member.

7.8.1.6. If no PCP is selected on the Member File received from the Enrollment Broker, the MCO shall contact the member, as part of the welcome call, within ten (10) business days of receiving the Member File from the Enrollment Broker to assist the member in making a selection of a PCP or auto assign a PCP;

7.8.1.7. Inform the member that each family member has the right to choose his/her own PCP. The MCO may explain the advantages of selecting the same primary care provider for all family members, as appropriate.

7.8.1.8. Members, for whom an MCO is the primary payor, who do not proactively choose a PCP will be auto-assigned to a PCP by the MCO. Members, for whom an MCO is a secondary payor, will not be assigned to a PCP by the MCO, unless the members request that the MCO do so.

7.8.1.9. The MCO shall be responsible for providing to the Enrollment Broker, information on the number of Medicaid member linkages and remaining capacity of each individual PCP of additional Medicaid member linkages on a quarterly basis.

7.8.1.10. If the member does not select a PCP and is auto assigned to a PCP by the MCO, the MCO shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP without cause.

7.8.1.11. Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve months (12) months beginning from the original date the member was assigned to the MCO.

7.8.1.12. If a member requests to change his or her PCP with cause, at any time during the enrollment period, the MCO must agree to grant the request.

7.8.1.13. The MCO shall have written policies and procedures for allowing members to select a new PCP, including auto-assignment, and provide information on options for selecting a new PCP when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the MCO, or when a PCP change is ordered as part of the resolution to a grievance proceeding. The MCO shall allow members to select another PCP within ten (10) business days of the postmark date of the termination of PCP notice to members and provide information on options for selecting a new PCP.

7.8.1.14. The MCO shall have policies for accessing emergency/urgent care during this transition period. These policies and procedures shall be submitted within thirty (30) days from the date the MCO signs the Contract with DHH.

7.8.1.15. The MCO shall notify the Fiscal Intermediary by close of business the next business day of a PCP's termination.

7.8.1.16. The MCO shall have written policies and procedures for handling the assignment of its members to a PCP. The MCO is responsible for linking to a PCP all assigned MCO members for whom the MCO is the primary payor.

7.8.1.17. PCP Auto-Assignments

7.8.1.17.1. The MCO is responsible for developing a PCP automatic assignment methodology in collaboration with DHH to assign to a PCP an enrollee for whom the MCO is the primary payor when the enrollee:

7.8.1.17.2. Does not make a PCP selection after a voluntary selection of an MCO; or

7.8.1.17.3. Selects a PCP within the MCO that has reached their maximum physician/patient ratio; or

7.8.1.17.4. Selects a PCP within the MCO that has restrictions/limitations (*e.g.* pediatric only practice).

7.8.1.17.5. Does not make a selection of a PCP for a newborn within fourteen (14) calendar days of birth. The effective date of a PCP selection or assignment of a newborn will be no later than the first month of enrollment subsequent to the birth of the child.

7.8.1.17.6. Assignment shall be made to a PCP with whom, based on fee-for-service claims history or prior linkage, the member has a historical provider relationship. If there is no historical PCP relationship, the member shall be auto-assigned to a provider who is the assigned PCP for an immediate family member enrolled in the MCO plan. If other immediate family members do not have an assigned PCP, auto-assignment shall be made to a provider with who a family member has a historical provider relationship.

7.8.1.17.7. If there is no member or immediate family historical usage, members shall be auto-assigned to a PCP using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.

7.8.1.17.8. The final MCO PCP automatic assignment methodology must be provided thirty (30) days from the date the MCO signs the contract with DHH Approval must be obtained from the Department prior to implementation. This methodology must be made available via the MCO's website, Provider Handbook, and Member Handbook.

7.8.2. Primary Care Provider Responsibilities

The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:

7.8.2.1. Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;

7.8.2.2. Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;

7.8.2.3. Communicating with all other levels of medical care to coordinate, and follow up the care of individual patients

7.8.2.4. Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid;

7.8.2.5. Maintaining a medical record of all services rendered by the PCP and a record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;

7.8.2.6. Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.

7.8.2.7. Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.

7.8.2.8. Providing after-hours availability to patients who need medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.

7.8.2.9. Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.

7.8.2.10. Working with MCO case managers to develop plans of care for members receiving case management services.

7.8.2.11. Participating in the MCO's case management team, as applicable and medically necessary.

7.8.2.12. Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.

7.8.3. Specialty Providers

7.8.3.1. The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.

7.8.3.2. The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).

7.8.3.3. The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care,

7.8.3.4. The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

- The MCO has signed a contract with providers of the specialty types listed in Appendix TT who accept new members and are available on at least a referral basis; and

- The MCO is in compliance with access and availability requirements.

7.8.3.5. The MCO shall assure, at a minimum, the availability of the specialists listed in Appendix TT with the ratio, distance, and appointment time requirements set in this Section and in Appendices SS and UU**.**

7.8.3.6. The MCO will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by DHH the MCO does not meet the access standards specified in the Contract.

7.8.3.7. In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

7.8.4. Hospitals

7.8.4.1. Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.

7.8.4.2. The MCO shall include, at a minimum, access to the following:

7.8.4.2.1. One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital.

7.8.4.2.2. MCO must establish access to the following within their network of hospitals:

- Level III Obstetrical services;
- Level III Neonatal Intensive Care (NICU) services;
- Pediatric services;
- Trauma services;
- Burn services; and
- A Children's Hospital that meets the CMS definition in 42 CFR Parts 412 and 413

7.8.4.3. The MCO may contract with out-of-state hospitals in the trade area.

7.8.4.4. If there are no hospitals within the parish that meet these requirements in section 7.8.4.2.1, or a contract cannot be negotiated, the MCO may contract with out-of-state hospitals to comply with these requirements.

7.8.5. Tertiary Care

Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.

7.8.6. Direct Access to Women's Health Care

The MCO shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.

7.8.6.1. The MCO shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services.

~~**7.8.6.1.**~~**7.8.6.2.** The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP.

~~**7.8.6.2.**~~**7.8.6.3.** MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.

~~**7.8.6.3.**~~**7.8.6.4.** The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services.

~~7.8.6.4.~~7.8.6.5. The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.

7.8.7. Prenatal Care Services

7.8.7.1. The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one. The MCO shall cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another network provider. The MCO shall compensate, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted with the MCO, but subject to the same requirements as a contracted provider.

7.8.8. Other Service Providers

The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.

7.8.9. Non-Emergency Medical Transportation

7.8.9.1. MCO shall have sufficient NEMT providers, including wheelchair lift equipped vans, to transport members to medically necessary services when notified 48 hours in advance, and MCOs must be able to arrive and provide services with sufficient time to ensure the member arrives at their appointment at least 15 minutes but no more than 1 hour early.

7.8.9.2. For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the MCO shall require its transportation contractor to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.

7.8.9.3. If a member requests an MCO provider who is located beyond access standards, and the MCO has an appropriate provider within the MCO who accepts new patients, it shall not be considered a violation of the access requirements for the MCO to grant the member's request. However, in such cases the MCO shall not be responsible for providing transportation for the member to access care from this selected provider, and the MCO shall notify the member in writing as to whether or not the MCO will provide transportation to seek care from the requested provider.

7.8.10. FQHC/RHC Clinic Services

7.8.10.1. The MCO must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the state.

7.8.10.2. See Section 9 of this RFP for FQHC/RHC reimbursement requirements

7.8.11. School-Based Health Clinics (SBHCs)

7.8.11.1. SBHC (certified by the DHH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.

7.8.11.2. The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.

7.8.12. Laboratory

7.8.12.1. All laboratory testing sites providing services under this Contract must have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.

7.8.13. Local Parish Health Clinics

7.8.13.1. The MCO must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (*e.g.* immunizations, STD, family planning).

7.8.13.2. The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the MCO.

7.8.14. Specialized Behavioral Health Providers

7.8.14.1. The MCO shall ~~work with the existing network of behavioral health providers to~~ ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring ~~including~~ mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.

7.8.14.2. The MCO shall ensure its provider network offers ~~an appropriate~~ covered ~~range of preventive and~~ specialized behavioral health services as reflected in the DHH Behavioral Health Provider Manual ~~Service Definitions Manual that is~~ and meets the network adequacy standards defined in this contract. The provider network shall be adequate for the anticipated number of members for the service area. The service array shall comply ~~, including compliance~~ with the waivers and Medicaid State Plan requirements.

7.8.14.3. The network shall be developed to meet the needs of members, including but not limited to providing assessment to identify and treat the behavioral health needs of members with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.

7.8.14.4. The MCO shall design its provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital admissions. The MCO shall coordinate with other state agencies, as appropriate, to match services to meet behavioral health needs in the community with services and supports to meet the members other needs in the community, such as I/DD.

7.8.14.5. The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing ~~required peer~~ services for youth, adults and parents/families served in community and residential settings, peer services as approved by LDH as cost-effective alternative services, and peer support specialists with OBH approved credentials~~(i.e., required peer services such as Youth Support Training and Parent Support Training), in lieu of peer services, and peers certified~~ to serve as qualified providers ~~of other state plan/waiver services (including, but not limited to, PSR or CPST)~~.

7.8.14.6. The MCO shall ensure that within the provider network, members enrolled in 1915(c) CSoC Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.

7.8.14.7. The MCO shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services during evenings and weekends ~~for members or their families/caregivers who are unavailable for appointments during traditional business hours~~.

7.8.14.8. The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. ~~The community-based crisis response system may include, but is not limited to,~~ Crisis services shall include an on-call, 24-hour crisis hotline~~, warm line~~, crisis counseling, crisis intervention and follow up, linkage to ongoing behavioral health management and intervention, ~~mobile crisis teams,~~ and crisis stabilization for children. The MCO may also coordinate with community resources to expand the crisis response. The community-based crisis response system may include, but is not limited to, warmlines, mobile crisis teams, collaboration with law enforcement crisis stabilization in an alternative settings, and crisis stabilization/crisis receiving centers for adults.

If shortages in provider network sufficiency are identified by DHH, the MCO shall conduct outreach efforts approved by DHH, and take necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a clinical

need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.

7.8.14.9. The MCO must ensure that all placements are at the most appropriate and medically necessary level to treat the specialty needs of the member.

7.8.14.10. The MCO shall require behavioral health providers to screen for basic medical issues~~, such as utilizing the healthy living questionnaire 2011 or the PBHCI medical screening short form~~.

7.8.14.11. The MCO shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability.

7.8.14.12. The MCO shall report the number of out-of-state placements as specified by LDH. LDH may require the MCO to take corrective action in the event LDH determines the MCO's rate of out of state placements to be excessive.

7.8.15. Indian Health Care providers (IHCPs)

7.8.15.1. The MCO shall demonstrate that there are sufficient IHCPs participating in the provider network of the MCO to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services.

7.8.15.2. The IHCPs, whether participating in the MCO network or not, shall be paid for covered services provided to Indian members who are eligible to receive services from such providers as follows:

7.8.15.2.1. At a rate negotiated between the MCO and the IHCP; or

7.8.15.2.2. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO would make for the services to a participating provider which is not an IHCP; and

7.8.15.2.3. Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and §447.46.

7.8.15.3. The MCO shall permit any Indian who is enrolled with the MCO and is eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services.

7.8.15.4. The MCO shall permit Indian members to obtain services covered under the contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.

7.8.15.5. Where timely access to covered services cannot be ensured due to few or no IHCPs, the MCO will be considered to have met the requirement in paragraph 42 CFR §438.14 (b)(1) if:

7.8.15.5.1. Indian members are permitted by the MCO to access out-of-state IHCPs; or

7.8.15.5.2. If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).

~~7.8.14.11.~~**7.8.15.6.** The MCO shall permit an out-of-network IHCP to refer an Indian member to a network provider.

7.9. Network Provider Development Management Plan

7.9.1. The MCO shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR §438.207(b)]. The Network Development and Management Plan shall be submitted to DHH as part of the proposal, as well as when significant changes occur and at least annually thereafter. The Network Development and Management Plan shall include the MCO'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 MCO shall consider the following (42 CFR §438.~~20~~68):

7.9.1.1. Anticipated maximum number of Medicaid members;

7.9.1.2. Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;

7.9.1.3. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;

7.9.1.4. The numbers of MCO providers who are not accepting new MCO members; and

7.9.1.5. 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.

7.9.2. The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:

7.9.2.1. Assurance of Adequate Capacity and Services and supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state standards for access to care, including the standards at 42 CFR §438.68 and 438.206(b)

7.9.2.2. Assurance it offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members in the service area;

~~**7.9.2.2.**~~**7.9.2.3.** Access to Primary Care Providers

~~**7.9.2.3.**~~**7.9.2.4.** Access to Specialists

~~**7.9.2.4.**~~**7.9.2.5.** Access to Hospitals

~~**7.9.2.5.**~~**7.9.2.6.** Access to Behavioral Health Services

~~**7.9.2.6.**~~**7.9.2.7.** Timely Access

~~**7.9.2.7.**~~**7.9.2.8.** Service Area

~~**7.9.2.8.**~~**7.9.2.9.** Other Access Requirements

- Direct Access to Women's Health
- Special Conditions for Prenatal Providers
- Second Opinion
- Out-of-Network Providers

7.9.3. The Network Provider Development and Management Plan shall identify gaps in the MCO's provider network and describe the process by which the MCO shall assure all covered services are delivered to MCO members. Planned interventions to be taken to resolve such gaps shall also be included. The MCO shall include the corrective action(s) taken when a network provider fails to comply with timely access requirements.

7.9.3.1. The MCO shall ensure network capacity sufficient to meet the specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders. The plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population.

7.9.3.2. Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified in the provider directory.

7.9.4. The MCO 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 MCO shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.

7.9.5. The MCO shall develop and implement Network Development and Management policies and policies detailing how the MCO will [42 CFR §438.214(a)]:

7.9.5.1. Communicate and negotiate with the network regarding contractual and/or program changes and requirements;

7.9.5.2. Monitor network compliance with policies and rules of DHH and the MCO, 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;

7.9.5.3. Evaluate the quality of services delivered by the network;

7.9.5.4. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;

7.9.5.5. 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; and

7.9.5.6. Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;

7.9.5.7. Provide training for its providers and maintain records of such training;

7.9.5.8. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;

7.9.5.9. Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from DHH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.

7.9.6. An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.

7.9.7. MCO Network Development and Management policies shall be subject to approval by DHH, Medicaid Managed Care Section and shall be monitored through operational audits.

7.9.8. Specialized Behavioral Health Network Development and Management Plan

An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to DHH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect material changes in network status.

7.9.8.1. The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract.

7.9.8.2. The MCO's Network Development and Management Plan shall include the following requirements for specialized behavioral health providers:

- The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this contract;
- The numbers and types (in terms of training, experience, and specialization) of specialized behavioral health providers required to furnish the contracted specialized behavioral health services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);
- GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to DHH quarterly by contract year, upon material change of the network, or upon request;
- An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include:
    - Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services;
    - Specialized behavioral health service needs of members; and
    - Growth trends in eligibility and enrollment, including:
        - Current and anticipated numbers of Title XIX and Title XXI eligibles; and
        - Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with DHH goals and principles.
- Accessibility of services, including:
    - The number of current qualified specialized behavioral health service providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible;
    - The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation;
    - Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and
    - Any service access standards detailed in a SPA or waiver.

7.9.8.3. The MCO shall submit to DHH as part of its annual Network Development and Management Plan, and upon request of DHH, specialized behavioral health provider profiling data, which shall include:

- Member eligibility/enrollment data;
- Specialized behavioral health service utilization data;
- The number of single case agreements by specialized behavioral health service type;
- Specialized behavioral health treatment and functional outcome data;
- The number of members diagnosed with developmental/cognitive disabilities;
- The number of prescribers required to meet specialized behavioral health members' medication needs;
- The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need;
- Provider grievance, appeal and request for arbitration data; and
- Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.

7.9.8.4. For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that:

- Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent;
- Includes specific specialized behavioral health services for adults eligible for services as defined in this contract;
- Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services;
- Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and

  Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.

7.9.8.5. For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as:

- Includes specific specialized behavioral health services for children;

- Targets the development of family and community-based services for children/youth in out-of-home placements;
- Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of-home placements; and
- Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.

7.9.8.6. The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows:

- Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206;
- Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by:
    - Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required);
    - Assessing the cultural competence of the providers on an ongoing basis, at least annually;
    - Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.;
    - Assessing provider satisfaction of the services provided by the MCO at least annually; and
    - Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.

7.9.8.7. The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.

7.10. Patient-Centered Medical Home (PCMH)

7.10.1. A Patient-Centered Medical Home (PCMH) is a system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, mental health programs, and home health agencies.

7.10.2. The MCO shall promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered coordinated care management processes and Health Information Technology to deliver improve quality of care, health outcomes and patient compliance and satisfaction.

7.10.3. PCMH transformation efforts, may include but are not limited to the attainment of National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home (PCH) accreditation.

7.10.4. The MCO shall provide a PCMH Implementation Plan within ninety (90) days of the "go live" date of this contract that identifies the methodology for promoting practice transformation to providing PCMHs for its members. The Plan shall include but is not limited to the following:

7.10.4.1. Any payment methodology for payment to primary care practices for the specific purpose of supporting necessary costs to transform and sustain a medical home practice:

7.10.4.2. Provision of technical support, to assist in their transformation ;

7.10.4.3. Facilitation of specialty provider network access and coordination to support the PCMH;

7.10.4.4. Efforts to increase and support the provision of appropriate basic behavioral services in the primary care setting, as well as, the coordination of services with specialty behavioral health providers and other community support services;

7.10.4.5. Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.

7.10.4.6. Methodology for evaluating the level of practice participation, level of practice transformation and any capacity and/or health outcomes achieved, The findings from all evaluations shall be included in the annual update of the PCMH Implementation Plan.

7.11. Material Change to Provider Network

7.11.1. The MCO shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO 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 MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following:

7.11.1.1. Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered.

7.11.1.2. A decrease in the total of individual PCPs by more than five percent (5%);

7.11.1.3. A loss of any participating specialist which may impair or deny the members' adequate access to providers;

7.11.1.4. A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or

7.11.1.5. Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.

7.11.2. The MCO 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~~value-added benefits and services, payments, or eligibility of a new population.

7.11.3. When the MCO has advance knowledge that a material change will occur, the MCO 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.

7.11.4. 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.

7.11.5. If DHH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, DHH will expedite the approval process.

7.11.6. The MCO shall notify the DHH/BHSF/Medicaid Managed Care Section within one (1) business day of the MCO becoming aware 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 MCO, 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:

7.11.6.1. Information about how the provider network change will affect the delivery of covered services, and

7.11.6.2. The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

7.11.7. MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.

7.11.8. As it pertains to a material change in the network for behavioral health providers, the MCO shall also:

7.11.8.1. Provide written notice to DHH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include:

- A decrease in a behavioral health provider type by more than five percent (5%);
- A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or
- A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by DHH.

7.11.8.2. The MCO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.

7.11.8.3. When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to DHH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change.

7.11.8.3.1. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including:

- Detailed information identifying the affected provider;
- Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category;
- Location and identification of nearest providers offering similar services; and
- A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.

7.11.8.4. If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to DHH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to appropriate alternative behavioral health service providers in accordance with the network notification requirements.

7.11.8.5. The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by DHH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).

7.12. Coordination with Other Service Providers

The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils, Areas on Aging, and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

7.13. Provider Subcontract Requirements

7.13.1. In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which the MCO represents or agrees that it will not contract with another provider. The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

7.13.2. The MCO shall have written policies and procedures for selection and retention of providers in accordance with 42 CFR §438.214.

7.13.2.1. Within 30 days of the MCO signing the contract, it shall provide DHH with written provider credentialing and re-credentialing policies that are compliant with NCQA Health Plan Accreditation standards and all applicable state laws

7.13.2.2. The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

7.13.3. The MCO shall inform all providers and subcontractors, at the time they enter into a contract, about members' rights to file grievances and appeals, and request State Fair Hearings per Section 13.

7.13.4. The MCO shall require the provider to report loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of receipt of notification, if required to be accredited.

7.13.5. The MCO shall require the provider to immediately report cancellation of any required insurance coverage, licensure, or certification to the MCO.

~~7.13.4.~~7.13.6. As required by 42 CFR §438.6(1), §438.230(a) and § 438.230(b)(1),(2),(3) the MCO 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:

~~7.13.4.1.~~7.13.6.1. All provider subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract;

~~7.13.4.2.~~7.13.6.2. 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;~~.~~

~~7.13.4.3.~~7.13.6.3. Prior to executing a network provider agreement, ~~T~~the MCO must evaluate the prospective provider's and/or subcontractor's qualifications and ability to perform the activities to be delegated;

~~7.13.4.4.~~7.13.6.4. The MCO must have a written agreement between the MCO 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;

~~7.13.4.5.~~7.13.6.5. The MCO 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;

~~7.13.4.6.~~7.13.6.6. The MCO shall identify deficiencies or areas for improvement, and take corrective action; and

~~7.13.4.7.~~7.13.6.7. The MCO shall specifically deny payments to subcontractors for Provider Preventable Conditions.

~~7.13.5.~~7.13.7. The MCO 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.

~~7.13.6.~~7.13.8. Notification of amendments or changes to any provider subcontract which, in accordance with Section 7.6 of this RFP, materially affects this Contract, shall be provided to DHH prior to the execution of the amendment in accordance with Section 23.1 of this RFP.

~~7.13.7.~~7.13.9. The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO 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.

~~7.13.8.~~7.13.10. The MCO shall provide written notification to DHH of its intent to terminate any provider subcontract that may materially impact the MCO'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 MCO shall provide immediate written notice to the provider.

~~ii. If termination is related to network access, the MCO shall include in the notification to DHH their plans to notify MCO members of such change and strategy to ensure timely access to MCO members through out-of-network providers. If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers.~~

~~7.13.9.~~7.13.11. The MCO shall make a good faith effort to give written notice of termination of a subcontract provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO 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).

~~7.13.10.~~7.13.12. All subcontracts executed by the MCO pursuant to this Section shall, at a minimum, include the terms and conditions listed in Section 25 of this RFP. No other terms or conditions agreed to by the MCO and its subcontractor shall negate or supersede the requirements in Section 25.

~~7.13.11.~~7.13.13. All contracts and/or agreements between a MCO and its subcontractors and/or providers shall provide that the contractor, subcontractor and/or provider shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU, the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

7.13.14. All subcontracts executed by the MCO shall specify that the subcontractor agrees that:

7.13.14.1. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State;

7.13.14.2. The subcontractor will make available, for purposes of an audit, evaluation, or inspection under Section 7.13.14.1, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members;

7.13.14.3. The right to audit under Section 7.13.14.1 will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

~~7.13.11.1.~~**7.13.14.4.** If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

7.14. Credentialing and Re-credentialing of Providers and Clinical Staff

7.14.1. The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230, and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to DHH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.

7.14.1.1. Prior to ~~sub~~contracting, the MCO shall ~~follow DHH~~ credential providers to ensure provider facilities, organizations, and staff meet all qualifications and requirements established by LDH policy ~~in requiring~~ including but not limited to the Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for all specialized behavioral health providers. MCO credentialing files on providers shall include verification of meeting said requirements. This shall include that agencies offering m~~M~~ental health rehabilitation services (CPST, PSR and/or CI), Assertive Community Treatment (ACT), PRTFs, TGHs and SUD residential treatment facilities ~~to~~ supply proof of accreditation ~~or~~ by an LDH approved accrediting body, which shall be made part of the agency's credentialing file with the MCO. Agencies not accredited at the time of credentialing shall supply proof that the ~~applicant~~ agency applied for accreditation and paid the initial application fee. ~~for one of the national accreditation organizations listed below. New a~~Agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with the MCO. Specialized behavioral health provider types required to be accredited by rule, regulation, waiver or State Plan Amendment (SPA) prior to contracting or prior to receiving Medicaid reimbursement, shall have proof of accreditation on file with the MCO. LDH approved national accrediting bodies include:

- The Council on Accreditation (COA);
- The Commission on Accreditation of Rehabilitation Facilities (CARF); or
- The Joint Commission (TJC).

7.14.2. The MCO shall use the **Louisiana Standardized Credentialing Application Form** (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if available for their provider type.

7.14.3. The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

7.14.4. If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.

7.14.5. The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. “Completely process” shall mean that the MCO shall:

7.14.5.1. Review, approve and load approved applicants to its provider files in its claims processing system; and

7.14.5.2. Submit on the weekly electronic Provider Directory to DHH or DHH’s designee; or

7.14.5.3. Deny the application and assure that the provider is not used by the MCO.

7.14.6. If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with DHH’s credentialing requirements.

7.14.7. The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by DHH in advance.

7.14.8. To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.

7.14.9. The MCO shall notify DHH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

7.14.10. The process of periodic re-credentialing shall be completed at least once every three (3) years.

7.14.11. The MCO 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.

7.14.12. The MCO shall develop and implement a mechanism, subject to DHH 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) days from the date the Contract is signed and at the time of any change.

7.14.13. The MCO shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.

7.14.14. The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.

7.15. Credentialing Committee

7.15.1. The MCO must designate a credentialing committee that uses a peer review process to evaluate provider credentialing files (including re-credentialing files). The credentialing committee, including the Medical Director, is responsible for credentialing decisions and is required to document its steps in the decision process and maintain individual provider files. A physician must oversee the credentialing committee.

7.15.1.1. Contracting of Behavioral Health Providers

7.15.1.1.1. The MCO shall enter into written subcontracts with qualified behavioral health service providers to deliver covered behavioral health services to members. The contract shall specify the activities and reporting responsibilities delegated to the provider; and provide for revoking delegation, terminating contracts, or imposing other sanctions if the provider's performance is inadequate.

7.15.1.1.2. Upon request, DHH shall be given copies of any subcontracts entered into by the MCO regarding behavioral health services, including provider subcontracts. Any proprietary information regarding rate setting may be redacted by the MCO.

7.15.1.1.3. All behavioral health provider subcontracts shall include the following provisions:

7.15.1.1.3.1. The name and address of the subcontracted behavioral health provider.

7.15.1.1.3.2. The method and amount of compensation, reimbursement, payment, and other considerations provided to the behavioral health provider.

7.15.1.1.3.3. Identification of the population to be served by the behavioral health provider, including the number of members the provider is expected to serve.

7.15.1.1.3.4. The amount, duration, and scope of covered behavioral health services to be provided.

7.15.1.1.3.5. The provider's treatment site shall be a smoke-free environment.

7.15.1.1.3.6. The term of the provider's subcontract, including beginning and ending dates, and procedures for extension, termination, and renegotiation.

7.15.1.1.3.7. The provider is responsible for ensuring any patient data (including data for the uninsured populations) required by the MCO is provided through an EHR interface or an ongoing data file submission.

7.15.1.1.3.8. Specific behavioral health provider subcontract duties relating to coordination of benefits and determination of third-party liability.

7.15.1.1.3.9. Identification of Medicare and other third-party liability coverage and requirements for seeking Medicare or third-party liability payments before submitting claims and/or encounters to MCO, when applicable.

7.15.1.1.3.10. Maintenance of an appropriate clinical record keeping system that ensures appropriateness of billing.

7.15.1.1.3.11. A requirement that contracted, allowable prescribing providers shall utilize the electronic Medicaid Clinical Data Inquiry (e-CDI) system (accessible via www.lamedicaid.com) to perform medication searches within the member's medical history to ensure that appropriate medication management is conducted.

7.15.1.1.3.12. Compliance with the requirements in the MCO QAPI and UM plans/program including PIP and Corrective Action Plans.

7.15.1.1.3.13. Language that requires a written contract amendment and prior approval of DHH, if the provider participates in any merger, reorganization, or changes in ownership or control, that is related to or affiliated with the MCO.

7.15.1.1.3.14. The HIPAA Business Associate Addendum.

7.15.1.1.3.15. Assumption of full responsibility for all tax obligations, worker's compensation insurance, and all other applicable insurance coverage obligations required in this contract, for itself and its employees, and that DHH shall have no responsibility or liability for any taxes or insurance coverage.

7.15.1.1.3.16. Incorporation by reference of the ~~DHH Service Definitions~~Medicaid Behavioral Health Provider Manual and the MCO's Provider Manual and language that the behavioral health provider subcontract complies with all requirements stated in this contract and CMS approved waiver and SPA.

7.15.1.1.3.17. A requirement that all behavioral health network providers request a standardized release of information from each member to allow the network provider to coordinate treatment with the member's primary care physician.

7.15.1.1.3.18. A requirement that the behavioral health provider notify the MCO when it is not accepting new clients, or if it does not accept a client and the associated cause.

7.15.1.1.3.19. Compliance with encounter reporting and claims submission requirements in accordance with this contract (to be detailed in the MCO's Provider Manual), including payment withhold provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting.

7.15.1.1.3.20. A provision that the MCO will not offset DHH recouped payments on the behavioral health provider after DHH has verified that the MCO was at fault for the error in payment.

7.15.1.1.3.21. A requirement that behavioral health providers adopt the utilization management guidelines, and to measure compliance with the guidelines.

7.15.1.1.3.22. The right of a provider to appeal a claims dispute in accordance with this contract (to be detailed in the MCO's Provider Manual).

7.15.1.1.3.23. The provider shall be responsible for assisting members in understanding their right to file grievances and appeals in accordance with the MCO's Provider Manual. The MCO must provide the information specified at 42 C.F.R. §438.10(g)(2~~1~~)(xi).

7.15.1.1.3.24. Compliance by the subcontractor with audits, inspections and reviews in accordance with the MCO's Provider Manual, including any reviews the MCO or DHH may conduct.

7.15.1.1.3.25. Facilitation by the provider of another provider's reasonable opportunity to deliver services, and the prohibition of any commission or condoning of any act or omission by the provider or by state employees that interferes with, delays, or hinders service delivery by another provider.

7.15.1.1.3.26. Compliance with adverse incident reporting policy and standards approved by DHH.

7.15.1.1.3.27. Timely implementation by the provider of DHH or MCO decisions related to grievances, member appeals, claims dispute or adverse incident mitigation recommendations.

7.15.1.1.3.28. Compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any behavioral health member, according to 42 CFR §438.12(e).

7.15.1.1.3.29. Submission to DHH and/or the MCO as determined by DHH of the NOMs, including access to services, engagement in services, independent and stable housing, employment, and employment training rates.

7.15.1.1.3.30. Members reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in providers.

7.15.1.1.3.31. The DHH definition of medically necessary covered behavioral health services and the DHH levels of care are incorporated by reference.

7.15.1.1.3.32. A requirement that the providers assess the cultural and linguistic needs of the service area, and deliver services that address these needs to the extent resources are available.

7.15.1.1.3.33. A requirement that the providers attend trainings on cultural competence. The MCO shall include a cultural competency component in each training topic.

7.15.1.1.3.34. Language for supplying business transaction information upon request as required by 42 CFR §455.105. The credentialing forms and provider agreements used by the MCO will require network providers to disclose business transactions with wholly owned suppliers or any subcontractors upon request.

7.15.1.1.4. The MCO shall evaluate and make a determination to retain behavioral health providers utilizing performance and QI data acquired while delivering services under this contract.

7.15.1.1.5. The MCO shall clearly describe and disseminate the process and criteria to be used for terminating behavioral health provider participation. If the MCO declines to subcontract with individuals or groups of behavioral health providers as part of the network, it shall give the affected providers prior written notice of the reason for its decision.

7.15.1.1.6. The MCO 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 behavioral health member who received his or her care from or was seen on a regular basis by the terminated provider.

7.15.2. Credentialing and Contracting of Permanent Supportive Housing Providers

7.15.2.1. Because Louisiana's Permanent Supportive Housing program is a cross-disability program, MCO contracted providers delivering PSH services must meet the following requirements prior to, and as a condition of maintaining, contracting and credentialing to provide tenancy supports for PSH program participants:

7.15.2.1.1. Fulfill the orientation, training, and annual review requirements required and delivered through the DHH PSH program office;

7.15.2.1.2. Be approved for participation by the DHH PSH Program Director with oversight of the DHH PSH Executive Management Committee;

7.15.2.1.3. Meet all requirements necessary to maintain credentialing to provide CPST;

7.15.2.1.4. Enroll to provide housing support services under the applicable 1915(c) HCBS waiver programs in FFS Medicaid and/or managed long term supports and services.

7.15.2.2. The MCO shall offer a contract to all providers meeting the above requirements and approved by the DHH PSH Program Director to participate in the Louisiana PSH program. The contract must meet all rate floor requirements, unless other terms are agreed to by both parties.

7.15.2.3. The MCO shall accept provider credentialing requests, review them for completeness, forward the request to the DHH PSH program for review, approval of program participation, and maintain a roster and records of qualified PSH providers.

7.15.2.4. At the request of the DHH PSH program the MCO shall assist the DHH PSH program in PSH provider certification (fidelity) reviews, including the mutual sharing of MCO audit and PSH program monitoring reports for PSH providers.

7.15.2.5. At the request of the DHH PSH program, the MCO shall assist in advertising PSH provider orientation to interested providers in each region where there is a need to expand PSH as identified by the DHH PSH program.

7.15.3. Network Guidelines for Subcontracted Providers Needing DCFS Licensing

It is the MCO's responsibility to ensure its subcontracted providers comply with DCFS licensing requirements as applicable and can submit proof of compliance upon request. The MCO shall follow communication protocols as established by DCFS if necessary.

7.16. Provider-Member Communication Anti-Gag Clause

7.16.1. Subject to the limitations described in 42 CFR §438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care 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:

7.16.1.1. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

7.16.1.2. Any information the member needs in order to decide among relevant treatment options;

7.16.1.3. The risks, benefits and consequences of treatment or non-treatment; and

7.16.1.4. The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.

7.16.1.5. Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.

7.16.1.6. The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.

7.17. Pharmacy Network, Access Standards and Reimbursement

7.17.1. Pharmacy Network Requirements

7.17.1.1. The MCO shall provide a pharmacy network that complies with DHH requirements but at a minimum includes only licensed and registered pharmacies that conform to the Louisiana Board of Pharmacy rules concerning the records to be maintained by a pharmacy.

7.17.1.2. No MCO may prohibit any pharmacy or pharmacist participating in the Medicaid program from contracting as a network provider provided the pharmacy or pharmacist is licensed and in good standing with the Louisiana State Board of Pharmacy and accepts the terms and conditions of the contract offered to them by the MCO.

7.17.1.3. The MCO must keep an up-to-date pharmacy provider directory on its website for public access. This directory must include, but not be limited to, the following information on all contracted network pharmacies:

7.17.1.3.1. Names, locations and telephone numbers.

7.17.1.3.2. Any non-English languages spoken.

7.17.1.3.3. Identification of hours of operation, including identification of providers that are open 24-hours per day.

7.17.1.3.4. Identification of pharmacies that provide vaccine services.

7.17.1.3.5. Identification of pharmacies that provide delivery services.

7.17.1.4. The MCO must make a hard copy of this directory available to its members upon request. The hard copy must be updated at least annually. The online version should be updated in real time, but no less than weekly.

7.17.1.5. The MCO shall ensure PBM/PBA has a network audit program that includes, at a minimum:

7.17.1.5.1. Random audits to determine provider compliance with the program policies, procedures and limitations outlined in the provider's contract. The MCO shall not utilize contingency-fee based pharmacy audits.

7.17.1.5.2. The MCO shall submit to DHH the policies of its audit program for approval.

7.17.1.6. The MCO shall ensure that Pharmacies submit the NPI of the prescriber on claims.

7.17.1.7. The MCO must educate network providers about how to access their formulary and PDL on their websites. The MCO must also provide provider education on claims processing and payment policies and procedures.

7.17.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall:

- Pay a per-prescription dispensing fee, as defined in this contract, at a rate no less than $2.50 to all “local pharmacies” as defined in Act 399 of the 2015 Regular Session of the Louisiana Legislature;
- Add any state imposed provider fees for pharmacy services, on top of the minimum dispensing fee required by DHH;
- Update the ingredient costs of medications at least weekly;
- Base Maximum Allowable Cost (MAC) price lists on generic drugs with a FDA rating beginning with an “A”;
- Make drug pricing list available to pharmacies for review;
- Afford individual pharmacies a chance to appeal inadequate reimbursement; and
- Provide for a “local pharmacy” appeals process in accordance with Act 399 of the 2015 Regular Session of the Louisiana Legislature.

7.17.1.9. The MCO and the PBM may not charge pharmacy providers claims processing or provider enrollment fees. This Section does not prohibit sanctioning pharmacy providers.

7.17.1.10. Thirty days after enrollment of a new MCO into Bayou Health, DHH will require that the MCO and PBM receive active agreement from pharmacy providers to participate in the MCO’s pharmacy network, even if the pharmacy provider has an existing relationship with the MCO’s PBM. This means that if a pharmacy provider is already contracted with an MCO’s PBM for other coverage products, notification alone will not be sufficient for that pharmacy provider to be considered part of the PBM’s Medicaid network. The

pharmacy provider must actively agree to the terms of the Medicaid contract addendum.

7.17.2. Local Pharmacy Claims Dispute Management

The provisions of this section shall apply to dates of service on or after December 1, 2015.

7.17.2.1. Internal Claims Dispute Process

7.17.2.1.1. The MCO shall develop an internal claims dispute process to permit local pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug.

7.17.2.1.2. A local pharmacy is defined as any pharmacy domiciled in at least one Louisiana parish that: contracts directly with the MCO or the MCO's contractor in its own name or through a Pharmacy Services Administrative Organization (PSAO) and not under the authority of a group purchasing organization; and has fewer than ten retail outlets under the pharmacy's corporate umbrella.

7.17.2.1.3. The MCO shall permit pharmacies to submit claim disputes directly to the MCO or through a PSAO at the pharmacy's option.

7.17.2.1.4. The MCO may require pharmacies to submit claim disputes within a predetermined time limit. Such limit shall be no less than seven (7) business days after the latter of the fill date or the resolution date of any pending AAC rate update request.

7.17.2.1.5. The MCO shall provide written notification of the outcome of the internal claims dispute process to the pharmacy within seven (7) business days of the date that the dispute was received by the MCO.

7.17.2.2. External Claims Dispute Process

7.17.2.2.1. The Department shall develop an external claims dispute process to permit local pharmacies to dispute the outcome of the internal claims dispute process.

7.17.2.2.2. The external claims dispute process shall serve as the final authority on local pharmacy claims disputes.

7.17.2.2.3. The Department shall define a reasonable reimbursement level to be used in the external claims dispute process. The Department may amend this definition unilaterally with sixty (60) calendar days' written notice to the MCO. Such notice shall include the revised definition and either an attestation that capitation rates remain actuarially sound or that actuarially sound capitation rates will be paid concurrent with implementation of the revised definition.

7.17.2.2.4. As specified in 7.15.1.8, MCOs shall reimburse pharmacies for any state imposed provider fees for pharmacy services. However, for

purposes of the external claims dispute process, such fees shall be excluded from the definition of reasonable reimbursement.

7.17.2.2.5. The Department may require pharmacies to submit disputes of the outcome of the internal claims dispute process within fourteen (14) business days of the date of the written notification from the MCO of the outcome of the internal claims dispute process.

7.17.2.2.6. The Department shall provide written notification of the outcome of the external claims dispute process to the pharmacy and the MCO within seven (7) business days of the Department receipt.

7.17.2.2.7. If the Department determines that the disputed reimbursement was not reasonable, it shall require the MCO to provide the pharmacy an increased reimbursement to the Fee for Service Medicaid rate and shall require the MCO to update its payable price on file to reflect the increase. The price update shall be completed within seven (7) business days of written notification of the outcome of the external claims dispute process to the MCO. All disputes that are submitted between the fill date of the original overturned dispute and the subsequent payable price file update shall be adjusted to the increased reimbursement.

7.17.2.3. Treatment of Excessive Disputes of Sufficiently Reimbursed Claims

7.17.2.3.1. If, within any thirty (30) calendar day period, a pharmacy has disputed claims across ten (10) or more drug entities with distinct pricing and for more than half of the disputes either the pharmacy declined to seek external review of the MCO's internal claims dispute process finding of reasonable reimbursement or the outcome of the external process was that the disputes were properly denied by the MCO on the basis of reasonable reimbursement, then the pharmacy shall be considered as having met the requirements for treatment of excessive disputes of reasonably reimbursed claims.

7.17.2.3.2. For pharmacies meeting such requirements, the MCO may dismiss all disputes submitted to the MCO for a sixty (60) calendar day period beginning on the date of the written notification of the outcome of the external dispute process for the claim that met requirements.

7.17.2.3.3. If the MCO implements this sixty (60) calendar day period, it must notify both the pharmacy and the Department within three (3) business days of such action and provide to the Department documentation demonstrating that the pharmacy has met the requirements for such treatment.

7.17.2.3.4. The MCO may pend reimbursement disputes submitted to the MCO's internal dispute process while awaiting the outcome of the external dispute process for the qualifying dispute.

7.17.2.3.5. Upon receipt of written notice of the outcome of the external claims dispute process wherein the internal dispute process outcome is in the pharmacy's favor, the MCO shall process pended disputes in

order of receipt. For pended disputes, the seven (7) business days dispute resolution and notification requirement applicable to the internal claims dispute process shall begin on the date of the written notification of the outcome of external claims dispute process.

7.17.2.3.6. A pharmacy may be considered as meeting requirements for treatment of excessive disputes of sufficiently reimbursed claims anew every sixty (60) calendar days.

7.17.3. Mail Order/Mail Service Pharmacy

The MCO cannot require its members to use a mail service pharmacy. Mail order must not exceed more than one (1) percent of all pharmacy claims. Members cannot be charged anything above applicable copays (*e.g.* shipping and handling fees).

7.17.4. Specialty Drugs and Specialty Pharmacies

7.17.4.1. DHH recognizes the importance of providing adequate access to specialty drugs to Medicaid members while ensuring proper management of handling and utilization. For the purposes of this contract, “specialty drugs” shall be determined by the definition below. The MCO shall not limit distribution of specialty drugs or self-refer to a MCO or PBM-owned specialty pharmacy. A network of specialty pharmacies to distribute specialty drugs. Any pharmacy that is able to procure specialty drugs from distributors, has any one of the nationally recognized accreditations and is willing to accept the terms of the MCO’s contract shall be allowed to participate in the MCO/PBM’s network (any willing provider). All specialty pharmacy contracts between the MCO and specialty pharmacy shall be sent to DHH pharmacy for approval prior to processing any specialty pharmacy claims. DHH reserves the right to deny specialty pharmacy contracts that include what DHH deems to be overly burdensome terms or requirements, including but not limited to requirements for excessive insurance coverage, unreasonable stocking requirements, or restrictive or duplicative accreditation requirements. The MCO shall accept any one of the nationally recognized accreditation programs to meet its specialty pharmacy network requirement. Specialty pharmacy network requirements shall be approved by DHH 30 days prior to implementation. Any pharmacy network cancellations shall be approved by DHH at least 60 days prior to cancellation.

7.17.4.1.1. A specialty drug is defined as a prescription drug which meets all of the following criteria:

7.17.4.1.1.1. The drug cannot be routinely dispensed at a majority of retail community pharmacies due to physical or administrative requirements that limit preparation and/or delivery in the retail community pharmacy environment. Such drugs may include but are not limited to chemotherapy, radiation drugs, intravenous therapy drugs, biologic prescription drugs approved for use by the federal Food and Drug Administration, and/or drugs that require physical facilities not typically found in a retail community pharmacy, such as a ventilation hood for preparation;

7.17.4.1.1.2. The drug is used to treat complex, chronic, or rare medical conditions:

- That can be progressive;
- That can be debilitating or fatal if left untreated or undertreated; or
- For which there is no known cure.

7.17.4.1.1.3. The drug requires special handling, storage, and/or has distribution and/or inventory limitations;

7.17.4.1.1.4. The drug has a complex dosing regimen or requires specialized administration;

7.17.4.1.1.5. Any drug that is considered to have limited distribution by the federal Food and Drug Administration;

7.17.4.1.1.6. The drug requires:

- Complex and extended patient education or counseling;
- Intensive monitoring; or
- Clinical oversight; and

7.17.4.1.1.7. The drug has significant side effects and/or risk profile.

7.17.4.1.2. Access to specialty drugs

No entity shall establish definitions, or require accreditation or licensure, effectively limiting access to prescription drugs, including specialty drugs, other than the appropriate governmental or regulatory bodies.

7.17. Provider Satisfaction Surveys

7.17.1. The MCO shall conduct an annual provider survey to assess overall satisfaction, as well as satisfaction with the following functions:

- Access to linguistic assistance;
- Provider enrollment;
- Provider communication;
- Provider education and trainings (including cultural competency trainings);
- Resolution to provider complaints/disputes;
- Claims processing;

- Claims reimbursement;
- Network/coordination of care; and
- Utilization management processes(including medical reviews and support toward Patient Centered Medical Home implementation)

7.17.2. The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval 90 days prior to administration.

7.17.3. All required components of the survey tool must be administered and reported to DHH annually within the provider satisfaction survey report. Survey response rates shall consider the population size and demographic category of providers with a minimum margin of error of +/- 5% and a confidence level of at least 95%. This shall be the minimum response rated for surveys completed and reported to DHH.

7.17.4. The MCO 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.

7.18. Provider Directory

7.18.1. The MCO shall maintain accurate provider directory data. LDH shall conduct periodic audits to verify the accuracy of the MCO's provider directory data. The MCO shall maintain an accuracy rate of at least 90%.

INTENTIONALLY LEFT BLANK

8.0 UTILIZATION MANAGEMENT

8.1. General Requirements

8.1.1. The MCO 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. The MCO shall submit UM policies and procedures to DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.

8.1.2. The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:

8.1.2.1. Are adopted in consultation with contracting health care professionals;

8.1.2.2. Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

8.1.2.3. Are considerate of the needs of the members; and

8.1.2.4. Are reviewed annually and updated periodically as appropriate.

8.1.3. The policies and procedures shall include, but not be limited to:

8.1.3.1. The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

8.1.3.2. The data sources and clinical review criteria used in decision making;

8.1.3.3. The appropriateness of clinical review shall be fully documented;

8.1.3.4. The process for conducting informal reconsiderations for adverse determinations;

8.1.3.5. Mechanisms to ensure consistent application of review criteria and compatible decisions;

8.1.3.6. Data collection processes and analytical methods used in assessing utilization of health care services;

8.1.3.7. Provisions for assuring confidentiality of clinical and proprietary information;

8.1.3.8. Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;

8.1.3.9. Collaborating with OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;

8.1.3.10. Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;

8.1.3.11. Collaborating with the Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and

8.1.3.12. Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.

8.1.4. The MCO shall coordinate the development of clinical practice guidelines with other DHH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.

8.1.5. The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.

8.1.5.1. The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.

8.1.6. The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:

8.1.6.1. The vendor must be identified if the criteria was purchased;

8.1.6.2. The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;

8.1.6.3. The guideline source must be identified if the criteria are based on national best practice guidelines; and

8.1.6.4. The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.

8.1.7. UM Program medical management criteria and practice guidelines shall be ~~disseminated to all affected providers, members and potential members upon request.~~posted to the MCO's website. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

8.1.8. The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.

8.1.9. The MCO 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 MCO may deny authorization of the requested service(s) within two (2) business days.

8.1.10. The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The MCO shall provide UM staff specifically assigned to:

8.1.10.1. Specialized behavioral health services, and

8.1.10.2. PSH to ensure appropriate authorization of tenancy services.

8.1.11. The MCO 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 MCO shall make medical necessity determinations that are consistent with the State's definition.

8.1.12. The MCO shall submit written policies and procedures for DHH approval, within thirty (30) days of the contract being signed by the MCO, addressing how the core benefits and services ensure:

8.1.12.1. The prevention, diagnosis, and treatment of health impairments;

8.1.12.2. The ability to achieve age-appropriate growth and development; and

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

8.1.13. The MCO must identify the qualification of staff who will determine medical necessity.

8.1.14. Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.

8.1.15. The MCO 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.

8.1.16. 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.

8.1.17. The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.

8.1.18. The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care 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 MCO 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 MCO 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.

8.1.19. The MCO shall conduct utilization management and review functions which include:

8.1.19.1. Apply initial risk screen for CSoC eligibility,

8.1.19.2. Refer calls (via a seamless "warm transfer") to the contracted administrator of CSoC program, who will apply Brief CANS assessment tool to assess for CSoC presumptive eligibility.

8.1.19.3. Document in the child's health record whether or not (according to CSoC contracted administrator) the child met criteria for CSoC presumed eligibility, when the child was referred to the WAA, and the date on which the Freedom of Choice (FOC) was signed.

8.1.19.4. The MCO shall also document in the child's health record if the child does not become enrolled in CSoC, for the reasons of 1) the youth and family refuse CSoC services, or 2) the youth does not meet clinical eligibility based on the comprehensive CANS, or for any other reason.

8.1.19.5. For youth who screened positively on the initial risk screen, but who do not complete enrollment in CSoC, the MCO shall offer voluntary participation in the Case Management Program, and/or other behavioral health services to meet the child and family's presenting needs.

8.1.20. Upon request, the MCO shall provide the PASRR Level II authority (OBH) with documentation supporting appropriate limits on a service on the basis of medical necessity for individuals determined by the PASRR Level II authority to need specialized behavioral health services.

8.1.21. The MCO 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 §438.36(hi) and, 42 CFR §422.208, and 42 CFR §422.210.

8.1.22. The MCO shall report fraud and abuse information identified through the UM program to DHH in accordance with 42 CFR §455.1(a)(1).

8.1.23. In accordance with 42 CFR §456.111 and §456.211, the MCO Utilization Review (UR) 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:

8.1.23.1. Identification of the enrollee;

8.1.23.2. The name of the enrollee's physician;

8.1.23.3. Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;

8.1.23.4. The plan of care required under 42 CFR §456.80 and §456.180;

8.1.23.5. Initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133, §456.233 and §456.234;

8.1.23.6. Date of operating room reservation, if applicable; and

8.1.23.7. Justification of emergency admission, if applicable.

8.2. Utilization Management Committee

8.2.1. The Utilization Management (UM) program shall include a UM Committee that integrates with other functional units of the MCO as appropriate and supports the quality assessment and performance improvement program (QAPI) Program (refer to the Quality Management subsection for details regarding the QAPI Program).

8.2.2. The UM Committee shall provide utilization review and monitoring of UM activities of both the MCO and its providers and is directed by the MCO Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to DHH upon request. DHH representatives, as appointed by DHH, shall be included as members of the UM Committee, if requested. UM Committee responsibilities include:

8.2.2.1. Monitoring providers' requests for rendering healthcare services to its members;

8.2.2.2. Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;

8.2.2.3. Reviewing the effectiveness of the utilization review process and making changes to the process as needed;

8.2.2.4. Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;

8.2.2.5. Monitoring consistent application of "medical necessity" criteria;

8.2.2.6. Application of clinical practice guidelines;

8.2.2.7. Monitoring over- and under-utilization;

8.2.2.8. Review of outliers, and

8.2.2.9. Medical Record Reviews - reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.

- **Medical ~~and Treatment~~ Record Review Strategy**

  - The MCO shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The strategy shall be provided within thirty (30) days from the date the Contract is signed 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 MCO shall use to review each site;

    – How the MCO shall link the information compiled during the review to other MCO functions (*e.g.* QI, credentialing, peer review, etc.); and

    – Schedule of reviews by provider type.

  - The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all providers.

8.2.3. The MCO shall conduct reviews at all PCP sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The MCO shall review each site at least one (1) time during each two (2) year period.

~~iii. The MCO shall conduct reviews at all LMHP sites serving fifty (50) or more members and practice sites which include both individual offices and large group facilities. The MCO shall review each site at least one (1) time during each two (2) year period.~~

8.2.4. The MCO shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target. For large group practices (six or more providers in the group), three record reviews per provider shall be required.

8.2.5. The MCO shall report the results of all medical ~~and treatment~~ record reviews to DHH quarterly with an annual summary.

8.3. Utilization Management Reports

The MCO shall submit utilization management reports as specified by DHH. DHH reserves the right to request additional reports as deemed by DHH. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports

8.4. Service Authorization

8.4.1. Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization. (For Pharmacy Service Authorizations see Section 8.6.)

8.4.2. The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of *Chisholm v. Kliebert* and *Wells v. Kliebert* for initial and continuing authorization of services that include, but are not limited to, the following:

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

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

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

8.4.2.4. 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;

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

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

8.4.3. The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level~~r~~ of care.

8.4.4. Not later than July 1, 2018, the MCO shall utilize a common hospital observation policy that is developed and maintained collectively by MCO personnel with approval of LDH. The common hospital observation policy shall be reviewed annually by the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.

8.4.5. The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.

8.4.5.1. The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].

8.4.5.2. Concurrent utilization reviews are administrative in nature and should not be reported to DHH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, DHH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.

8.4.5.3. Concurrent utilization review includes:

- Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post-stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized.

- Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric

personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized.

- Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.

8.4.6. Certification of Need (CON) for PRTFs

8.4.6.1. The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.

8.4.6.2. The MCO shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to-face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154.

8.4.6.3. The MCO may use an LMHP/team composed of the MCO's staff or the MCO may subcontract with an LMHP. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the MCO shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).

8.4.6.4. Recertification shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.

8.4.6.5. In addition to certifying the need, the MCO shall:

- Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due.
- Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility.

- o Upon completion of the screen~~certification of need~~, if the PRTF is approved, within 48 hours~~,~~ the MCO shall notify in writing~~,~~ the provider requesting the certification of the results, the member/guardian and, with member guardian consent, the referring party requesting the PRTF services on behalf of the youth. If approved, the MCO shall, in consultation with the member's guardian and referring party, locate a PRTF provider appropriate to meet the member's needs with availability to admit the member.
- o If denied, the MCO shall notify the provider requesting the certification immediately and~~,~~ within 48 hours~~,~~ provide written notification to the provider requesting the certification of the results, the member/guardian and, with the member/guardian consent, the referring party requesting the PRTF services on behalf of the youth. The notification shall include: information on ~~whether or not an~~ alternative community services that may meet the member's needs to ensure health and safety, including information on available providers of those services~~plan is appropriate~~, the right of the member to appeal, and the process to do so.
- o For youth pending release from a secure setting for whom a PRTF is being requested, the MCO is required to coordinate the completion of the screen and the CON prior to the youth's release if it is anticipated that the youth will be re-linked to the MCO following release.
- o Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen.
- o Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions.
- o Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable.
- o Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.

8.5. Timing of Service Authorization Decisions

8.5.1. Standard Service Authorization

8.5.1.1. The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical 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.

8.5.1.1.1. The service authorization decision may be extended up to fourteen (14) additional calendar days if:

8.5.1.1.1.1. The member, or the provider, requests the extension; or

8.5.1.1.1.2. The MCO justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.

8.5.1.2. The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.

8.5.2. Expedited Service Authorization

8.5.2.1. In the event a provider indicates, or the MCO 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 MCO 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.

8.5.2.2. The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to DHH a need for additional information and how the extension is in the member's best interest.

8.5.3. Post Authorization

8.5.3.1. The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.

8.5.3.2. The MCO 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.

8.5.4. Timing of Notice

8.5.4.1. Notice of Action

8.5.4.1.1. Approval

8.5.4.1.1.1. For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or 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.

8.5.4.1.1.2. For service authorization approval for extended stay or additional services, the MCO shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or 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.

8.5.4.1.2. Adverse

8.5.4.1.2.1. The MCO shall notify the member, in writing using language that is easily understood by the member, 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 Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210, Section 12 of this RFP for member written materials, and any agreements that the Department may have entered into relative to the contents of member notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.

8.5.4.1.2.2. The MCO shall notify the requesting provider of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the notify the provider rendering the service, whether a health care professional or facility or both, verbally or 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 written notification to the provider within two (2) business days of making the initial certification.

8.5.4.1.3. Informal Reconsideration

8.5.4.1.3.1. As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

8.5.4.1.3.2. In a case involving an initial determination or a concurrent review determination, the MCO should 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 physician or clinical peer making the adverse determination [§438.402(b)(ii)].

8.5.4.1.3.3. The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.

8.5.4.1.3.4. The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.

8.5.4.2. Exceptions to Requirements

- The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.

- The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.

- The MCO shall not require service authorization or referral for EPSDT screening services.

- The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.

- The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.

- The MCO shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's healthcare services and prenatal care.

- The MCO shall not require a PCP referral for in-network eye care and vision services.

- The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.

- The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. The MCO is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding forty-eight (48) hours after vaginal delivery. In this case, the MCO is allowed to deny only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours.

- The MCO may require notification by the provider of Obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. The MCO is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, the MCO is allowed to deny only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours.

- The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission. The MCO is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify the MCO of inpatient emergency admission within one (1) business day of admission.

8.6. Service Authorization Pharmacy Services

8.6.1. Prior authorization may be used for drug products under the following conditions:

8.6.1.1. When prescribing medically necessary non-Formulary or non-preferred (non PDL) drugs.

8.6.1.2. When prescribing drugs inconsistent with FDA approved labeling, including behavioral health drugs. When prescribing is inconsistent with nationally accepted guidelines.

8.6.1.3. When prescribing brand name medications which have A-rated generic equivalents.

8.6.1.4. To minimize potential drug over-utilization.

8.6.1.5. To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy.

8.6.2. DHH may require prior authorization overrides for selected drug products or devices at its discretion.

8.6.3. Prior authorization shall be automatically approved upon notification to the plan by the prescriber's office for a dosage change for any medications in behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including Suboxone and Naloxone), that have been previously authorized and/or approved within current health plan for any member with a behavioral health or substance use disorder diagnosis, as long as the newly prescribed dose is within established FDA guidelines for that medication.

8.6.4. Any prior approval issued by the MCO shall take into consideration prescription refills related to the original pharmacy service. The MCO must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber.

8.6.5. The MCO must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests by phone, fax or automated process. If the MCO or its pharmacy benefit manager operates a separate call center for prior authorization requests, it will be subject to the provider call center standards set forth in Section 10 of this contract and monetary penalties set forth in Section 20 of this contract.

8.6.6. The MCO shall not penalize the prescriber or enrollee, financially or otherwise, for such requests and approvals.

8.6.7. Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and/or member in writing.

8.6.8. An enrollee receiving a prescription drug that was on the MCO's Formulary or PDL and subsequently removed or changed, shall be permitted to continue to receive that prescription drug if determined to be medically necessary for at least sixty (60) days. The MCO must make that determination in consultation with the prescriber.

8.6.9. If a prescription for a medication is not filled when the prescription is presented to the pharmacy due to a prior authorization requirement, the MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable but the MCO is only required to pay one dispensing fee. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.

8.6.10. A member, or a provider on Member's behalf, may appeal prior authorization denials in accordance with Section 13 (Grievances and Appeals) of this contract.

8.7. Step Therapy and/or Fail First Protocols

The MCO is allowed to implement step therapy or fail first protocols to first drive utilization toward the most cost-effective and safest drug therapy. These protocols may be applied to either individual drugs or classes of drugs. However, the MCO must provide a clear process for a provider to request an override of such restrictions. An override shall be granted when the prescribing physician can demonstrate, based on sound clinic evidence, that the preferred treatment required under the step therapy or fail first protocol: (1) has been ineffective in the treatment of the Medicaid enrollee's disease or medical condition; (2) will be expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the Medicaid enrollee and known characteristics of the drug regimen; or (3) will cause or will likely cause an adverse reaction or other physical harm to the Medicaid enrollee.

8.8. Medication Therapy Management

8.8.1. Within 90 days of implementation, the MCO is required to implement a Medication Therapy Management (MTM) program. The MTM program should include participation from community pharmacists, and include both in-person and telephonic interventions with trained clinical pharmacists.

8.8.2. Reimbursement for MTM services with participating pharmacists should be separate and above dispensing and ingredient cost reimbursement.

8.8.3. These programs should be developed to identify and target members who would most benefit from these interactions. They should include coordination between the MCO, the member, the pharmacist and the prescriber using various means of communication and education.

8.9. Lock-In (Restriction) Program

8.9.1. The MCO may implement a restriction program including policies, procedures and criteria for establishing the need for the lock-in, which must be prior approved by DHH.

8.9.2. Lock-in is a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The lock-in mechanism does not prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits.

8.9.3. The lock-in mechanism must:

- Ensure appropriate use of Medicaid benefits by recipients and/or providers; and

- Serve as an educational and monitoring parameter in instructing recipients in the most efficient method of using Medicaid services to ensure maximum health benefits.

8.9.4. A Medicaid recipient who has shown a consistent pattern of misuse or overuse of program benefits may be placed into the lock-in mechanism by the MCO. Misuse and overuse is a determination made by the MCO. The MCO shall submit for approval to DHH a list of criteria for which a member may be restricted. Misuse and overuse can occur in a variety of ways.

8.9.5. Misuse may take the form of obtaining prescriptions under the pharmacy program from various prescribers and/or pharmacies in an uncontrolled and unsound way.

8.9.6. Misuse may take the form of obtaining prescriptions or the dispersal of prescriptions by fraudulent actions.

8.9.7. In its Lock-In program, the MCO should abide by the following protocols:

8.9.7.1. Enrollees shall be notified prior to the lock-in and must be permitted to change providers for good cause. A seventy-two (72)-hour emergency supply or a full unbreakable package of medication at pharmacies other than the designated lock-in pharmacy shall be permitted to ensure the provision of necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication.

8.9.7.2. The MCO shall initiate contact with the recipient in instances when the recipient fails to contact the MCO.

8.9.7.3. MCO shall notify the recipient and the prescribers of the intent to enroll a recipient in the Pharmacy Lock-In Program or the Physician-Pharmacy Lock-In Program. The plan shall notify the recipient of their intent to lock-in the recipient to a pharmacy and/or physician provider. In the case of Pharmacy-Only Lock-In, the recipient will be given a list of three potential Lock-In pharmacies and asked to select one pharmacy. The pharmacy selection will be reviewed and deemed acceptable by the MCO before notifying the

recipient of potential lock-in enrollment. Recipients will always be notified of their rights and responsibilities to appeal enrollment in a Lock-In Program.

8.9.7.4. The MCO shall notify lock-in providers of their selection.

8.9.7.5. The continued need for lock-in shall be periodically (at least every two (2) years) evaluated by the MCO for each member in the program. Prescriptions from all participating prescribers shall be honored and may not be required to be written by the PCP only unless the member is also locked in to his/her PCP.

8.9.7.6. The MCO shall submit monthly reports within ten (10) days after the last day of the month on the pharmacy lock-in program activities as defined by DHH. The MCO shall transmit a monthly file to DHH identifying the recipients that are enrolled in Physician and Pharmacy Lock-In and those enrolled in Pharmacy-Only Lock-In. This can be a one byte field. In addition to the Lock-In recipients, the MCO shall also lock in providers that manage the recipients.

8.9.7.7. The MCO shall develop criteria and protocols to avoid enrollee injury due to the prescribing of drugs by more than one prescriber.

8.10. Pharmacy Administrative Simplification

Not later than September 30, 2015, the MCO shall develop jointly with all other Bayou Health MCOs a common pharmacy administrative framework that applies equally to each Bayou Health MCO and collectively meets the requirements of Sections 6.3.1 through 6.3.5.3. The framework and any revision thereto, shall be reviewed and approved by DHH prior to implementation. Any changes to the framework shall be submitted to DHH at least 30 days prior to implementation.

8.11. Medical History Information

8.11.1. The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations.

8.11.2. The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.

8.11.3. Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.

8.11.4. Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by DHH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.

8.12. PCP and Behavioral Health Provider Utilization and Quality Profiling

8.12.1. The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.

8.12.2. The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.

8.12.3. The MCO shall submit individual PCP and specialized behavioral health provider profile reports to DHH quarterly. MCO provider profiling activities shall include, but are not limited to, the following:

8.12.3.1. Utilization of out-of-network providers – The MCO shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;

8.12.3.2. Specialist referrals – The MCO shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;

8.12.3.3. Emergency department utilization – The MCO shall maintain a procedure to identify and evaluate member emergency department referral utilization by its provider panel;

8.12.3.4. Hospital admits, lab services, medications, and radiology services – The MCO shall maintain a procedure to identify and evaluate member's utilization; and

8.12.3.5. Individual provider clinical quality performance measures as indicated in Appendix J.

8.13. PCP and Behavioral Health Provider Utilization & Quality Profile Reporting Requirements

The MCO shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.

8.14. Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay

8.14.1. All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order to be eligible for payment, the service must be medically necessary and a covered benefit/service, as determined by the MCO within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.

INTENTIONALLY LEFT BLANK

9.0 PROVIDER REIMBURSEMENT

The MCO shall administer an effective, accurate and efficient claims processing system that adjudicates provider claims for covered services that are filed within the time frames specified by this Section and in compliance with all applicable State and Federal laws, rules and regulations.

9.1. Diagnosis Related Groups

~~8.14.2.~~9.1.1. The system shall have the capacity to group claims and to reimburse inpatient hospital services under a Diagnosis Related Grouping (DRG) methodology as defined by DHH within 180 days of notification by DHH that such reimbursement method is required. LDH shall be responsible for establishing DRG rates. Upon implementation, the MCO shall reimburse no less than the DRG rate established by LDH, unless mutually agreed to by both the plan and the provider in the provider contract.

~~8.15.~~9.2. Minimum Reimbursement to In-Network Providers

9.2.1. The MCO shall provide reimbursement for defined core benefits and services provided by an in-network provider. The MCO rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both the plan and the provider in the provider contract. DHH shall retain responsibility for setting and defining minimum provider rates for Medicaid covered services.

Note: For providers who receive cost-based reimbursement (cost settlement and outliers) for Medicaid services, the published Medicaid fee-for-service rate shall be the rate that would be received in the fee-for-service Medicaid program. Hereafter in this Section, unless otherwise specified, the above reimbursement arrangement is referred to as the "Medicaid rate." DHH will notify MCOs of updates to the Medicaid fee schedule and payment rates.

9.3. FQHC/RHC Contracting and Reimbursement

9.3.1. The MCO shall reimburse contracted FQHC/RHC the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.

9.3.2. The MCO shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without written prior approval from DHH.

9.3.3. If an MCO is unable to contract with an FQHC or RHC, the MCO is not required to reimburse that FQHC or RHC without prior approval for out-of-network services unless:

9.3.3.1. The medically necessary services are required to treat an emergency medical condition; or

9.3.3.2. FQHC/RHC services are not available through at least one MCO within DHH's established distance travel standards.

.

9.3.3.3. The MCO may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical information required to update the member's medical record.

9.3.3.4. The MCO shall inform members of these rights in their member handbooks.

9.4. Indian Health Care Providers (IHCPs)

9.4.1. The MCO shall reimburse the IHCP at the annual rates published in the Federal Register by the Indian Health Service (IHS). IHS issues the payment rate based on a calendar year that will be effective retroactive to January 1st of that year. The MCO will recycle claims for the calendar year to capture the adjusted rate. See 42 CFR §438.14(c).

~~9.4.~~9.5. Reimbursement to Out-of-Network Providers

~~9.4.1.~~9.5.1. The MCO shall make payment for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the MCO for the provision of such services. The MCO shall reimburse the provider one hundred percent (100%) of the Medicaid rate for emergency services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the MCO to out-of-network providers for the provision of emergency services shall be no more than the Medicaid rate.

~~9.4.2.~~9.5.2. For services that do not meet the definition of emergency services, the MCO is not required to reimburse more than 90% of the published Medicaid rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts (as defined in Glossary) to include the provider in their network (except as noted in Section 9.2). The MCO may require prior authorization of out-of-network services, unless services are required to treat an emergency medical condition.

~~9.5.~~9.6. Effective Date of Payment for New Members

The MCO is responsible for payment of core benefits and services from the effective date of a member's eligibility for Louisiana Medicaid. This includes reimbursement to a member for payments already made by the member for Medicaid payable services during the retroactive eligibility period. The date of enrollment in an MCO will match the Medicaid eligibility effective date and may be retroactive for a period not to exceed 12 months.

~~9.6.~~9.7. Claims Processing Requirements

~~9.6.1.~~9.7.1. At a minimum, the MCO shall run one (1) provider payment cycle per week, on the same day each week, as determined by the MCO

~~9.6.2.~~9.7.2. The MCO shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

~~9.6.3.~~9.7.3. The MCO 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).

~~9.6.4.~~9.7.4. Claims must be processed in adherence to information exchange and data management requirements specified in Section 17 of this RFP.

~~9.6.5.~~9.7.5. The MCO 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 MCO shall not pay any claim submitted by a provider that is on payment hold under the authority of DHH or its authorized agent(s).

~~9.6.6.~~9.7.6. The MCO shall inform all network Providers about Clean Claim requirements at least thirty (30) Calendar Days prior to the Operational Start Date. The MCO shall make available to network Providers requirements and guidelines for claims coding and processing that are specific to Provider types. The MCO shall notify Providers ninety (90) Calendar Days before implementing changes to Claims coding and processing guidelines.

~~9.6.7.~~9.7.7. In addition to the specific Web site requirements outlined above, the MCOs Web site shall be functionally equivalent to the Web site maintained by the DHH FI.

~~9.6.8.~~9.7.8. 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 MCO, or if a time period is not specified in the contract:

~~9.6.8.1.~~9.7.8.1. The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or

~~9.6.8.2.~~9.7.8.2. If the MCO 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.

~~9.7.~~9.8. Inappropriate Payment Denials

If the MCO has a pattern of inappropriately denying or delaying provider payments for services, the MCO 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).

~~9.8.~~9.9. Payment for Emergency Services and Post-stabilization Services

~~9.8.1.~~9.9.1. The MCO shall reimburse providers for emergency services rendered without a requirement for service authorization of any kind.

~~9.8.2.~~9.9.2. The MCO's protocol for provision of emergency services must specify that emergency services will be covered when furnished by a provider with which the MCO does not have a subcontract or referral arrangement.

~~9.8.3.~~9.9.3. The MCO may not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

~~9.8.4.~~9.9.4. The MCO shall not deny payment for treatment when a representative of the MCO instructs the member to seek emergency services.

~~9.8.5.~~9.9.5. The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency medical condition.

~~9.8.6.~~9.9.6. The MCO shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or MCO of the member's screening and treatment within 10 calendar days of presentation for emergency services.

~~The MCO may, however, enter into contracts with providers or facilities that require, as a condition of payment, the provider or facility to provide notification to the MCO within a minimum of ten (10) calendar days after members are present at the ED, assuming adequate provision is given for such notification. The policy for non-payment must be included in the MCO Provider Manual.~~

~~9.8.7.~~9.9.7. The MCO shall be financially responsible for emergency medical services, including transportation, and shall not retroactively deny a claim for emergency services, including transportation, to an emergency provider because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

~~9.8.8.~~9.9.8. The MCO is financially responsible for post-stabilization care services, as specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), obtained within or outside the MCO that are:

~~9.8.8.1.~~9.9.8.1. Pre-approved by a network provider or other MCO representative; or

~~9.8.8.2.~~9.9.8.2. Not preapproved by a network provider or other MCO representative, but:

- Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services;
- Administered to maintain, improve or resolve the member's stabilized condition if the MCO:
  - Does not respond to a request for pre-approval within one (1) hour;
  - Cannot be contacted; or
  - MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until

a network physician is reached or one of the criteria of 42 CFR §422.133(c)(3) is met.

- Are for post-stabilization hospital-to-hospital ambulance transportation of members with a behavioral health condition, including hospital to behavioral health specialty hospital.

~~9.8.9.~~9.9.9. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO as responsible for coverage and payment as per 42 CFR §438.114(d). The MCO's financial responsibility ends for post stabilization care services it has not pre-approved when:

~~9.8.9.1.~~9.9.9.1. A network physician with privileges at the treating hospital assumes responsibility for the member's care;

~~9.8.9.2.~~9.9.9.2. A network physician assumes responsibility for the member's care through transfer;

~~9.8.9.3.~~9.9.9.3. A representative of the MCO and the treating physician reach an agreement concerning the member's care; or

~~9.8.9.4.~~9.9.9.4. The member is discharged.

~~9.8.10.~~9.9.10. Expenditures for the medical services as previously described have been factored into the capitation rate described in Section 5.0 of this RFP and the MCO will not receive any additional payments.

~~9.9.~~9.10. Physician Incentive Plans

~~9.9.1.~~9.10.1. In accordance with 42 CFR §422.208 and §422.210, the MCO may operate a Physician Incentive Plan, but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

9.10.2. The MCO's ~~incentive plans for its network providers/subcontractors~~ Physician Incentive Plans shall be in compliance with 42 CFR §438.~~3~~6(~~ih~~), §422.208 and §422.210. (See Appendix Q, **Requirements for MCO Physician Incentive Plans**).

~~9.9.2.~~9.10.3. Any sub-capitation arrangement with contracted providers is considered a provider incentive plan and subject to ~~all~~ appropriate requirements of 9.10~~8~~.

~~9.9.3.~~9.10.4. The MCO shall provide an annual written assurance to DHH that either: ~~submit any information regarding the incentive plans as may be required by DHH . For this proposal the MCO must submit al of the information specified in Section 9.8 and Appendix PP. The MCO shall obtain approval from DHH prior to implementation of the incentive plan.~~

9.10.4.1. The MCO is not operating any Physician Incentive Plans that put providers at "substantial financial risk" as defined in 42 CFR §422.208; or

9.10.4.2. The MCO is operating Physician Incentive Plans that put providers at "substantial financial risk" as defined in 42 CFR §422.208 and those plans meet all applicable federal requirements.

~~9.9.4.~~**9.10.5.** The MCO shall provide written notification to DHH within thirty (30) days upon implementation of any new plan or when an existing plan is modified. The written notification must include a list of participating providers and specify that all terms and conditions of the plans are compliant with all applicable federal regulations. DHH reserves the right to request additional documentation, including but not limited to the actual incentive plans. ~~receive prior DHH approval of the Physician Incentive Plan and shall submit to DHH any contract templates that involve an incentive plan for review as a material modification. The MCO shall disclose the following:~~

~~**9.9.5.** Services that are furnished by a physician/group that are covered by any incentive plan;~~

~~**9.9.6.** Type of incentive arrangement, e.g. withhold, bonus, capitation;~~

~~**9.9.7.** Percent of withhold or bonus (if applicable);~~

~~**9.9.8.** Panel size, and if patients are pooled, the approved method used; and~~

~~**9.9.9.** If the physician/group is at substantial financial risk, the entity must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.~~

~~9.9.10.~~**9.10.6.** The MCO shall provide the information specified in 42 CFR §422.210(b) regarding its Physician Incentive Plans to any Medicaid member upon request.

~~9.9.11.~~**9.10.7.** The proposed monetary value of ~~these~~ Physician ~~i~~Incentive~~s~~ Plans ~~and/or enhanced payments~~ outlined in the MCO's proposal and any subsequent additional under Section 9.10 will be considered a binding contract deliverable (Appendix PP). If for some reason, including but not limited to lack of provider participation or performance, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

~~9.9.12.~~**9.10.8. Non-Payment for Specified Services**

~~9.9.12.1.~~**9.10.8.1.** The MCO shall deny payment to providers for deliveries occurring before 39 weeks without a medical indication. MCO will use LEERS data as directed by the state to process claims for all deliveries occurring before 39 weeks.

9.10.9. Provider Preventable Conditions

9.10.9.1. The MCO shall deny payment to providers for Provider Preventable Conditions as defined by DHH in Section 25.8 of the Louisiana Medicaid Program Hospital Services Provider Manual.

~~9.9.12.2.~~**9.10.9.2.** The MCO shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. The MCO shall report all identified provider preventable conditions to DHH in a format specified by DHH.

~~9.10.~~9.11. Payment for Newborn Care

The MCO shall cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another network provider. The MCO shall compensate, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted with the MCO, but subject to the same requirements as a contracted provider.

~~9.11.~~9.12. Payment for Hospital Services

The MCO is not responsible for reimbursement of graduate medical education (GME) payments or disproportionate share hospital (DSH) payments to providers. The MCO must use the increased hospital funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Appendix G – **Mercer Certification, Rate Development Methodology and Rates,** for reimbursement of inpatient and outpatient hospital services.

~~9.12.~~9.13. Payment for Ambulance Services

The MCO must use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in **Appendix G** Contract Attachment D **– Mercer Certification, Rate Development Methodology and Rates,** for reimbursement of ambulance services.

~~9.13.~~9.14. Payment for Physician Services

The MCO must use the increased physician services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in **Appendix G** Contract Attachment D**– Mercer Certification, Rate Development Methodology and Rates**, for reimbursement of physician services.

INTENTIONALLY LEFT BLANK

10.0 PROVIDER SERVICES

10.1. Provider Relations

The MCO shall, at a minimum, provide a Provider Relations function to provide support and assistance to all providers in their MCO network. This function shall:

10.1.1. Be available Monday through Friday from 7 am to 7 pm Central Time to address non-emergency provider issues and on a 24/7 basis for non-routine prior authorization requests;

10.1.2. Assure each MCO provider is provided all rights outlined the **Provider's Bill of Rights** (see Appendix R);

10.1.3. Provide for arrangements to handle emergent provider issues on a 24/7 basis;

10.1.4. Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements;

10.1.5. Ensure regularly scheduled visits to provider sites, as well as *ad hoc* visits as circumstances dictate; and provide technical assistance, including assistance on MCO systems and billing practices. Documentation of these visits shall be provided upon request by DHH and shall include sign-in sheets, agendas, documented follow-up action items (as appropriate), and any distributed materials.

10.2. Provider Toll-free Telephone Line

10.2.1. The MCO must operate a toll-free telephone line to respond to provider questions, comments and inquiries.

10.2.2. 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 provider complaints and regarding provider responsibilities. The provider access component must be staffed on a 24/7 basis for prior authorization requests.

10.2.3. The MCO's call center system must have the capability to track provider call management metrics.

10.2.4. 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 MCO member with an emergency or urgent medical condition. This shall not be construed to mean that the provider must obtain verification before providing emergency department services and care.

10.3. Provider Website

10.3.1. The MCO shall have a provider website. The provider website may be developed on a page within the MCO's existing website (such as a portal) to meet these requirements.

10.3.2. The MCO provider website shall include general and up-to-date information about the MCO as it relates to the Louisiana Medicaid program. This shall include, but is not limited to:

10.3.2.1. MCO provider manual;

10.3.2.2. MCO-relevant DHH bulletins;

10.3.2.3. Limitations on provider marketing;

10.3.2.4. Information on upcoming provider trainings;

10.3.2.5. A copy of the provider training manual;

10.3.2.6. Information on the provider complaint/dispute system;

10.3.2.7. Information on obtaining prior authorization and referrals;

10.3.2.8. Information on how to contact the MCO Provider Relations; and

10.3.2.9. General up-to-date information about all behavioral health programs and services. This shall include, but is not limited to information on requirements and reporting fraud, waste, and abuse.

10.3.2.10. The MCO shall maintain all of the above information and forms on its provider website to allow submittal of complaints and disputes electronically. In addition, the MCO shall provide providers with an address to submit grievances and appeals in writing and a phone number to submit grievances and appeals by telephone.

10.3.2.11. The MCO provider website shall provide a secure provider portal with the following capabilities:

- The MCO shall use current state and federal standards and procedures (e.g., HL7, HIPAA, CMS, CPT, ICD-10, and DSM-5) for all provider used systems and will maintain a uniform service and provider (credentials) taxonomy for billing and information management purposes.

- The MCO shall, with appropriate member consent, allow the provider access to member clinical data including assessments and Plans of Care and/or relevant data necessary to provide for appropriate coordination of care.

- The MCO is encouraged to provide online accessible methodology for providers to review and update staff rosters of credentialed and contracted providers of mental health rehabilitation services.

- The MCO shall grant user-defined DHH access to and training on the provider website.

- A link to the LDH Behavioral Health Provider Manual and the MCO's provider handbook, and any updates for behavioral health service providers and subcontractors.

10.3.2.12. The MCO shall provide, in accordance with national standards, claims inquiry information to providers and subcontractors via the MCO's website.

10.3.2.13. The MCO shall develop and maintain methods to communicate policies, procedures and relevant information to providers through its website, including a Provider Manual developed to disseminate all relevant information to qualified behavioral health service providers.

10.3.2.14. The MCO shall provide all qualified behavioral health service providers and subcontractors access to the DHH Service Definitions Manual and the MCO's Provider Manual, and any updates, either through the MCO's website, or by providing paper copies to providers upon request.

10.3.3. The MCO provider website is considered marketing material and, as such, must be reviewed and approved in writing within thirty (30) days of the date the MCO signs the Contract.

10.3.4. The MCO must notify DHH when the provider website is in place.

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

10.3.6. The MCO 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.

10.3.7. The MCO is responsible for ensuring that the website is maintained with accurate and current information and is compliant with requirements of this RFP.

10.4. Provider Handbook

10.4.1. The MCO shall develop and issue a provider handbook within thirty (30) days of the date the MCO signs the Contract with DHH. The MCO 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 MCO's website. This notification shall also detail how the provider can request a hard copy from the MCO 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 MCO covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all MCO requirements are met. At a minimum, the provider handbook shall include the following information:

10.4.1.1. Description of the MCO;

10.4.1.2. Core benefits and services the MCO must provide including a description of all behavioral health services;

10.4.1.3. Emergency service responsibilities;

10.4.1.4. Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the MCO to file a provider complaint the timeframes allowed for resolving claims payment issues, and the process a provider would take to escalate unresolved issues.

10.4.1.5. Information about the MCO's Grievance System, that with written permission from the member, the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers, the member's right to request continuation of services while undergoing due process in the MCO's appeal process, and any additional information specified in 42 CFR §438.10(g)(~~1~~2)(xi). The member's written approval may be obtained in advance as part of the member intake process;

10.4.1.6. Medical necessity standards as defined by DHH and practice guidelines;

10.4.1.7. Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

10.4.1.8. PCP responsibilities;

10.4.1.9. Other provider responsibilities under the subcontract with the MCO;

10.4.1.10. Prior authorization and referral procedures;

10.4.1.11. Standards for record keeping;

10.4.1.12. Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;

10.4.1.13. MCO prompt pay requirements (see Section 9);

10.4.1.14. The MCO's chronic care management program;

10.4.1.15. Quality performance requirements;

10.4.1.16. Provider rights and responsibilities;

10.4.1.17. Service authorization criteria to make medical necessity determinations;

10.4.1.18. Information on reporting suspicion of provider or member fraud, waste or abuse; and

10.4.1.19. Information on obtaining Medicaid transportation services for members.

10.4.2. The MCO shall disseminate bulletins as needed to incorporate any changes to the provider handbook.

10.4.3. The MCO shall make available to DHH for approval a provider handbook specific to the Louisiana MCO Program, no later than thirty (30) days prior to the date the MCO signs the Contract with DHH.

10.5. Provider Education and Training

10.5.1. The MCO shall provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special needs of members. The MCO shall conduct initial training within thirty (30) days of placing a newly contracted provider, or provider group, on active status. The MCO shall also conduct ongoing training, as deemed necessary by the MCO or DHH, in order to ensure compliance with program standards and the Contract.

10.5.2. The MCO 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 MCO 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.

10.5.3. The MCO shall develop and offer specialized initial and ongoing training in the areas including but not limited to billing procedures and service authorization requirements ~~for network providers who have traditionally billed and obtained service authorization primarily from Medicaid and/or Medicare only. This includes but is not limited to personal care services providers and hospice providers and may include other provider types at the discretion of DHH~~.

10.5.4. Specialized Behavioral Health Provider Education and Training

10.5.4.1. All specialized behavioral health services training will be documented with agendas, written training materials, invited attendees, and sign-in sheets (including documentation of absent attendees). Training to be provided will include but not be limited to:

- Cultural Competency;
- Specialized Behavioral Health Services (SBHS) program requirements, rules, and regulations including but not limited to staff qualifications and requirements, approved training curricula, approved provider types and specialties, service definitions, clinical components, service limitations and exclusions, assessment, treatment planning and medical record requirements, quality management documentation,
- Evidence-Based practices, promising practices, emerging best practices;
- Billing options and requirements and documentation requirements;
- Utilizing the ~~Child and Adolescent Needs and Strengths (CANS) and~~ LOCUS assessment tool~~s~~ for specialized behavioral health providers;
- Integrating physical and behavioral health;
- Assessing and treating individuals with co-occurring I/DD;
- Use of MCO systems and website; and

- Additional topics as determined through provider/member surveys and/or as directed by DHH.

10.5.5. The MCO shall provide prescriber education, training and outreach to support the implementation, maintenance, and updating of its behavioral health pharmacy management activities, including, but not limited to education and training relative to the Preferred Drug List, prior authorization requirements, fail first, step-therapy, approved prescribing caps, and relevant member appeal, expedited appeal, and peer-to-peer procedures and protocols. The MCO shall submit its tentative prescriber training and education schedule or plan to DHH by January 1, 2016, and 7 days before any newly scheduled training event.

10.5.6. The MCO shall provide technical assistance and network development training (e.g., billing, behavioral health services and authorization, linguistic/cultural competency, etc.) for its behavioral health providers, including required trainings for certain behavioral health providers (e.g. Child and Adolescent Needs and Strengths (CANS), Level of Care Utilization System (LOCUS), OBH standardized training for non-licensed providers, etc.). The MCO shall maintain records of such training including completion dates trainings, which shall be made available to DHH upon request.

10.5.7. The MCO shall ensure that behavioral health providers (i.e. organizations, practitioners and staff) are trained and/or meet training requirements in accordance with the ~~Service Definitions~~LDH Behavioral Health Provider Manual for the services contracted to be delivered including curriculum or equivalent standards, and DHH ~~standard~~ approved training.

~~**10.5.8.** The MCO shall develop, implement, and provide DHH with a copy of an annual training plan that addresses all training requirements, including involvement of members and family members in the development and delivery of trainings. The initial annual training plan including behavioral health topics shall be submitted to DHH by November 1, 2015.~~

~~The MCO shall submit a copy of any behavioral health provider training materials and a training schedule to DHH.~~

10.5.8. The MCO shall provide at least seven ~~thirty~~ (7~~30~~) days advance notice of all trainings to DHH, and DHH shall be invited ~~permitted~~ to attend ~~any and~~ all provider sessions. The MCO shall maintain and provide upon DHH request all provider training reports identifying training topics provided, dates, sign-in sheets, invited/attendees' lists, and organizations trained.

10.6. Provider Complaint System

10.6.1. Applicable Definitions

10.6.1.1. Definition of Provider Complaint

For the purposes of this subsection, a provider complaint (also referred to as provider grievance) is any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the MCO, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies. Note that member grievances and appeals filed by providers on

behalf of a member should be documented and processed in accordance with member grievance and appeals policies.

10.6.1.2. Definition of Action

For purposes of this subsection an action is defined as:

- The denial or limited authorization of a requested service, including the type or level of service; or
- The reduction, suspension, or termination of a previously authorized service; or
- The failure to provide services in a timely manner, as defined by Section 7.3 and Section 7.5 of this RFP; or
- The failure of the MCO to act within the timeframes provided in Section 10.6.5 of this RFP.

10.6.2. The MCO shall establish a Provider Complaint System with which to track the receipt and resolution of provider complaints from in-network and out-of-network providers.

10.6.3. This system must be capable of identifying and tracking complaints received by phone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.

10.6.4. As part of the Provider Complaint system, the MCO shall:

10.6.4.1. 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;

10.6.4.2. Identify a key staff person specifically designated to receive and process provider complaints;

10.6.4.3. Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's written policies and procedures; and

10.6.4.4. Ensure that MCO executives with the authority to require corrective action are involved in the provider complaint escalation process, provide the names, phone numbers and e-mail address to DHH within one week of contract approval, and within 2 business days of any changes.

10.6.5. The MCO shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The MCO 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. Note that provider complaints must be acknowledged within business 3 days. They should be resolved as soon as feasible, but within no more than 30 calendar days unless both the provider and DHH have been notified of the

outstanding issues, including a timeline for resolution and reason for the extension of time. ~~All complaints should be resolved in no more than 90 days.~~ The policies and procedures shall include, at a minimum:

10.6.5.1. Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaint with the MCO and the resolution time;

10.6.5.2. A description of how and under what circumstances providers are advised that they may file a complaint with the MCO for issues that are MCO 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 MCO;

10.6.5.3. A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf;

10.6.5.4. 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;

10.6.5.5. A process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation;

10.6.5.6. A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary;

10.6.5.7. A process for giving providers (or their representatives) the opportunity to present their cases in person;

10.6.5.8. Identification of specific individuals who have authority to administer the provider complaint process;

10.6.5.9. 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

10.6.5.10. A provision requiring the MCO to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.

10.6.6. The MCO shall include a description of the Provider Complaint System in the Provider Handbook and include specific instructions regarding how to contact the MCOs Provider Relations staff; and contact information for the person from the MCO who receives and processes provider complaints.

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

INTENTIONALLY LEFT BLANK

11.0 ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

DHH contracts with an Enrollment Broker who is responsible for the Bayou Health Program's enrollment and disenrollment process for all Medicaid enrollees. The Enrollment Broker shall be the primary contact for Medicaid eligibles concerning the selection of an MCO and shall assist the potential enrollee to become a member of an MCO. The Enrollment Broker shall be the only authorized entity other than DHH, to assist a Medicaid eligible in any manner in the selection of an MCO and shall be responsible for notifying all MCO members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this Section. The Enrollment Broker's responsibilities regarding enrollment counseling can be found in Appendix W – **Enrollment Broker Responsibilities.**

The MCO shall abide by all enrollment and disenrollment procedures in this Section. Auto assignment algorithms and decisions are at the sole discretion of DHH and all proposers expressly agree to abide by those decisions.

DHH and its agent will make every effort to ensure that recipients ineligible for enrollment in the Bayou Health Program are not to be enrolled in an MCO. However, to ensure that such recipients are not enrolled in an MCO, the MCO shall assist DHH or its agent in the identification of recipients that are ineligible for enrollment in the Bayou Health Program, should such recipients become enrolled inadvertently or if their status changes from eligible to ineligible.

11.1. Maintenance of MCO for Enrollees

11.1.1. In order to minimize member disruptions, the initial contract enrollment period and annual open enrollment will be aligned with the contract start date. In subsequent years, the annual open enrollment will be in conducted in accordance with Section 11.8.

11.1.1.1. All members will be given a sixty (60) day choice period to proactively choose an MCO.

11.1.1.2. If a proactive choice of MCO is not made by the member within sixty (60) days, all members enrolled as of January 31, 2015 in an incumbent MCO (defined as an entity contracted as an CCN-P with Louisiana Medicaid as of January 31, 2015), whether through voluntary selection during the 2014 annual open enrollment period or by default if no change was requested, will be assigned automatically to that MCO on the effective date of this contract. Members of a CCN-S or CCN-P which no longer contracts with the state will be automatically enrolled using the methodology in Section 11.3.

11.1.2. All members shall be subject to the provisions in Section 11.5 below (MCO Lock-in).

11.2. Voluntary Selection of MCO for New Enrollees After February 1, 2015

11.2.1. Medicaid applicants whose financial eligibility determination is made by DHH will be provided an opportunity to choose an MCO at the time of application Upon Medicaid enrollment, this choice, if provided, will be transmitted to the Enrollment Broker.

11.2.2. All members will be provided an annual sixty day open enrollment period between November and January.

11.2.3. All Medicaid applicants will be provided an opportunity to choose an MCO at the start of a new MCO contract either through the regularly scheduled open enrollment period or special enrollment period.

11.3. Special Enrollment Period for Specialized Behavioral Health Integration

11.3.1. All populations required to mandatorily enroll into Bayou Health for Specialized Behavioral Health Services only and those Voluntary Opt-in Populations who remain in FFS Medicaid will be given a 60 day choice period to proactively choose an MCO.

11.3.2. If a proactive choice of MCO is not made by the member within sixty (60) days, DHH will automatically enroll members using the methodology in 11.4.4.

11.4. Automatic Assignment

11.4.1. DHH will auto-assign potential enrollees who do not request enrollment in a specified MCO at the time of financial application for Medicaid or through the help of the enrollment broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the MCO having reached its enrollment capacity limit or as a result of DHH-initiated sanctions. As specified in Section 11.8, members who fail to select a new MCO during their annual open enrollment period will remain enrolled with their existing MCO. These members will not be subject to the automatic assignment process.

11.4.2. In accordance with 42 CFR §438.5~~40(f)~~ the automatic assignment methodology will seek to preserve existing provider-~~recipient~~ beneficiary relationships and relationships with providers that have traditionally served Medicaid recipients. After consideration of provider-~~recipient~~ beneficiary relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction.

11.4.3. If the MCO is noncompliant with the terms of this RFP, LDH may exclude the MCO from any or all components of automatic assignment until the defect is cured to LDH's satisfaction. LDH shall have sole discretion to determine compliance with all such requirements and to define the period of exclusion. LDH may make such determination on a case-by-case basis and failure to exclude an MCO from automatic assignment or to take any other punitive action shall not constitute ratification or approval of such noncompliance.

~~11.4.3.~~**11.4.4.** The automatic assignment methodology for ~~Mandatory Populations for~~ all ~~covered services~~populations shall be based on the following hierarchy:

~~11.4.3.1.~~**11.4.4.1.** If the member has ~~immediate family or~~ household members enrolled in an MCO the member will be enrolled in that MCO.

~~11.4.3.2.~~**11.4.4.2.** If MCO assignment cannot be made based on the beneficiary's ~~member's family or~~ household enrollment, the Enrollment Broker will seek to preserve existing provider-beneficiary relationships which is defined as one in which the provider was the main source of Medicaid services for the

beneficiary during the past twelve months~~the member's most current previous relationship with an MCO (including previous enrollment in a CCN-S plan)~~. If a provider relationship is identified, the beneficiary will be randomly assigned to an MCO in which the provider participates that maximizes the preservation of existing provider-beneficiary relationships~~If a previous MCO relationship is identified and the member's PCP is in-network, the member will be enrolled with the previous MCO~~.

11.4.4.3. If there is no previous provider relationship, the Enrollment Broker will seek to preserve prior MCO relationships within the past six months. If a MCO relationship is identified, the beneficiary will be assigned to the most recent MCO.

~~**11.4.3.3.**~~**11.4.4.4.** If there is no previous MCO relationship, ~~or the member's PCP is not currently in-network,~~ the Enrollment Broker shall use a round robin method to determine the MCO assignment ~~that maximizes the preservation of existing provider-recipient relationships~~.

~~**11.4.3.4.**~~**11.4.4.5.** If an MCO's membership is comprised of forty percent (40%) or more of total statewide membership at the end of any quarter, that plan will be removed from the auto assignment round robin process for the following quarter but members can continue to pro-actively select that plan.

~~**11.4.3.5.**~~**11.4.4.6.** In addition, the MCO's quality measures may be factored into the algorithm for automatic assignment, at the discretion of DHH. Members will be auto-assigned to those plans that have higher quality scores, effective January 1, 2019.

~~**11.4.4.** The auto assignment methodology for Mandatory Populations for Specialized Behavioral Health services only and for Voluntary Opt-in populations shall be based on the following hierarchy:~~

~~**11.4.4.1.** If the member has immediate family or household members enrolled in an MCO, the member will be enrolled in that MCO.~~

~~**11.4.4.2.** If MCO assignment cannot be made based on the member's family or household enrollment, the Enrollment Broker shall use a round robin method to determine the MCO assignment that maximizes the preservation of existing Specialized Behavioral Health provider-recipient relationships.~~

11.5. MCO Lock-In Period

11.5.1. The MCO members shall be enrolled for a period of twelve (12) months or until their next open enrollment period. MCO members will be given ninety (90) days from the effective date of the Initial Enrollment in which they may change MCOs for any reason. After the initial ninety (90) day period, Medicaid enrollees/members shall be locked into an MCO for twelve (12) months from the effective date of enrollment or until the next annual open enrollment period, unless disenrolled for cause, contingent upon their continued Medicaid eligibility.

11.6. Voluntary Opt In Enrollees

11.6.1. Voluntary opt in enrollees will be allowed to request participation in the Bayou Health program for physical health services at any time. The effective date of enrollment shall be effective no later than the first day of the second month following the calendar month the request for enrollment is received. Voluntary opt in enrollees will not be enrolled with a retroactive begin date for their physical health services.

11.6.2. The Enrollment Broker will ensure that all voluntary opt-in populations are notified at the time of enrollment of their ability to opt out of the Bayou Health program for their physical health services without cause at any time. The effective date of disenrollment shall be the first day of a month and no later than the first day of the second month following the calendar month the request for disenrollment is received.

11.6.3. Following their opt into the Bayou Health program for their physical health services and selection of an MCO and subsequent ninety (90) day choice period, during which they can change MCO for any reason, these members will be locked in to the MCO for twelve (12) months from the effective date of enrollment or until the next annual open enrollment, unless they opt out of the Bayou Health program for their physical health services.

11.7. Assistance with Medicaid Eligibility Renewal

Renewals of Medicaid and CHIP eligibility are conducted annually. The MCO shall assist with Medicaid eligibility renewal efforts with their members. DHH will provide the MCO with a list of members up for renewal no less than 60 days prior to a member's renewal date. The list will be a subset of the entire renewal population, as determined by DHH. Assistance should include, but is not limited to, education and outreach to members detailing how a member can renew their Medicaid eligibility, through letters, text messages, e-mails and outbound calls. All materials should comply with the requirements set forth in Section 12 of the RFP.

11.8. Annual Open Enrollment

11.8.1. DHH, through its Enrollment Broker, will provide an opportunity for all MCO members to retain or select a new MCO during a single statewide annual open enrollment period. Prior to the annual open enrollment period, the Enrollment Broker will mail a re-enrollment offer to the MCO member to determine if they wish to continue to be enrolled with their current MCO.

11.8.1.1. The first opportunity for New Adults to retain or select a new MCO during a single statewide annual open enrollment period will be in late 2017.

11.8.2. Each MCO member shall receive information and the offer of assistance with making informed choices about the participating MCOs and the availability of choice counseling. The Enrollment Broker shall provide the individual with information on the MCOs from which they may select. Each Medicaid enrollee shall be given sixty (60) calendar days to retain their existing MCO or select a new MCO.

11.8.3. Unless the member becomes ineligible for the Bayou Health Program, members that fail to select a new MCO during their annual open enrollment period will remain enrolled with the existing MCO.

11.9. Suspension of and/or Limits on Enrollments

11.9.1. The MCO shall identify the maximum number of MCO members it is able to enroll and maintain under the Contract prior to initial enrollment of Medicaid eligibles. The MCO shall accept Medicaid enrollees as MCO members in the order in which they are submitted by the Enrollment Broker without restriction [42 CFR §438.6(d)(1)] as specified by DHH up to the limits specified in the Contract. The MCO shall provide services to MCO members up to the maximum enrollment limits specified in the Contract. DHH reserves the right to approve or deny the maximum number of MCO members to be enrolled in the MCO based on DHH's determination of the adequacy of MCO capacity.

11.9.2. Consistent with reporting requirements in Section 18.0 of this RFP, the MCO shall submit a quarterly update of the maximum members. The MCO shall track slot availability and notify DHH's Enrollment Broker when filled slots are within ninety percent (90%) of capacity. The MCO is responsible for maintaining a record of total PCP linkages of Medicaid members and provide this information quarterly to DHH.

11.9.3. DHH will notify the MCO when the MCO's enrollment levels reach ninety-five percent (95%) of capacity and will not automatically assign Medicaid eligibles.

11.9.4. In the event the MCO's enrollment reaches forty percent (40%) of the total enrollment in the state, the MCO will not receive additional members through the automatic assignment algorithm. However, the MCO may receive new members as a result of: member choice and newborn enrollments; reassignments when a member loses and regains eligibility selection when other family or case members are members of the MCO; need to ensure continuity of care for the member; or determination of just cause by DHH. DHH's evaluation of an MCO's enrollment market share will take place on a calendar quarter.

11.10. MCO Enrollment Procedures

11.10.1. Acceptance of All Eligibles

11.10.1.1. The MCO shall enroll any mandatory or voluntary MCO eligible who selects it or is assigned to it regardless of the individual's age, sex, ethnicity, language needs, or health status. The only exception will be if the MCO has reached its enrollment capacity limit.

11.10.1.2. The MCO shall accept potential enrollees in the order in which they are assigned without restriction, up to the enrollment capacity limits set under the Contract with DHH.

11.10.1.3. The MCO shall not discriminate against MCO members on the basis of their health history, health status, need for health care services or adverse change in health status; or on the basis of age, religious belief, sex/gender, ~~or~~ sexual orientation, gender identity, or disability. Further, the MCO shall not use any policy or practice that has the effect of discriminating on the basis of age, religious belief, race, color, national origin, sex, sexual orientation, gender identity, or disability. This applies to enrollment, re-enrollment or disenrollment from the MCO. The MCO shall be subject to monetary

penalties and other sanctions if it is determined by DHH that the MCO has requested disenrollment for any of these reasons.

11.10.1.4. The MCO shall comply with all federal and state statutes and rules governing direct reimbursement to Medicaid eligibles for payments made by them for medical services and supplies delivered during a period of retroactive eligibility.

11.10.2. Effective Date of Enrollment

The effective date of initial enrollment in an MCO shall be the date provided on the outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance electronic transaction initiated by the Enrollment Broker.

A member's effective date of enrollment in an MCO will be the member's effective date of eligibility for Medicaid, subject to the following limitation.

Individuals may be retroactively eligible for Medicaid. Individuals retroactively eligible for Medicaid may be retroactively enrolled in an MCO. However, retroactive enrollment in an MCO is limited to 12 months.

In cases of retroactive eligibility, the effective date of MCO enrollment may occur prior to either the individual or the MCO being notified of the person's MCO enrollment.

The MCO shall not be liable for the cost of any covered services prior to the effective date of MCO enrollment, but shall be responsible for the costs of covered services obtained on or after 12:01 am on the effective date of MCO enrollment.

DHH shall make monthly capitation payments to the MCO from the effective date of an enrollee's MCO enrollment. Claims for dates of service prior to the effective date of MCO enrollment shall be submitted by providers directly to the Medicaid Fiscal Intermediary for payment.

Except for applicable Medicaid cost sharing, the MCO shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the MCO.

11.10.3. Change in Status

11.10.3.1. The MCO shall report 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, e-mail address, telephone number, the manner and format determined by DHH.

11.10.3.2. The MCO shall submit an MCO Initiated Request for Disenrollment to DHH through to the Enrollment Broker for other known changes in status of eligibility for participation in Bayou Health including but not limited to death, admission to intermediate care facility for people with developmental disabilities for members age 21 and over, and entry into involuntary custody/incarceration.

11.10.4. Newborn Enrollment

11.10.4.1. The MCO shall contact members who are expectant mothers sixty (60) calendar days prior to the expected date of delivery to encourage the mothers to choose a PCP for their newborns. In the event that the pregnant member does not select a PCP, the MCO shall provide the member with a minimum of fourteen (14) days after birth to select a PCP prior to assigning one.

Medicaid eligible newborns and their mothers, to the extent that the mother is eligible for Medicaid, shall be enrolled in the same MCO with the exception of newborns placed for adoption or newborns who are born out of state and are not Louisiana residents at the time of birth.

A newborn may be inadvertently enrolled in an MCO different than its mother. When such cases are identified, DHH shall immediately:

- Disenroll the newborn from the incorrect MCO
- Enroll the newborn in the same MCO as its mother with the same effective date as when the newborn was enrolled in the incorrect MCO
- Recoup any payments made to the incorrect MCO for the newborn; and
- Make payments only to the correct MCO for the period of coverage.

The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of covered serviced provided to the newborn for the full period of eligibility. The MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO assignment. DHH shall only be liable for the capitation payment to the correct MCO.

11.10.4.2. The MCO shall be responsible for assuring that hospital subcontractors report the births of newborns within twenty-four (24) hours of birth for enrolled members using DHH's web-based Facility Notification System (FNS) Newborn Manual (See Appendix S). If the member makes a PCP selection during the hospital stay and one was not already identified, this information shall be reported to the plan. If no selection is made, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one. Enrollment of newborns who are Louisiana residents at the time of birth and who are not surrendered prior to hospital discharge shall be retroactive to the date of the birth.

11.10.4.3. The MCO shall require its hospital providers to register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.

11.10.4.4. LEERS information and training materials at the following url: http://new.dhh.louisiana.gov/index.cfm/page/669

11.10.5. All justice-involved members releasing from incarceration that meet eligibility for the New Adult Group under expansion shall be enrolled in accordance with the

process outlined in the Justice-Involved Pre-release Enrollment Program Manual. Justice-involved members shall be given sixty (60) days from the date of their release to change plans.

11.11. Disenrollment

11.11.1. Disenrollment is any action taken by DHH or its designee to remove a Medicaid MCO member from the MCO 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 Bayou Health Program.

11.11.2. The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.

11.11.3. Member Initiated Disenrollment – a member may request disenrollment from an MCO as follows:

11.11.3.1. For cause, at any time. The following circumstances are cause for disenrollment:

- The MCO does not, because of moral or religious objections, cover the service the member seeks;
- The member requests to be assigned to the same MCO as family members;
- The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;
- The contract between the MCO and DHH is terminated;
- Poor quality of care;
- Lack of access to MCO core benefits and services covered under the contract;
- Documented lack of access within the MCO to providers experienced in dealing with the member's healthcare needs;
- The member's active specialized behavioral health provider ceases to contract with the MCO;
- Member moves out of the MCO's service area, i.e. out of state; or
- Any other reason deemed to be valid by DHH and/or its agent.

11.11.3.2. Without cause for the following reasons:

- During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members;

- During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO;

  Once a year thereafter during the member's annual open enrollment period;

- Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or

- If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a) (3).

11.11.3.3. The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.

11.11.3.4. If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.

11.11.4. MCO Initiated Disenrollment

11.11.4.1. The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise her/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).

11.11.4.2. The MCO shall not request disenrollment for reasons other than those stated in this RFP. (See Appendix U – **Guidelines for Involuntary Member Disenrollment**). In accordance with 42 CFR §438.56(b)(3), DHH will ensure that the MCO is not requesting disenrollment for other reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.

~~**11.11.4.3.**~~ The ~~following is the only allowable reason for which the~~ MCO may request involuntary disenrollment of a member if the ~~:~~

~~**11.11.4.4.**~~**11.11.4.3.** ~~The~~ member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to DHH.

~~**11.11.4.5.**~~**11.11.4.4.** When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.

~~**11.11.4.6.**~~**11.11.4.5.** The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the

measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).

~~11.11.4.7.~~11.11.4.6. The MCO shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.

~~11.11.4.8.~~11.11.4.7. All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.

~~11.11.4.9.~~11.11.4.8. The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new MCO. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has a right to file an appeal directly through the State Fair Hearing process.

~~11.11.4.10.~~11.11.4.9. Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.

11.11.5. Disenrollment Effective Date

11.11.5.1. 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 filed.

11.11.5.2. If DHH or its designee fails to make a disenrollment determination by the first (1^{st}) day of the second (2^{nd}) month following the month in which the request for disenrollment is filed, the disenrollment is considered approved.

11.11.5.3. DHH, the MCO, and the Enrollment Broker shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.

11.11.6. DHH Initiated Disenrollment and Changes

DHH will notify the MCO of the member's disenrollment or change in enrollment status due to the following reasons:

11.11.6.1. Loss of Medicaid eligibility or loss of MCO enrollment eligibility;

11.11.6.2. Death of a member;

11.11.6.3. Member's intentional submission of fraudulent information;

11.11.6.4. Member becomes an inmate in a public institution;

11.11.6.5. Member moves out-of-state;

11.11.6.6. Member becomes Medicare eligible;

11.11.6.7. Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);

11.11.6.8. To implement the decision of a hearing officer in an appeal proceeding by the member against the MCO or as ordered by a court of law.

11.12. Enrollment and Disenrollment Updates

11.12.1. DHH's Enrollment Broker will notify each MCO at specified times each month of the Medicaid eligibles that are enrolled, re-enrolled, or disenrolled from their MCO for the following month. The MCO will receive this notification through the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction.

11.12.2. DHH will use its best efforts to ensure that the MCO receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or irresolvable differences between DHH and the MCO regarding enrollment, disenrollment and/or termination, DHH's decision is final.

11.13. Daily Updates

The Enrollment Broker shall make available to the MCO daily via electronic media, (ASC X12N 834 Benefit Enrollment and Maintenance transaction) updates on members newly enrolled into the MCO in the format specified in the ***MCO Systems Companion Guide***. The MCO 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 pre-implementation Readiness Review.

11.14. Weekly Reconciliation

11.14.1. Enrollment

The MCO is responsible for weekly reconciliation of the membership list of new enrollments and disenrollments received from the Enrollment Broker against its internal records. The MCO shall provide written notification to the Enrollment Broker of any data inconsistencies within 10 calendar days of receipt of the data file.

11.14.2. Payment

The MCO will receive monthly electronic file (ASC X12N 820 Transaction) from the Medicaid Fiscal Intermediary (FI) listing all members for whom the MCO received a capitation payment and the amount received. The MCO is responsible for reconciling this listing against its internal records. It is the MCO's responsibility to notify the FI of any discrepancies within three (3) months of the file date. Lack of compliance with reconciliation requirements will result in the withholding of portion of future monthly payments and/or monetary penalties as defined Section 20.0 of this RFP until requirements are met.

INTENTIONALLY LEFT BLANK

12.0 MARKETING AND MEMBER EDUCATION

12.1. General Guidelines

12.1.1. Marketing, for purposes of this RFP, is defined in 42 CFR §438.104 (a) as any communication from an MCO to a Medicaid eligible who is not enrolled in that MCO that can reasonably be interpreted to influence the Medicaid eligible to 1) enroll in that particular MCO's Medicaid product, or 2) either not enroll in, or disenroll from, another MCO's Medicaid product.

12.1.2. Marketing differs from member education, which is defined as communication with an **enrolled** member of an MCO for the purpose of retaining the member as an enrollee, and improving the health status of enrolled members.

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

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

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

12.1.6. All marketing and member education guidelines are applicable to the MCO, its agents, subcontractors, volunteers, and/or providers.

12.1.7. All marketing and 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.

12.1.8. All marketing and member materials and activities shall comply with the requirements in 42 CFR §438.10 and the DHH requirements set forth in this RFP.

12.1.9. The MCO is responsible for creation, production and distribution of its own marketing and member materials to its enrollees. DHH and the DHH Enrollment Broker will only be responsible for distributing general material developed and produced by the MCO for inclusion in the enrollment package distributed to Medicaid enrollees. DHH will determine which materials will be included in the Enrollment Broker generated packet and which materials will be distributed by the MCO.

12.1.10. Under the Bayou Health Program, all direct marketing to eligibles or potential eligibles will be performed by DHH or its designee in accordance with 42 U.S.C. §1396u-2(d)(2)(A) and 42 CFR §438.104.

12.1.11. Activities involving distribution and completion of an MCO enrollment form during the course of enrollment activities is an enrollment function and is the sole responsibility of DHH's Enrollment Broker.

12.1.12. The MCO shall assure DHH that marketing and member materials are accurate and do not mislead, confuse, or defraud the enrollee/potential enrollee or DHH as specified in 42 U.S.C. §1396u-2(d)(2) and 42 CFR §438.104.

12.1.13. The MCO shall 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.

12.1.14. The MCO shall develop marketing and member materials that address the MCO populations outlined in Section 3.3.3 of the Contract (i.e., those who receive the full range of benefits as outlined in this contract versus members covered only for specialized behavioral health and NEMT services).

12.2. Marketing and Member Education Plan

12.2.1. The MCO shall develop and implement a plan detailing the marketing and member education activities it will undertake and materials it will create during the contract period, incorporating DHH's requirements for participation in the MCO Program. The detailed plan must be submitted to DHH for review and approval within thirty (30) calendar days from the date the Contract is signed.

12.2.2. The MCO shall not begin member education activities associated with this contract prior to the approval of the marketing and member education plan.

12.2.3. The MCOs' plan shall take into consideration projected enrollment levels for equitable coverage of the entire MCO service area. The plan should clearly distinguish between **marketing** activities and materials and **member education** activities and materials. The plan shall include, but is not limited to:

12.2.3.1. Stated marketing and member education goals and strategies;

12.2.3.2. A marketing and member education calendar, which begins with the date of the signed contract, between DHH and the MCO, and runs through the first calendar year of providing services to Medicaid enrollees, that addresses all marketing areas: advertising plans, coverage areas, Web site development and launch plans, printed materials, material distribution plans (including specific locations), outreach activities (health fairs, area events, etc.);

12.2.3.3. A summary of value added benefits to be used in the creation of a plan comparison chart to assist potential enrollees in selecting the MCO that best meets their needs;

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

12.2.3.5. The MCO's plans for new member outreach, including welcome packets and welcome call;

12.2.3.6. The MCO's plan to incorporate patient engagement tools such as smartphone-based support programs, mobile applications or text messaging innovations. ~~A smartphone-based support program could include the following features:~~

- ~~Native mobile applications and / or mobile-friendly content that is accessible across a broad range of smartphones;~~
- ~~Consumer-friendly, engaging content that helps keep patients on-track with key health appointments and screenings;~~
- ~~Tools to help stratify users by risk profile and direct the higher risk users to State-based or plan-based resources;~~
- ~~Outreach support to educate patients about the mobile tools; and~~
- ~~Reporting and analytics to help the State measure the effectiveness of the smartphone-based support program.~~

12.2.3.7. How the MCO plans intends to meet the informational needs, relative to marketing (for prospective enrollees) and member education (for current enrollees), for the physical and cultural diversity of the service area. This may include, but is not limited to: a description of provisions for non-English speaking prospective enrollees, interpreter services, alternate communication mechanisms (such as sign language, Braille, audio tapes);

12.2.3.8. A list of all subcontractors engaged in marketing or member education activities for the MCO;

12.2.3.9. A copy of the MCO training curriculum for marketing representatives (both internal and subcontractor);

12.2.3.10. The MCO's procedure for monitoring and enforcing compliance with all marketing and member education guidelines, in particular the monitoring of prohibited marketing methods, among internal staff and subcontractors;

12.2.3.11. Copies of all marketing and member materials (print and multimedia) planned for distribution by the MCO or any of its subcontractors that are directed at Medicaid eligibles or potential eligibles.

12.2.3.12. Copies of marketing and member materials that are 1) currently in concept form, but not yet produced (should include a detailed description) or 2) samples from other states that will be duplicated in a similar manner for the Louisiana Bayou Health population.

12.2.3.13. Details of proposed marketing and member education activities and events. All activities must be submitted in the plan using the approved format, **Event Submission Calendar**;

12.2.3.14. Details regarding the basis it uses for awarding bonuses or increasing the salary of marketing representatives and employees involved in marketing;

12.2.3.15. Details for supplying current materials to service regions as well as plans to remove outdated materials in public areas; and

12.2.3.16. The MCO's protocol for responding to unsolicited direct contact (verbal or written) from a potential member (the MCO is not allowed to engage in marketing encounters with potential members, but Medicaid enrollees may seek out specific MCOs for information).This should include:

- Circumstances that will initiate referral to the Enrollment Broker;
- Circumstances that will initiate referral to the Medicaid Customer Service Line (toll free #1-888-342-6207);
- Circumstances that will terminate the encounter; and
- Circumstances that will prompt the MCO to distribute materials to the potential member and a draft of those materials (which must refer all enrollment inquiries to the Enrollment Broker).

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

12.3. Prohibited Marketing Activities

The MCO and its subcontractors are prohibited from in engaging in the following activities:

12.3.1. Marketing directly to Medicaid potential enrollees or MCO prospective enrollees, including persons currently enrolled in Medicaid or other MCOs (including direct mail advertising, "spam", door-to-door, telephonic, or other "cold call" marketing techniques);

12.3.2. Asserting that the MCO is endorsed by CMS, the federal or state government or similar entity;

12.3.3. Distributing plans and materials or making any statement (written or verbal) that DHH determines to be inaccurate, false, confusing, misleading or intended to defraud members or DHH. This includes statements which mislead or falsely describe covered services, membership or availability of providers and qualifications and skills of providers and assertions the recipient of the communication must enroll in a specific plan in order to obtain or not lose benefits;

12.3.4. Portraying competitors or potential competitors in a negative manner;

12.3.5. Attaching a Medicaid application and/or enrollment form to marketing materials to any member not currently enrolled with the MCO ;

12.3.6. Assisting with enrollment or improperly influencing MCO selection;

12.3.7. Inducing or accepting a member's enrollment or disenrollment to any member not currently enrolled with the MCO

12.3.8. Using the seal of the state of Louisiana, DHH's name, logo or other identifying marks on any materials produced or issued, without the prior written consent of DHH;

12.3.9. Distributing marketing information (written or verbal) that implies that joining MCOs or a particular MCO is the only means of preserving Medicaid coverage or that MCOs or a particular MCO is the only provider of Medicaid services and the potential enrollee must enroll in the MCO or MCOs to obtain benefits or not lose benefits;

12.3.10. Comparing their MCO to another organization/ MCO by name;

12.3.11. Sponsoring or attending any marketing or community health activities or events without notifying DHH within the timeframes specified in this RFP;

12.3.12. Engaging in any marketing activities, including unsolicited personal contact with a potential enrollee, at an employer-sponsored enrollment event where employee participation is mandated by the employer;

12.3.13. Marketing or distributing marketing materials, including member handbooks, and soliciting members in any other manner, inside, at the entrance or within 100 feet of check cashing establishments, public assistance offices, /DCFS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), FITAP, Health Units, Medicaid Eligibility Offices, and/or certified Medicaid Application Centers without prior approval from DHH. Medicaid Eligibility Office staff or approved DHH agents shall be the only authorized personnel to distribute such materials;

12.3.14. Conducting marketing or distributing marketing materials in hospital EDs, including the ED waiting areas, patient rooms or treatment areas;

12.3.15. Copyrighting or releasing any report, graph, chart, picture, or other document produced in whole or in part relating to services provided under this Contract on behalf of the MCO without the prior written consent of DHH;

12.3.16. Purchasing or otherwise acquiring or using mailing lists of Medicaid eligibles from third party vendors, including providers and state offices;

12.3.17. Using raffle tickets or event attendance or sign-in sheets to develop mailing lists of prospective enrollees;

12.3.18. Charging members for goods or services distributed at events;

12.3.19. Charging members a fee for accessing the MCO Web site;

12.3.20. Influencing enrollment in conjunction with the sale or offering of any private insurance or Medicare Advantage Plan;

12.3.21. Using terms that would influence, mislead or cause potential members to contact the MCO, rather than the DHH-designated Enrollment Broker, for enrollment;

12.3.22. Referencing the commercial or Medicare Advantage Plan component of the MCO in any of its Medicaid MCO enrollee marketing materials, if applicable;

12.3.23. Using terms in marketing materials such as “choose,” “pick,” “join,” etc. unless the marketing materials include the Enrollment Broker’s contact information;

12.4. Allowable Marketing Activities

12.4.1. The MCO and its subcontractors shall be permitted to perform the following activities:

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

12.4.1.2. Make telephone calls and home visits only to members currently enrolled in the MCO (member education and outreach) for the purpose of educating them about services offered by or available through the MCO;

12.4.1.3. Respond to verbal or written requests for information made by potential members, in keeping with the response plan outlined in the marketing plan approved by DHH prior to response;

12.4.1.4. Provide promotional giveaways that exceed the $15.00 value to current members only;

12.4.1.5. Attend or organize activities that benefit the entire community such as health fairs or other health education and promotion activities. Notification to DHH must be made of the activity and details must be provided about the planned marketing activities using the **Event Submission Calendar**;

12.4.1.6. Attend activities at a business at the invitation of the entity. Notification to DHH must be made of the activity and details must be provided about the planned marketing activities using the **Event Submission Calendar**;

12.4.1.7. Conduct telephone marketing only during incoming calls from potential members. The MCO may return telephone calls to potential members only when requested to do so by the caller. The MCO must utilize the response plan outline in the marketing plan, approved by DHH, during these calls; and

12.4.1.8. Send plan-specific materials to potential members at the potential member’s request.

12.4.2. In any instance where an MCO-allowable activity conflicts with a prohibited activity, the prohibited activity guidance shall be followed.

12.5. Marketing and Member Materials Approval Process

12.5.1. The MCO must obtain prior written approval from DHH for all marketing and member materials for potential or current enrollees. This includes, but is not limited to, print, television, web, and radio advertisements; member handbooks,

identification cards and provider directories; call scripts for outbound calls or customer service centers; MCO website screen shots; promotional items; brochures; letters and mass mailings and e-mailings. Neither the MCO nor its subcontractors may distribute any MCO marketing or member materials without DHH consent.

12.5.2. All proposed materials must be submitted via email to DHH. Materials must be submitted in PDF format unless an alternative format is approved or requested by DHH.

12.5.2.1. Materials submitted as part of the original marketing and member education plan will be considered approved with the approval of the plan if the materials were in final draft form.

12.5.3. MCOs must obtain prior written approval for all materials developed by a recognized entity having no association with the MCO, including but not limited to, those developed by a government entity or a nonprofit organization, that the MCO wishes to distribute. DHH will only consider materials when submitted by the MCO (not subcontractors).

12.5.4. Review Process for Materials

12.5.4.1. DHH will review the submitted marketing and member materials and either approve, deny or submit changes within thirty (30) calendar days from the date of submission;

12.5.4.2. Once member materials are approved in writing by DHH, the MCO shall submit an electronic version (PDF) of the final printed product, unless otherwise specified by DHH, within ten (10) calendar days from the print date. If DHH requests that original prints be submitted in hard copy, photo copies may not be submitted for the final product. Upon request, the MCO must provide additional original prints of the final product to DHH;

12.5.4.3. Prior to modifying any approved member material, the MCO shall submit for written approval by DHH, a detailed description of the proposed modification accompanied by a draft of the proposed modification;

12.5.4.4. DHH reserves the right to require the MCO to discontinue or modify any marketing or member materials after approval;

12.5.4.5. MCO materials used for the purpose of marketing and member education, except for the original MCO marketing and member education plan, are deemed approved if a response from DHH is not returned within thirty (30) calendar days following receipt of materials by DHH; and

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

12.6. Events and Activities Approval Process

12.6.1. The MCO must provide written notice to DHH for all marketing and member education events and activities for potential or current enrollees as well as any

community/health education activities that are focused on health care benefits (health fairs or other health education and promotion activities). Notice to DHH may be made prior to the event, or in the form of the Marketing Plan Monthly Report (Appendix BB).

12.6.2. The MCO must obtain prior written approval from DHH for any activities that include sponsorships.

12.6.3. The MCO must obtain prior written approval from DHH for any press or media events or activities.

12.6.4. All proposed events and activities, including proposed sponsorships, must be submitted to DHH using the **Event Submission Calendar**. (See Appendix X)

12.6.4.1. Activities and events submitted as part of the original marketing and member education plan will be considered approved with the approval of the plan if the activity or event details are complete.

12.6.5. Review Process for Events and Activities

12.6.5.1. DHH will review proposed sponsorship, press or media events and activities and either approve or deny within fourteen (14) business days from the date of submission.

12.6.5.2. In the case where a sponsorship, press, or media event or activity arises and approval within the seven (7) business day timeframe is not possible due to the proximity of the event or activity, the MCO may request an expedited approval. DHH reserves the right to deny such requests.

12.6.5.3. DHH reserves the right to require the MCO to discontinue or modify any marketing or member education events after approval.

12.6.5.4. Proposed sponsorships, press or media events and activities, except for those included in the original MCO marketing and member education plan, are deemed approved if a response from DHH is not returned within seven (7) business days following notice of event to DHH.

12.6.5.5. Any revisions to approved sponsorships, press or media events and activities must be resubmitted for approved by DHH prior to the event or activity using the **Event Submission Calendar**.

12.7. MCO Provider Marketing Guidelines

12.7.1. When conducting any form of marketing in a provider's office, the MCO must acquire and keep on file the written consent of the provider.

12.7.2. The MCO may not require its providers to distribute MCO-prepared marketing communications to their patients.

12.7.3. The MCO may not provide incentives or giveaways to providers to distribute them to MCO members or potential MCO members.

12.7.4. The MCO may not conduct member education or distribute member education materials in provider offices.

12.7.5. The MCO may not allow providers to solicit enrollment or disenrollment in an MCO, or distribute MCO-specific materials at a marketing activity.

12.7.6. The MCO may not provide printed materials with instructions detailing how to change MCOs to members of other MCOs to providers.

12.7.7. The MCO shall instruct participating providers regarding the following communication requirements:

12.7.7.1. Participating providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they have contracts;

12.7.7.2. Participating providers may display and/or distribute health education materials for **all** contracted MCOs or they may choose not to display and/or distribute for **any** contracted MCOs. Health education materials must adhere to the following guidance:

- Health education posters cannot be larger than 16” X 24”;
- Children’s books, donated by MCOs, must be in common areas;
- Materials may include the MCOs name, logo, phone number and Web site; and
- Providers are not required to distribute and/or display all health education materials provided by each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable.

12.7.7.3. Providers may display marketing materials for MCOs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom the provider has a contract.

12.7.7.4. Providers may display MCO participation stickers, but they must display stickers by **all** contracted MCOs or choose to not display stickers for **any** contracted MCOs.

12.7.7.5. MCO stickers indicating the provider participates with a particular MCO cannot be larger than 5" x 7” and not indicate anything more than “the MCO or MCO is accepted or welcomed here.”

12.7.7.6. Providers may inform their patients of the benefits, services and specialty care services offered through the MCOs in which they participate. However, providers may not recommend one MCO over another MCO, offer patients incentives for selecting one MCO over another, or assist the patient in deciding to select a specific MCO in any way, including but not limited to faxing, using the office phone, or a computer in the office.

12.7.7.7. Upon actual termination of a contract with the MCO, a provider that has contracts with other MCOs may notify their patients of the change in status and the impact of such a change on the patient included the date of the contract termination. Providers must continue to see current patients enrolled in the MCO until the contract is terminated according to all terms and conditions specified in the contract between the provider and the MCO.

12.7.7.8. MCOs shall not produce branded materials instructing members on how to change a MCO. They must use DHH provided or approved materials and should refer members directly to the Enrollment Broker for needed assistance.

12.8. MCO Marketing Representative Guidelines

12.8.1. All MCO marketing representatives, including subcontractors assigned to marketing, must successfully complete a training program about the basic concepts of Louisiana Medicaid, Bayou Health and the enrollees' rights and responsibilities relating to enrollment in MCOs and grievance and appeals rights before engaging in direct marketing to potential enrollees.

12.8.2. The MCO shall ensure that all marketing representatives engage in professional and courteous behavior. The MCO shall not participate, encourage, or accept inappropriate behavior by its marketing representatives, including but not limited to interference with other MCO presentations or talking negatively about other MCOs.

12.8.3. The MCO shall not offer compensation to a marketing representative, including salary increases or bonuses, based solely on an overall increase in MCO enrollment. Compensation may be based on periodic performance evaluations which consider enrollment productivity as one of several performance factors.

12.8.4. Sign-on bonuses for marketing representatives are prohibited.

12.8.5. The MCO shall keep written documentation of the basis it uses for awarding bonuses or increasing the salary of marketing representatives and employees involved in marketing and make such documentation available for inspection by DHH.

12.9. Written Materials Guidelines

The MCO must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.). The MCO shall also comply with guidance outlined in 42 CFR §438.10 and 42 USC §1396u-(2)(d)(2)(A)(i):

12.9.1. All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy:

- Flesch – Kincaid;
- Fry Readability Index;

- PROSE The Readability Analyst (software developed by Educational Activities, Inc.);
- Gunning FOG Index;
- McLaughlin SMOG Index; or
- Other computer generated readability indices accepted by DHH

12.9.2. All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by DHH.

12.9.3. DHH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.

12.9.4. If a person making a testimonial or endorsement for an MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.

12.9.5. All written materials must be in accordance with the **DHH "Person First" Policy**, Appendix NN.

12.9.6. The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.

12.9.7. The MCO's name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.

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

12.9.9. All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.

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

12.9.11. Marketing materials must be made available through the MCO's entire service area. Materials may be customized for specific parishes and populations within the MCOs service area.

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

12.9.13. Marketing materials must accurately reflect general information, which is applicable to the average potential enrollee of the MCO.

12.9.14. The MCO Shall include in all member materials the following:

12.9.14.1. The date of issue;

12.9.14.2. The date of revision; and/or

12.9.14.3. If the prior versions are obsolete.

12.9.15. Except as indicated, the MCO may develop their own materials that adhere to requirements set forth in this document or use state developed model member notices. State developed model notices must be used for denial notices and lock-in notices.

12.10. MCO Website Guidelines

12.10.1. The MCO website must include a member-focused section which can be a designated section of the MCO's general informational website, which is interactive and accessible using mobile devices, and has the capability for bidirectional communications, i.e. members can submit questions and comments to the MCO and receive responses.

12.10.2. The MCO website must include general and up-to-date information about its Bayou Health Plan as it relates to the Louisiana Medicaid program. This may be developed on a page within its existing website to meet these requirements.

12.10.3. The MCO must obtain prior written approval from DHH before updating the website.

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

12.10.5. The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. The MCO web site must follow all written marketing guidelines included in this Section.

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

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

12.10.7.1. The most recent version of the Member Handbook;

12.10.7.2. Telephone contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number;

12.10.7.3. A searchable list of network providers with a designation of open versus closed panels, shall be updated in real time, upon changes to the network;

12.10.7.4. The link to the Enrollment Broker's website (www.bayouhealth.com) and toll free number (1-855-BAYOU-4U, 1-855-229-6848) for questions about enrollment;

12.10.7.5. The link to the Medicaid website (www.medicaid.dhh.louisiana.gov) and the toll free number (888-342-6207) for questions about Medicaid eligibility;

12.10.7.6. A section for the MCO's providers that includes contact information, claims submittal information, prior authorization instructions, and a toll-free telephone number;

12.10.7.7. General customer service information;

12.10.7.8. Updates on emergency situations that may impact the public, such as natural and human-caused disasters that would require time sensitive action by members, such as evacuation from their homes or communities or other preparedness-related activities. The website shall include hyperlinks to state and federal emergency preparedness websites;

12.10.7.9. Information on how to file grievances and appeals; and

12.10.7.10. Information specific to access for specialized behavioral health services, including but not limited to:

- The link to the DHH-OBH and CSoC websites;
- Information on how to access specialized behavioral health services;
- Crisis response information and toll-free crisis telephone numbers;
- Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for members receiving services, their families/caregivers, providers, and stakeholders to become involved; and
- Information regarding advocacy organizations, including how members and other families/caregivers may access advocacy services.

12.11. Member Education – Required Materials and Services

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

12.11.1. New Member Orientation

12.11.1.1. The MCO shall have written policies and procedures as applicable to the covered populations (see Section 3.3.3) for the following, but not limited to:

- Orienting new members of its benefits and services;
- Role of the PCP;

- What to do during the first thirty (30) to sixty (60) days after enrollment, (*e.g.* How to access services, continue medications, and obtain emergency or urgent medical services when transferring from FFS to MCO, or from one MCO to another, etc.);

- How to utilize services;

- What to do in an emergency or urgent medical situation; and

- How to a file a grievance and appeal.

12.11.1.2. The MCO shall identify and educate members who access the system inappropriately and provide continuing education as needed.

12.11.1.3. The MCO may propose, for approval by DHH, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.

12.11.1.4. The MCO shall have written policies and procedures for notifying new members within ten (10) business days after receiving notification from the Enrollment Broker of enrollment. This notification must be in writing.

12.11.1.5. The MCO shall submit a copy of the procedures to be used to contact MCO members for initial member education to DHH for approval within thirty (30) days following the date the Contract is signed. These procedures shall adhere to the enrollment process and procedures outlined in this RFP and the Contract.

12.11.1.6. New Medicaid eligibles shall be provided the opportunity to select a PCP within the MCO that: 1) is accepting new members; 2) has entered into a subcontract with the MCO; and 3) is within a reasonable commuting distance from their residence.

12.11.2. Communication with New Enrollees

12.11.2.1. DHH's Enrollment Broker shall send the MCO a daily electronic transmission ANSI ACS X-12 834 as specified in the **MCO Systems Companion Guide**. The file shall contain the names, addresses and phone numbers of all newly eligible enrollees assigned to the MCO with an indicator for individuals who are automatically assigned to the MCO. The MCO shall use the file in assignment of PCPs and to identify and initiate communication with new members via welcome packet mailings and welcome calls, as prescribed in this RFP.

12.11.2.2. The MCOs shall adhere to the requirements and procedures as set forth in the Justice-Involved Pre-release Enrollment Program Manual.

12.11.2.3. Welcome Packets

12.11.2.3.1. The MCO shall send a welcome packet to new members within ten (10) business days from the date of receipt of the ANSI ACS X-12 834 file identifying the new enrollee. During the integration of behavioral health into Bayou Health, an MCO shall have up to twenty-

one (21) business days to send welcome packets; however, ID cards must be mailed within ten (10) business days.

12.11.2.3.2. The MCO 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 in the same eligibility group (as per Section 3.3.3), the MCO is only required to send one welcome packet. If members are in different eligibility groups that equate to different levels of coverage, separate welcome packets for each type of coverage should be included.

12.11.2.3.3. All contents of the welcome packet are considered member materials and, as such, shall be reviewed and approved in writing by DHH prior to distribution according to the provisions described in this RFP. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:

- A Member Handbook and/or Welcome Member Newsletter;
- The MCO Member ID Card (if not mailed under a separate mailing);
- If the Member ID Card is mailed separately, a welcome letter highlighting major program features, details that a card specific to the MCO's Bayou Health Plan will be sent via mail separately and contact information for the MCO's Bayou Health Plan; and
- A current Provider Directory when specifically requested by the member (also must be available in searchable format on-line).

12.11.2.3.4. The MCO shall adhere to the requirements for the Member Handbook, Welcome Member Newsletter, ID card, and Provider Directory as specified in this RFP, its attachments, and in accordance with 42 CFR §438.10 (f)(6).

12.11.2.3.5. The MCO shall agree to make available the full scope of core benefits and services to which a member is entitled immediately upon his or her effective date of enrollment, which, with the exception of newborns, will always be the 1st day of a month.

12.11.2.4. Welcome Calls

12.11.2.4.1. The MCO shall make welcome calls to new members within fourteen (14) business days of the date the MCO sends the welcome packet. During the integration of behavioral health into Bayou Health, an MCO shall have up to twenty-one (21) business days to make welcome calls.

12.11.2.4.2. The MCO shall review PCP assignment if an automatic assignment was made and assist the member in changing the PCP if requested by the member.

12.11.2.4.3. The MCO shall develop and submit to DHH for approval a script(s), for all covered populations as specified in section 3.3.3, to be used during the welcome call to discuss the following information with the member:

- A brief explanation of the program;
- Statement of confidentiality;
- The availability of oral interpretation and written translation services and how to obtain them free of charge;
- The concept of the patient-centered medical home, including the importance of the member(s) making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition and instructions about changing PCPs; and
- A discussion to discover whether the member is pregnant has a chronic condition, or any special health care needs. Assistance in making an appointment with the PCP shall be offered to all members with such issues.

12.11.2.4.4. The MCO shall make three (3) attempts to contact the member. If the MCO discovers that the member lost or never received the welcome packet, the MCO shall resend the packet.

12.11.3. Member Materials and Programs for Current Enrollees

The MCO shall develop and distribute member educational materials, including, but not limited to, the following:

12.11.3.1. A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;

12.11.3.2. Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;

12.11.3.3. Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Bayou Health Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;

12.11.3.4. Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;

12.11.3.5. Materials focused on health promotion programs available to the members;

12.11.3.6. Communications detailing how members can take personal responsibility for their health and self-management;

12.11.3.7. Materials that promote the availability of health education classes for members;

12.11.3.8. Materials that provide education for members, with, or at risk for, a specific disability or illness;

12.11.3.9. Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;

12.11.3.10. Notification to its members of their right to request and obtain the welcome packet (including all items noted in Section 12.11.2.1 except for the Member ID card) at least once a year;

12.11.3.11. Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and

12.11.3.12. All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.

12.12. MCO Member Handbook

12.12.1. The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10(g~~f)(6~~) and use the state developed model member handbook for each of the covered populations as specified in section 3.3.3.

12.12.1.1. At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook (see Section 3.3.3):

12.12.1.2. Table of contents;

12.12.1.3. A general description about how MCOs operate, and detailed descriptions of the following: enrollee rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, behavioral health services available, a description of the PCP selection process, the PCP's role as coordinator of services, and an explanation of how the enrollees can access LDH's policy on how to receive continued services during a termination of an MCO contract or disenrollment from an MCO as required by 42 CFR §438.62;~~member rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;~~

12.12.1.4. Member's right to disenroll from MCO including disenrollment for cause;

12.12.1.5. Member's right to select and change ~~providers~~ PCPs within the MCO and how to do so;

12.12.1.6. Any restrictions on the member's freedom of choice among MCO providers;

12.12.1.7. Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;

12.12.1.8. The amount, duration, and scope of benefits available to the member under the contract between the MCO and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management, tobacco cessation, and problem gaming;

12.12.1.9. Procedures for obtaining benefits, including authorization requirements;

12.12.1.10. Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;

12.12.1.11. The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers. An explanation shall be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider;

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

- What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a);
- That prior authorization is not required for emergency services;
- The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;
- The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and
- That, subject to the provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.

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

12.12.1.14. Policy on referrals for specialty care, including **specialized** behavioral health services and for other benefits not furnished by the member's PCP;

12.12.1.15. How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with DHH;

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

12.12.1.17. For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;

12.12.1.18. Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §438.400-424 and this RFP;

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

- For State Fair Hearing:
  - The right to a hearing;
  - The method for obtaining a hearing; and
  - The rules that govern representation at the hearing.
- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the member can use to file a grievance or an appeal by phone;
- The fact that, when requested by the member:
  - Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and
  - The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
- In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.

12.12.1.20. Advance Directives, as set forth in 42 CFR §438.10~~6~~(g~~i~~)(~~1~~2)(xii) - A description of advance directives which shall include:

- The MCO policies related to advance directives;
- The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;
- Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and
- Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.

12.12.1.21. Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana Medicaid website at www.medicaid.la.gov, or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;

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

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

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

12.12.1.25. Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

12.12.1.26. Information about the requirement that a member shall notify the MCO immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;

12.12.1.27. Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the MCO;

12.12.1.28. Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;

12.12.1.29. Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish;

12.12.1.30. Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;

12.12.1.31. Ways to report suspected provider fraud and abuse including but not limited to DHH and MCO toll-free numbers and website established for that purpose;

12.12.1.32. Any additional text provided to the MCO by DHH or deemed essential by the MCO;

12.12.1.33. The date of the last revision;

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

- Information on the structure and operation of the MCO;
- Physician incentive plans [42 CFR §438.36~~(h)~~(i)].

- Service utilization policies; and
- How to report alleged marketing violations to DHH utilizing the **Marketing Complaint Form**. (See Appendix Z of this RFP)

12.12.1.35. Information regarding specialized behavioral health services, including but not limited to:

- A description of covered behavioral health services;
- Where and how to access behavioral health services and behavioral health providers;
- General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices;
- Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and
- Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.

12.12.1.36. Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services;

12.12.1.37. The information specified in 12.12.1 et. seq. will be considered to be provided if the MCO:

12.12.1.37.1. Mails a printed copy of the information to the member's mailing address;

12.12.1.37.2. Provides the information by email after obtaining the member's agreement to receive the information by email;

12.12.1.37.3. Posts the information on their member website and advises the member in paper or electronic form that the information is available at the specified web address; or

12.12.1.37.4. Provides the information in any other method that can be reasonably expected to result in the member receiving the information.

~~**12.12.1.36.**~~**12.12.1.38.** At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.

~~**12.12.1.37.**~~**12.12.1.39.** The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to DHH for approval

within four weeks of the annual renewal, ~~and~~ upon any changes, and prior to being made available to members.

~~12.12.1.38.~~12.12.1.40. **MCO Welcome Newsletter**

~~12.12.1.38.1.~~12.12.1.40.1. Should the MCO elect not to provide a Member Handbook hard copy at the time of sending the welcome packet for new members, the MCO shall develop and maintain a welcome newsletter that adheres to the requirements in 42 CFR §438.10.

~~12.12.1.38.2.~~12.12.1.40.2. The MCO shall review and update the Welcome Member Newsletter at least once a year. The Newsletter must be submitted to DHH for approval within four weeks of the annual renewal and upon any changes prior to being made available to members

~~12.12.1.38.3.~~12.12.1.40.3. At a minimum, each welcome newsletter shall include the following information as it applies to the covered populations as specified in section 3.3.3.:

- Right to request an updated Member Handbook at no cost to the member. Notification that the Handbook is available on the Contractor's website, by electronic mail or through postal mailing must be referenced;
- Member Grievance and Appeal rights;
- Right to access oral interpretation services, free of charge, and how to access them that adheres to the requirements in 42 CFR §438.10(4) and (5);
- MCO service hours and availability with contact information including but not limited to Member Services, Nurse Line, Behavioral Health Crisis Line, Dental Benefit Manager, Reporting suspected Fraud and Abuse, Pharmacy Benefit Manager, and Transportation;
- Tobacco Cessation Information with a website link to tobacco education and prevention program;
- Information on how to search for providers, including specialized behavioral health providers, and how to obtain, at no charge, a directory of providers;
- Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services;
- How to file a grievance;
- What to do in case of an emergency, information on proper emergency service utilization, and the right to obtain emergency services at any hospital or other ED facility, in or out of network;
- Description of fraud, waste, and abuse, including instruction on how to report suspect fraud, waste, and abuse;
- Right to be treated fairly regardless of race, religion, gender, age, and ability to pay;

- Right to request a medical record copy and/or inspect medical records at no cost as specified in 45 CFR Part 164;
- How to access afterhours care;
- How to change Health Plans;
- Instructions on changing your PCP;
- Instructions where to find detailed listing of covered benefits;
- Identification of services for which copays are applicable; and
- Specialized behavioral health services information, including where and how to access behavioral health services (including emergency or crisis services).
- Problem gaming treatment with a website link to potential resources, such as http://new.dhh.louisiana.gov/index.cfm/page/2253

12.13. Member Identification (ID) Cards

12.13.1. MCO members will be issued at a minimum two (2) different member identification cards related to their enrollment in the Louisiana Medicaid managed care delivery system. The MCO may opt to provide members with a third ID card, if the MCO elects to issue a separate pharmacy-related ID card.

12.13.2. A DHH issued ID card will be issued to all Medicaid eligibles, including MCO members. This card is not proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by MCO providers. These systems will contain the most current information available to DHH, including specific information regarding MCO enrollment. There will be no MCO specific information printed on the card. The MCO member may need to show this card to access Medicaid services not included in the MCO core benefits and services.

12.13.3. An MCO-issued member ID card that contains information specific to the MCO. The member's ID card shall at a minimum include, but not be limited to, the following information as it applies to the covered populations as specified in section 3.3.3:

- The member's name and date of birth;
- The MCO's name and address;
- Instructions for emergencies;
- The PCP's name and telephone numbers (including after-hours number, if different from business hours number);
- The toll-free number(s) for:
  - 24-hour Nurse Line
  - The Member Services Line
  - and Filing Grievances
  - 24-hour behavioral health crisis line

- Provider Services and Prior Authorization and
- Reporting Medicaid Fraud (1-800-488-2917)

12.13.3.1. The MCO may provide the MCO Member ID card in a separate mailing from the welcome packet, however the card must be sent no later than ten (10) business days from the date of receipt of the file from DHH or the Enrollment Broker identifying the new enrollee. As part of the welcome packet information, the MCO must explain the purpose of the card, how to use the card, and how to use it in tandem with the DHH-issued card.

12.13.3.2. The card will be issued without the PCP information if no PCP selection has been made on the date of the mailing.

12.13.3.3. Once PCP selection has been made by the member or through auto assignment, the MCO will reissue the card in keeping with the time guidelines of this RFP and the Contract. As part of the mailing of the reissued card, the MCO must explain the purpose of the reissued card, the changes between the new card and the previous card, and what the enrollee should do with the previous card.

12.13.3.4. The MCO shall reissue the MCO ID card within ten (10) calendar days of notice that a member reports a lost card, there is a member name change or the PCP changes, or for any other reason that results in a change to the information on the member ID card.

12.13.3.5. The holder of the member identification card issued by the MCO shall be an MCO member or guardian of a member. If the MCO has knowledge of any MCO member permitting the use of this identification card by any other person, the MCO shall immediately report this violation to the Medicaid Fraud Hotline number 1-800-488-2917.

12.13.3.6. The MCO shall ensure that its subcontractors can identify members in a manner which will not result in discrimination against the members, in order to provide or coordinate the provision of all **core** benefits and services and/or ~~expanded services~~value-added benefits and services and out of network services.

12.13.4. Pharmacy-Related ID Card Requirements

12.13.4.1. The MCO shall provide on the member's identification card, or on a separate prescription benefit card, or through other technology, prescription billing information that:

12.13.4.1.1. Complies with the standards set forth in the National Council for Prescription Drug Programs pharmacy ID card prescription benefit card implementation guide at the time of issuance of the card or other technology; or

12.13.4.1.2. Includes, at a minimum, the following data elements:

12.13.4.1.2.1. The name or identifying trademark of the MCO and the prescription benefit manager (see co-branding restrictions in Section 12.20.3);

12.13.4.1.2.2. The name and MCO member identification number of the recipient;

12.13.4.1.2.3. The telephone number that providers may call for:

- Pharmacy benefit assistance;
- 24-hour member services and filing grievances;
- Provider services and prior authorization; and
- Reporting Medicaid Fraud (1-800-488-2917)

12.13.4.1.3. All electronic transaction routing information and other numbers required by the MCO or its benefit administrator to process a prescription claim electronically.

12.13.4.1.4. If the MCO chooses to include the prescription benefit information on the Bayou Health Plan card, the MCO must ensure all members have a card that includes all necessary prescription benefit information, as outlined above.

12.13.4.1.5. If the MCO chooses to provide a separate prescription benefit card, the card mailer that accompanies the card must include language that explains the purpose of the card, how to use the card and how to use it in tandem with the DHH-issued Medicaid Card and the MCO-issued card.

12.14. Provider Directory for Members

12.14.1. The MCO shall develop and maintain a Provider Directory in four (4) formats:

12.14.1.1. A hard copy directory, when requested, for members and potential members;

12.14.1.2. Web-based~~,~~ searchable, web-based machine readable, online directory for members and the public;

12.14.1.3. Electronic file of the directory to be submitted and updated weekly to the Medicaid FI or other designee as determined by DHH; for the Enrollment Broker; and

12.14.1.4. Hard copy, abbreviated version upon request by the Enrollment Broker.

12.14.2. The MCO shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed.

12.14.3. The hard copy directory for members shall be revised with updates at least ~~annually~~monthly or no more than 30 days after the receipt of updated provider information. Inserts may be used to update the hard copy directories monthly to

fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by DHH.

12.14.4. In accordance with 42 CFR §438.10(f)(6), the provider directory shall include, but not be limited to:

12.14.4.1. Names, locations, telephone numbers of, website URLs, specialties, whether the provider is accepting new members, and ~~non-English languages spoken~~ cultural and linguistic capabilities by current contracted providers by each provider type specified in this RFP in the Medicaid enrollee's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment; ~~, including identification of providers, PCPs, behavioral health and other specialists, and hospitals at a minimum, that are not accepting new patients;~~

12.14.4.2. Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;

12.14.4.3. Identification of any restrictions on the enrollee's freedom of choice among network providers; and

12.14.4.4. 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).

12.14.4.5. DHH reserves the right to request additional data needed for enhancements to the provider search function.

12.14.5. To assist Medicaid potential enrollees in identifying participating providers for each MCO, the Enrollment Broker will maintain and update weekly an electronic provider directory that is accessible through the website www.bayouhealth.com and will make available, (by mail) paper provider directories which comply with the member material requirements of this RFP.

12.15. Member Call Center

12.15.1. The MCO shall maintain a toll-free member service call center, physically located in the United States, with dedicated staff to respond to member questions including, but not limited to, such topics as:

12.15.1.1. Explanation of MCO policies and procedures;

12.15.1.2. Prior authorizations;

12.15.1.3. Access information;

12.15.1.4. Information on PCPs or specialists;

12.15.1.5. Referrals to participating specialists;

12.15.1.6. Resolution of service and/or medical or behavioral health delivery problems;

12.15.1.7. Member rights and responsibilities;

12.15.1.8. Coordination of support services available through Medicaid or community organizations;

12.15.1.9. Member grievances; and

12.15.1.10. Information on Specialized Behavioral Health Services and Providers

12.15.2. The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday, excluding state-declared holidays.

12.15.3. The toll-free line shall have an automated system, available 24-hours a day, seven-days a week. This automated system must include the capability of providing callers with operating instructions on what to do in case of an emergency and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The MCO 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.

12.15.4. The MCO shall have sufficient telephone lines to answer incoming calls. The MCO 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.

12.15.5. The MCO 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 MCO performance. The MCO must develop and implement a plan to sustain call center performance levels in situations where there is high call/e-mail 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.

12.15.6. The MCO 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 and emergencies including but not limited to hurricane-related evacuations. The MCO 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 MCO 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.

12.15.7. The MCO 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 MCO shall submit call center quality criteria and protocols to DHH for review and approval annually.

12.15.8. The MCO shall provide general assistance and information to individuals and their families seeking to understand how to access care. For CSoC eligible members, provide information to families about the specialized services and how to contact the contractor.

12.16. 24-hour Behavioral Health Crisis Line

12.16.1. The MCO shall maintain a 24-hour toll-free crisis response center to respond to specialized behavioral health needs. The call center may be combined with the MCO's 24-hour nurse line or may be a separate line, but must provide the following:

12.16.1.1. 24-hour, 7-day a week access to staff;

12.16.1.2. Answered by a live voice at all times; and

12.16.1.3. Have sufficient telephone lines to answer incoming calls.

12.16.2. The MCO shall assist and triage callers who may be in crisis by effectuating an immediate transfer to a care manager. The call shall be answered within thirty (30) seconds and only transferred via a warm line to a LMHP. The MCO shall respect the caller's privacy during all communications and calls

12.17. ACD System

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

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

12.17.2. Transfer calls to other telephone lines;

12.17.3. 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;

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

12.17.5. Measure the number of calls in the queue;

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

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

12.17.8. Measure the average hours of use per day;

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

12.17.10. Record calls to assess whether answered accurately;

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

12.17.12. Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and

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

12.17.14. Call Center Performance Standards

12.17.14.1. Answer ninety-five (95) percent of calls within thirty (30) seconds or direct the call to an automatic call pickup system with IVR options;

12.17.14.2. No more than one percent (1%) of incoming calls receive a busy signal;

12.17.14.3. Maintain an average hold time 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.

12.17.14.4. Maintain abandoned rate of calls of not more than five (5) percent.

12.17.14.4.1. The MCO must conduct ongoing quality assurance to ensure these standards are met.

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

12.17.15. Members' Rights and Responsibilities

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

12.17.15.2. Member's Rights -The rights afforded to current members are detailed in Appendix AA, **Members' Bill of Rights**.

12.17.16. Member Responsibilities

12.17.16.1. The MCO shall encourage each member to be responsible for his own health care 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 medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

12.17.16.2. The MCO members' responsibilities shall include but are not limited to:

- Informing the MCO of the loss or theft of their ID card;
- Presenting their MCO ID card when using health care services;
- Being familiar with the MCO procedures to the best of the member's abilities;
- Calling or contacting the MCO to obtain information and have questions answered;
- Providing participating network providers with accurate and complete medical information;
- 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;
- Living healthy lifestyles and avoiding behaviors known to be detrimental to their health;
- Following the grievance process established by the MCO if they have a disagreement with a provider; and
- 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.

12.18. Notice to Members of Provider Termination

12.18.1. The MCO shall make a good faith effort to 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.

12.18.2. The MCO shall provide notice to a member, or the parent/legal guardian and the involved state agency as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The

written notice shall be provided within seven (7) calendar days from the date the MCO 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 MCO, 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 MCO becoming aware of the circumstances.

12.19. Oral Interpretation and Written Translation Services

12.19.1. In accordance with 42 CFR §438.10(db)~~(1)~~ DHH shall provide on its website the prevalent non-English languages spoken by enrollees in the state.

12.19.2. The MCO must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language ~~and written information is available in Spanish~~ and how to access those services. On materials where this information is provided, the notation should be written in Spanish.

12.19.3. The MCO shall ensure that translation services are provided for all written marketing and member materials for any language that is spoken as a primary language for four percent (4%) or more enrollees, or potential enrollees of an MCO. Within ninety (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 MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).

12.19.4. Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a font size no smaller than 18 point.

12.20. Marketing Reporting and Monitoring

12.20.1. Reporting to DHH

12.20.1.1. A summary report of all marketing and member education efforts must be submitted to DHH within thirty (30) days of the end of the calendar year using a **Marketing Plan Annual Review** format guidance provided by DHH.

12.20.2. Reporting Alleged Marketing Violations

12.20.2.1. To ensure the fair and consistent investigation of alleged violations, DHH has outlined the following reporting guidelines:

12.20.2.2. Alleged marketing violations must be reported to DHH in writing utilizing the ***Marketing Complaint Form***, (See Appendix Z).

12.20.2.3. Upon written receipt of allegations, DHH will:

- Acknowledge receipt, in writing, within five (5) business days from the date of receipt of the allegation.
- Begin investigation within five (5) business days from receipt of the allegation and complete the investigation within thirty (30) calendar days. DHH may extend the time for investigation if there are extenuating circumstances.
- Analyze the findings and take appropriate action (see Section 20 of this RFP, for additional details).
- Notify the complainant after appropriate action has been taken.

12.20.3. Sanctions

DHH may impose sanctions against the MCO for marketing and member education violations as outlined in Section 20 of this RFP.

12.21. Pharmacy-Related Marketing and Member Education

12.21.1. The MCO and all subcontractors, including PBMs and providers, are subject to the Marketing and Member Education requirements set forth in Section 12.1 – 12.10 of the contract. This includes the review and approval of all marketing and member materials including, but not limited to, websites and social media, ID cards, call scripts for outbound calls or customer service centers, provider directories, advertisement and direct member mailings.

12.21.2. Members of an MCO must have free access to any pharmacy participating in the MCO's network (except in cases where the member is participating in the pharmacy lock-in program). Neither the MCO nor any subcontractor is allowed to steer members to certain network providers. DHH retains the discretion to deny the use of marketing and member material that it deems to promote undue patient steering.

12.21.3. MCO are prohibited from displaying the names and/or logos of co-branded PBMs on the MCO's member identification card. MCOs that choose to co-brand with providers must include on marketing materials (other than ID cards) the following language: "Other Pharmacies are Available in Our Network."

12.21.4. Co-branded marketing materials must be submitted to DHH by the MCO for approval.

12.22. Web and Mobile-Based Member Applications

12.22.1. No later than February 1, 2019, the MCO shall provide ~~A~~a web- or mobile-~~smartphone-~~based ~~support program application~~member/patient portal that ~~could includinge~~includes the following information and features:

12.22.1.1. ~~Personal health records;~~Medical claims information such as lab and imaging results, medications and key health appointments;

~~**12.21.4.1.1.** Native mobile applications and / or mobile-friendly content that is accessible across a broad range of smartphones;~~

12.22.1.2. Social services information and resources, such as housing supports, food programs, etc.;

12.22.1.3. The capability for additional health information to be entered by the member;

12.22.1.4. ~~-~~Consumer-friendly ~~,~~ ~~engaging~~ content that complies with MCO member education guidelines~~that helps keep patients on-track with key health appointments and screenings~~; and

12.22.1.5. Tools to help ~~stratify~~higher risk users access ~~users by risk profile and direct the higher risk users to~~ State-based or plan-based resources, such as smoking cessation or weight management programs. Need will be determined by the MCO health-risk assessment or other tools used for establishing higher risk users.~~:~~;

~~**12.21.4.1.2.** Outreach support to educate patients about the mobile tools; and~~

12.22.2. The MCO shall provide ~~R~~reporting and analytics to help the State measure the effectiveness of ~~the smartphone-based support program~~such applications.

INTENTIONALLY LEFT BLANK

13.0 Member Grievance and Appeals Procedures

The MCO shall make adverse benefit determinations only as provided for in this agreement and only in accordance with state and federal law and regulation. Upon making such determination, the MCO shall provide all notices required herein as well as all opportunities for grievance and appeals required by this Section or by state or federal law or regulation.

The MCO must have a grievance system that complies with 42 CFR Part 438, Subpart F. The MCO 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 MCO's grievance and appeals procedures 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 MCO shall refer all MCO members who are dissatisfied with the MCO or its subcontractor in any respect to the MCO's designee authorized to review and respond to grievances and appeals and require corrective action.

The member must exhaust the MCO's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.

The MCO shall not create barriers to timely due process. The MCO shall be subject to sanctions if it is determined by DHH that the MCO has created barriers to timely due process, and/or, if ten (10) percent or higher of appeal decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to:

- Including binding arbitration clauses in MCO member choice forms;
- Labeling grievances as inquiries and funneled into an informal review;
- Failing to inform members of their due process rights;
- Failing to log and process grievances and appeals;
- Failure to issue a proper notice including vague or illegible notices;
- Failure to inform members of the right to continuation of benefits; and
- Failure to inform members of their right to State Fair Hearing following the MCO's internal appeals process.

When the term "member" is used throughout Section 13, it includes the member, member's authorized representative, or provider with the member's prior written consent.

13.1. Applicable Definitions – See Glossary

13.2. General Grievance System Requirements

13.2.1. Grievance System

The MCO 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 MCO's appeal process has been exhausted.

The MCO shall permit a member to file a grievance and request an MCO level appeal subject only to the limitations expressly provided in this Section. A member shall be permitted to request a State Fair Hearing after receiving notice that the action is upheld or once the MCO's appeals process has been exhausted.

13.2.2. Filing Requirements

13.2.2.1. Authority to File

13.2.2.1.1. A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.

13.2.2.1.2. 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.

13.2.3. Time Limits for Filing

The member shall be permitted to file a grievance at any time.

The member must be allowed ~~thirty~~ sixty (~~36~~0) calendar days from the date on the MCO's notice of action or inaction to ~~file a grievance or~~ request an appeal. ~~Within that timeframe the member or a representative acting on their behalf and with the member's written consent may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.~~

13.2.4. Procedures for Filing

13.2.4.1. The member may file a grievance orally or in writing with either DHH or the MCO.

~~13.2.4.1.~~**13.2.4.2.** The member ~~or the provider~~ may file an appeal either orally or in writing. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution.

~~13.2.4.2.~~**13.2.4.3.** The MCO shall ensure that all MCO members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The MCO shall provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and paper copies must be provided by the MCO upon request of the member. The MCO shall make all forms easily available on the MCO's website.

13.3. Grievance/Appeal Records and Reports

13.3.1. The MCO must maintain accurate records of all grievances and appeals in a manner accessible to LDH and available upon request to CMS. A copy of grievances logs and records of disposition of appeals shall be retained for ~~six~~ ten (~~6~~10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ~~six~~ ten (~~6~~10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ~~six~~ ten (~~6~~10) year period, whichever is later.

13.3.2. The MCO shall electronically ~~provide DHH with a monthly report of~~maintain data on ~~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; date of review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; and resulting corrective action. ~~Reports with personally identifying information redacted will be made available for public inspection.~~

13.3.3. The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.

13.4. Handling of Grievances and Appeals

13.4.1. General Requirements

In handling grievances and appeals, the MCO must meet the following requirements:

13.4.1.1. Acknowledge receipt of each grievance and appeal in writing within five (5) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log;

13.4.1.2. Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;

13.4.1.3. Ensure that the individuals who make decisions on grievances and appeals are individuals:

13.4.1.3.1. Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual; ~~and~~

13.4.1.3.2. Who, if deciding any of the following, are health care 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.

- A grievance regarding denial of expedited resolution of an appeal.

- A grievance or appeal that involves clinical issues

13.4.1.3.3. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial action.

13.4.2. Special Requirements for Appeals

The process for appeals must:

13.4.2.1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative 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. Unless the member requests an expedited appeal, the oral appeal shall be confirmed in writing.~~No additional enrollee follow-up is required~~.

13.4.2.2. Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this sufficiently in advance of the date by which the MCO shall resolve the appeal in the case of expedited resolution).

13.4.2.3. Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, ~~and~~ any other documents and records considered during the appeals process, and any evidence considered, relied upon, or generated by the MCO in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the date by which the MCO shall resolve the appeal.

13.4.2.4. Include, as parties to the appeal:

- The member and his or her representative; or

- The legal representative of a deceased member's estate.

13.4.3. Training of MCO Staff

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

13.4.4. Identification of Appropriate Party

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

13.4.5. Failure to Make a Timely Decision

Appeals shall be resolved no later than stated time frames and all parties shall be informed of the MCO's decision. If a determination is not made in accordance with the timeframes specified in Section 13.6 of this RFP, the member's request will be deemed to have ~~been approved~~exhausted the MCO's appeal process as of the date upon which a final determination should have been made. The member may then initiate a State Fair Hearing.

13.4.6. Right to State Fair Hearing

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

13.5. Notice of Action

13.5.1. Language and Format Requirements

The notice must be in writing and must meet the language and format requirements of 42 CFR §438.10~~(c) and (d)~~ and Section 12~~.~~ of this RFP to ensure ease of understanding.

13.5.2. Content of Notice of Action

The Notice of Action must explain the following:

13.5.2.1. The action the MCO or its contractor has taken or intends to take;

13.5.2.2. The reasons for the action, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits

13.5.2.3. The member's right to file an appeal with the MCO;

13.5.2.4. The member's right to request a State Fair Hearing, after the MCO's one level appeal process has been exhausted;

13.5.2.5. The procedures for exercising the rights specified in this Section;

13.5.2.6. The circumstances under which expedited ~~resolution~~ appeal is available and how to request it;

13.5.2.7. 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

13.5.2.8. ~~Oral~~ Availability of interpretation services ~~is available~~ for all languages and how to access ~~it~~them.

13.5.3. Timing of Notice of Action

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

13.5.3.1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action~~:, except:~~

13.5.3.2. In cases of verified member fraud, or when DHH has facts indicating that action should be taken because of ~~The period of advanced notice is shortened to five (5) days if~~ probable member fraud, at least five (5) days before the date of action;

~~13.5.3.2.~~13.5.3.3. ~~has been verified or b~~By the date of action for the following:

- in the death of a recipient
- if the member submits a signed written recipient 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 recipient's admission to an institution where he is eligible for further services;
- the recipient's address is unknown and mail directed to him has no forwarding address;
- the recipient has been accepted for Medicaid services by another local jurisdiction; or
- the recipient's physician prescribes the change in the level of medical care; or
- as otherwise permitted under 42 CFR §431.213.

~~13.5.3.3.~~13.5.3.4. For denial of payment, at the time of any action affecting the claim according to the terms and conditions outlined in the contract between the provider and the individual MCO.

~~13.5.3.4.~~13.5.3.5. 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:

~~13.5.3.4.1.~~13.5.3.5.1. The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or

~~13.5.3.4.2.~~13.5.3.5.2. The MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

~~13.5.3.5.~~13.5.3.6. If the MCO extends the timeframe in accordance with Section 13.5.3.5~~3~~.1 or 13.5.3.5~~3~~.2 above, it must:

- Make reasonable efforts to give the member prompt oral notice of the delay;

- Within two (2) days, ~~G~~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.

~~13.5.3.6.~~13.5.3.7. On the date the timeframe for service authorization as specified in Section 13.5.3.~~3~~5 expires. Untimely service authorizations constitute a denial and are thus adverse actions.

~~13.5.3.7.~~13.5.3.8. For expedited service authorization decisions where a provider indicates, or the MCO 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 MCO 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.

~~13.5.3.8.~~13.5.3.9. The MCO 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 MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

~~13.5.3.9.~~13.5.3.10. DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.

13.6. Resolution and Notification

The MCO 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 in Section 13.16.1 below.

13.6.1. Specific Timeframes

13.6.1.1. 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 MCO receives the grievance.

13.6.1.2. 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 MCO receives the appeal. This timeframe may be extended under Section 13.6.1.2 of this Section.

13.6.1.3. 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 MCO receives the appeal. This timeframe may be extended under Section 13.6.2 of this Section.

13.6.1.4. Pharmacy appeal requests not resolved in the appropriate timeframe shall be submitted by the MCO to DHH Pharmacy staff for a clinical review. Penalties may be levied for the MCO's failure to adhere to the timeframe according to Section 20.

13.6.2. Extension of Timeframes

13.6.2.1. The MCO may extend the timeframes from Section 13.6.1 of this Section by up to fourteen (14) calendar days if:

- The member requests the extension; or
- The MCO 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.

13.6.2.2. Requirements Following Timeframe Extension
If the MCO extends the timeframes, it must, for any extension not requested by the member:~~,~~

- ~~g~~Give the member written notice of the reason for the delay.
- Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

13.6.3. In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate a state fair hearing.

~~13.6.3.~~13.6.4. Format of Notice of Disposition
All notices shall meet the standards described at 42 CFR §438.10.

~~13.6.3.1.~~13.6.4.1. Grievances
The MCO will provide written notice to the member of the disposition of a grievance.

~~13.6.3.2.~~13.6.4.2. Appeals
For all appeals, the MCO must provide written notice of disposition.

For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

~~13.6.4.~~13.6.5. Content of Notice of Appeal Resolution

~~13.6.4.1.~~13.6.5.1. The written notice of the resolution must include the following:

- The results of the resolution process and the date it was completed.

~~13.6.4.2.~~13.6.5.2. 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 MCO's action.

~~13.6.5.~~13.6.6. Requirements for State Fair Hearings

~~DHH~~ The MCO shall comply with the requirements of 42 CFR ~~§431.200(b), §431.220(5),~~ §438.414 and §438.10(g)(1). The MCO shall comply with all requirements as outlined in this RFP.

~~13.6.5.1.~~13.6.6.1. Availability

If the member has exhausted the MCO-level appeal procedures, the member may request a State Fair Hearing within ~~thirty (30)~~one hundred twenty (120) days from the date of the MCO's notice of resolution. The member may also initiate a State Fair Hearing following deemed exhaustion of appeals processes.

~~13.6.5.2.~~13.6.6.2. Parties

The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.

13.7. Expedited Resolution of Appeals

The MCO must establish and maintain an expedited review process for appeals, when the MCO 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.

13.7.1. Prohibition Against Punitive Action

The MCO must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.

13.7.2. Action Following Denial of a Request for Expedited Resolution

If the MCO denies a request for expedited resolution of an appeal, it must:

13.7.2.1. Transfer the appeal to the timeframe for standard resolution in accordance with Section **13.6.1.2**;

13.7.2.2. 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.

13.7.2.3. 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.

13.7.3. Failure to Make a Timely Decision

Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the MCO's decision in writing. If a determination is not made by the above timeframes, the member's request will be deemed to have ~~been approved~~ exhausted the MCO's appeal process as of the date upon which a final determination should have been made.

13.7.4. Process

13.7.4.1. The MCO is 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. No additional follow-up may be required.

13.7.4.2. The MCO 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.

13.7.5. 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.

13.7.6. Format of Resolution Notice

In addition to written notice, the MCO must also make reasonable effort to provide oral notice.

13.8. Continuation of Benefits

13.8.1. Terminology

As used in this Section, "timely" filing means filing on or before the later of the following:

13.8.1.1. Within ten (10) days of the MCO mailing the notice of action, or

13.8.1.2. The intended effective date of the MCO's proposed action.

13.8.2. Continuation of Benefits

The MCO must continue the member's benefits if:

13.8.2.1. The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely in accordance with 42 CFR §438.402(c)(1)(ii) and (c)(2)(ii);

13.8.2.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

13.8.2.3. The services were ordered by an authorized provider;

13.8.2.4. The original period covered by the original authorization has not expired; and

13.8.2.5. The member requests an extension of benefits.

13.8.3. Duration of Continued or Reinstated Benefits

If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

13.8.3.1. The member withdraws the appeal.

13.8.3.2. Ten (10) days pass after the MCO 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.

13.8.3.3. A State Fair Hearing Officer issues a hearing decision adverse to the member.

13.8.3.4. The time period or service limits of a previously authorized service has been met.

13.8.4. 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 MCO's action, the MCO 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).

13.9. Information to Providers and Contractors

The MCO must provide the information specified at 42 CFR. §438.10(g)(2~~1~~)(xi) about the grievance system to all providers and contractors at the time they enter into a contract.

13.10. Recordkeeping and Reporting Requirements

Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH.

13.11. Effectuation of Reversed Appeal Resolutions

13.11.1. Services not Furnished While the Appeal is Pending

If the MCO 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 MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the decision.

13.11.2. Services Furnished While the Appeal is Pending

If the MCO 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 MCO must pay for those services, in accordance with this Contract.

INTENTIONALLY LEFT BLANK

14.0 QUALITY MANAGEMENT

14.1 Quality Assessment and Performance Improvement Program (QAPI)

14.1.1 The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.~~240~~330(a)(1), to:

14.1.1.1 Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;

14.1.1.2 Incorporate improvement strategies that include, but are not limited to:

- performance improvement projects;
- medical record audits;
- performance measures;
- Plan-Do-Study-Act cycles or continuous quality improvement activities;
- member and/or provider surveys; and
- activities that address health disparities identified through data collection.

14.1.1.3 Detect and address underutilization and overutilization of services.

14.1.2 The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by DHH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.

14.1.3 The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.

14.1.4 The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.

14.1.5 The MCO shall increase the utilization of evidence-based practices within the target rates specified in the LDH Quality Management Strategy.

14.1.6 The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.

14.1.7 The MCO shall promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.

14.1.8 The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of DHH.

14.1.9 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.

14.1.10 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.

14.1.11 The MCO shall submit its QAPI Program description to DHH for written approval by June 30, 2015, and any updates within thirty (30) days.

14.1.12 The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO'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 MCO.

14.1.13 The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.

14.1.14 The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to DHH and other key stakeholders as directed by DHH.

14.1.15 The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence-based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.

14.1.16 The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.

14.1.17 The MCO shall participate in the DHH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by DHH.

14.1.18 The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable

functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.

14.1.18.1 For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment, as well as the amount of improvement.

14.1.18.2 In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to DHH-OBH on an annual basis.

14.2 QAPI Committee

The MCO shall form a QAPI Committee that shall, at a minimum include:

14.2.1 QAPI Committee Members

14.2.1.1 The MCO Medical Director must serve as either the chairman or co-chairman;

14.2.1.2 The MCO Behavioral Health Director;

14.2.1.3 Appropriate MCO staff representing the various departments of the organization will have membership on the committee;

14.2.1.4 The MCO is encouraged to include a member advocate representative on the QAPI Committee; and

14.2.1.5 The MCO shall include DHH representative(s) on the QAPI Committee, as designated by DHH, as non-voting member(s).

14.2.2 QAPI Committee Responsibilities

The committee shall meet on a quarterly basis. Its responsibilities shall include:

14.2.2.1 Direct and review quality improvement (QI) activities;

14.2.2.2 Assure than QAPI activities take place throughout the MCO;

14.2.2.3 Review and suggest new and/or improved QI activities;

14.2.2.4 Direct task forces/committees to review areas of concern in the provision of healthcare services to members;

14.2.2.5 Designate evaluation and study design procedures;

14.2.2.6 Conduct individual PCP and LMHP and practice quality performance measure profiling;

14.2.2.7 Report findings to appropriate executive authority, staff, and departments within the MCO;

14.2.2.8 Direct and analyze periodic reviews of members' service utilization patterns;

14.2.2.9 Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH;

14.2.2.10 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 services;

14.2.2.11 Ensure that the QAPI committee chair attends DHH's quality meetings; and

14.2.2.12 Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.

14.2.3 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 thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:

14.2.3.1 Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;

14.2.3.2 Include processes to evaluate the impact and effectiveness of the QAPI Program;

14.2.3.3 Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;

14.2.3.4 Describe the role of its providers in giving input to the QAPI Program; and

14.2.3.5 Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.

14.2.3.6 Describe the methods for ensuring data collected and reported to DHH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.

14.2.3.7 Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.

14.2.4 QAPI Reporting Requirements

14.2.4.1 The MCO 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

- Results of the evaluation of the impact and effectiveness of the QAPI program.

14.2.4.2 DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.

14.2.4.3 The MCO shall provide data reports, including but not limited to ad-hoc reports and reports for special populations (e.g., DCFS/OJJ, nursing home populations), to DHH using the specifications and format approved by DHH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and DHH.

14.2.5 Performance Measures

14.2.5.1 The MCO shall report on ~~clinical and administrative~~ performance measures listed in Appendix J and in accordance with the timeline and format specified in the MCO Quality Companion Guide. ~~(PM) data on an annual basis, as specified by DHH and in accordance with the specifications of the MCO Quality Companion Guide and the Behavioral Health Companion Guide.~~

~~The MCO is required to report on Performance Measures listed in Appendix J and Reporting Companion Guide which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, CMS Children's Health Insurance Program Reauthorization ACT (CHIPRA) Children's Core Quality Measures, CMS Adult Core Quality Measures, and/or other measures as determined by DHH.~~

14.2.5.2 The MCO shall have processes in place to monitor and self-report all performance measures.

~~**14.2.5.3** Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.~~

~~**14.2.5.4** Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.~~

~~**14.2.5.5**~~**14.2.5.3** The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.

~~**14.2.5.6**~~**14.2.5.4** The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.

~~**14.2.5.7**~~**14.2.5.5** The tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.

~~**14.2.5.8**~~**14.2.5.6** The MCO shall maintain integrity, accuracy, and consistency in data reported. Upon request, the MCO shall submit to DHH detail sufficient to independently validate the data reported.

~~**14.2.5.9**~~**14.2.5.7** **Incentive Based Performance Measures**

~~14.2.5.9.1~~14.2.5.7.1 Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Appendix J annotated with "$$".

~~14.2.5.9.2~~14.2.5.7.2 Based on an MCO's Performance Measure outcomes for CYE 12/31/201~~5~~7, a maximum of $2,250,000 ($250,000 per measure) ~~in October~~ following the measurement CY will be withheld from payment if specified performance measures fall below DHH's established benchmarks for improvement.

~~14.2.5.9.3~~14.2.5.7.3 DHH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and DHH will provide six (6) months' notice of such change.

~~**14.2.5.10 Performance Measures Reporting**~~

~~**14.2.5.10.1** All measures contained in Appendix J MCO Performance Measures and the Behavioral Health Companion Guide are reporting measures.~~

~~**14.2.5.10.2** Performance measures shall be reported to DHH in an electronic format as specified in Section 18.10 and Appendix J.~~

~~**14.2.5.10.3** DHH may add or remove Performance Measure reporting requirements with a sixty (60) day advance notice.~~

~~**14.2.5.10.4** The MCO shall report on performance measures in accordance with the current specifications developed by the measure steward and/or approved by DHH.~~

~~**14.2.5.10.5** The MCO shall utilize the file naming convention established by DHH for all specialized behavioral health report submissions and re-submissions.~~

~~**14.2.5.10.6** The MCO shall maintain data integrity, accuracy, and consistency in data. As such, all reports submitted to DHH shall include analytical methodology (e.g., numerator, denominator, sampling methodology, data source, data validation methods, results summary, and source code in a statistical language matching one used by DHH). DHH holds the right to validate all reporting for specialized behavioral health measure performance monitoring.~~

~~**14.2.5.11 Performance Measure Goals**~~

~~**14.2.5.11.1** The Department will establish benchmarks for IB Performance measures utilizing the prior year statewide data for the Bayou Health population.~~

~~**14.2.5.11.2** Minimum performance goals shall be presented at the first Bayou Health Quality Committee meeting following the contract award date.~~

~~**14.2.5.11.3** DHH shall have the authority to establish final performance measure goals after consultation with the Bayou Health Quality Committee.~~

~~Final determination of goals is at the sole discretion and approval of DHH.~~

~~14.2.5.12~~14.2.5.8 **Performance Measure Reporting**

~~14.2.5.12.1~~14.2.5.8.1 The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.

~~14.2.5.12.2~~14.2.5.8.2 The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH.

~~14.2.5.12.3~~14.2.5.8.3 The MCO shall have processes in place to monitor and self-report performance measures as specified in Section 14.~~3.3~~2.5 ~~Reporting~~Performance Measures.

~~The MCO shall provide individual PCP clinical quality profile reports as indicated in Section 8.7 PCP Utilization and Quality Reporting~~

~~14.2.5.13~~14.2.5.9 Beginning in 2018, the MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year).

14.2.6 Performance Measure Monitoring

14.2.6.1 DHH will monitor the MCO's performance using Benchmark Performance and Improvement Performance data obtained from administrative encounter data submitted by the MCO to the state's FI.

14.2.6.2 During the course of the Contract, DHH or its designee will actively participate with the MCO to review the results of performance measures.

14.2.6.3 The MCO shall comply with External Quality Review Organization's requests for information, including but not limited to a review of the Quality Assessment Committee meeting minutes and annual medical record audits to ensure that it provides quality and accessible health care to MCO members, in accordance with standards contained in the Contract. Such audits shall allow DHH or its duly authorized representative to review individual medical 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.

14.2.6.4 The standards by which the MCO will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the MCO 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 MCO's progress in correcting the deficiencies.

14.2.7 Performance Measure Corrective Action Plan

A corrective action plan (CAP) will be required for performance measures that do not reach the Department's performance benchmark.

14.2.7.1 The MCO 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.

14.2.7.2 Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the MCO shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH. If the second CAP does not meet DHH and EQRO approval, DHH may impose liquidated damages, sanctions, and/or restrict enrollment pending attainment of acceptable quality of care.

14.2.7.3 Upon approval of the CAP, whether the initial CAP or the revised CAP, the MCO shall implement the CAP within the time frames specified by DHH.

14.2.7.4 DHH may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

14.2.8 Performance Improvement Projects

14.2.8.1 The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focus~~es~~ on clinical and non-clinical performance measures as specified in 42 CFR §438.~~240~~330.

14.2.8.2 The MCO shall perform two (2) DHH-approved PIPs listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. DHH may require up to two (2) additional projects for a maximum of four (4) projects

14.2.8.2.1 Effective 2/1/16, the MCO shall perform a minimum of one (1) additional DHH-approved behavioral-health PIP each contract year.

14.2.8.3 Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following:

- Measurement of performance using objective quality indicators;
- Implementation of ~~system~~ interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

14.2.8.4 Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to DHH for approval. The detailed description shall include:

- An overview explaining how and why the project was selected, the status of the PIP, and ~~as well as~~ its relevance to the MCO members and providers;

- The study question;
- The study population;
- The quantifiable measures to be used, including the baseline and goal for improvement;
- Baseline methodology;
- Data sources;
- Data collection methodology and plan;
- Data collection plan and cycle, which must be at least monthly;
- Results with quantifiable measures;
- Analysis with time period and the measures covered;
- Explanation of the methods to identify opportunities for improvement; and
- An explanation of the initial interventions to be taken.

14.2.8.5 PIPs used to measure performance improvement shall include diagrams (*e.g.* algorithms and/or flow charts) for monitoring and shall:

- Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation;
- Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions;
- Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered;
- Implement system interventions to achieve improvement in quality, including a (PDSA) cycle;
- Evaluate the effectiveness of the interventions;
- Provide sufficient information to plan and initiate activities for increasing or sustaining improvement;
- Monitor the quality and appropriateness of care furnished to enrollees with special health care needs;
- Reflect the population served in terms of age groups, disease categories, and special risk status,

- Ensure that multi-disciplinary teams will address system issues;

- Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark;

- Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and

- Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

14.2.8.6 DHH, in consultation with CMS and other stakeholders, may require specific performance measures and topics for performance improvement projects. The MCO shall report the status and results of each Performance Improvement Project as specified in the **MCO Quality Companion Guide**.

14.2.8.7 If CMS specifies a Performance Improvement Project, the MCO will participate and this will count toward the state-approved projects.

14.2.8.8 Each project shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.

14.2.9 Performance Improvement Projects Reporting Requirements

14.2.9.1 The MCO shall submit to DHH project data analysis monthly or as determined by DHH

14.2.9.2 The MCO shall submit project outcomes annually to DHH.

14.2.9.3 Reporting specifications are detailed in the ***MCO Quality Companion Guide***.

14.2.9.4 DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than thirty (30) days prior to due date of those reports.

14.2.10 Member Satisfaction Surveys

14.2.10.1 The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.

14.2.10.2 The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.

14.2.10.3 The MCO's vendor shall perform CAHPS Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.

14.2.10.4 Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.

14.2.10.5 The CAHPS survey results shall be reported to DHH or its designee for each survey question. These results may be used by DHH for public reporting. Responses will be aggregated by DHH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.

14.2.10.6 The surveys shall provide valid and reliable data for results.

14.2.10.7 Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.

14.2.10.7.1 The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include:

14.2.10.7.1.1 Getting Needed Care

14.2.10.7.1.2 Getting Care Quickly

14.2.10.7.1.3 How Well Doctors Communicate

14.2.10.7.1.4 Health Plan Customer Service

14.2.10.7.1.5 Global Ratings

14.2.11 The MCO's vendor shall perform a DHH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to DHH on an annual basis.

14.2.12 DHH Oversight of Quality

14.2.12.1 DHH shall evaluate the MCO'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.

14.2.12.2 If DHH determines that the MCO's quality performance is not acceptable, DHH will require the MCO to submit a corrective action plan (CAP) for each unacceptable performance measure. If the MCO fails to provide a CAP within the time specified, DHH will sanction the MCO in accordance with the provisions of sanctions set forth in the Contract, and may immediately terminate all new enrollment activities and automatic assignments.

14.2.12.3 Upon any indication that the MCO's quality performance is not acceptable, DHH may restrict the MCO's enrollment activities including, but not limited to, termination of automatic assignments.

14.2.12.4 When considering whether to impose a limitation on enrollment activities or automatic assignments, DHH may take into account the MCO's cumulative performance on all quality improvement activities.

14.2.12.5 The MCO shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), the University of Louisiana at Monroe's Office of Outcomes Research and Evaluation, and any other Department designees during monitoring.

14.3 External Independent Review

14.3.1 The MCO shall provide all information requested by the External Quality Review Organization (EQRO) and/or DHH including, but not limited to, quality outcomes concerning timeliness of, and member access to, core benefits and services.

14.3.2 The MCO shall cooperate with the EQRO during the review (including medical records review), which will be done at least one (1) time per contract year. 2015 annual compliance review results shall be made publically available before March 31, 2016.

14.3.3 If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, DHH may sanction the MCO in accordance with the **provisions** of Section 20 of the Contract and may immediately terminate all enrollment activities and automatic assignment until the MCO attains a satisfactory level of quality of care as determined by the EQRO.

14.3.4 A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings will be included in the MCO's QAPI program. DHH may also require separate submission of an improvement plan specific to the findings of the EQRO.

14.4 Health Plan Accreditation

14.4.1 The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA accreditation standards.

14.4.2 The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide DHH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.

14.4.3 The MCO shall provide DHH with a copy of its most recent accreditation review including:

14.4.3.1 Accreditation status, survey type, and level (as applicable);

14.4.3.2 Accreditation results, including recommended actions or improvements, corrective action plan, and summaries of findings; and

~~14.4.1.1~~**14.4.3.3** Expiration date of the accreditation.

~~14.4.2~~**14.4.4** Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.

14.5 Member Advisory Council

14.5.1 The MCO shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs.

14.5.2 The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.

14.5.3 Every effort shall be made to include statewide broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at least fifty percent (50%) of the membership.

14.5.4 The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.

14.5.5 The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the Contract and annually thereafter.

14.5.6 DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.

14.6 Fidelity to Evidence-Based Practices

14.6.1 The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for ~~Family~~ Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders and Assertive Community Treatment Act (ACT) as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports.

14.6.2 The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards utilizing the LDH-specified ACT Monitoring tool. The MCO shall ensure their staff are ~~met.~~properly trained on utilization of the identified ACT Monitoring tool.

~~14.6.1~~14.6.3 A formal fidelity-monitoring plan will be submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by DHH. ~~These shall take into account the monitoring responsibilities and efforts of the state agencies.~~ Reports will be submitted to DHH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.

14.7 Best Practices in Children's Behavioral Health Residential Treatment

The MCOs will ~~support~~ advance initiatives aimed at increased alignment of children's behavioral health residential programming with national best practice standards. The MCO will utilize authorization, continued stay review, and discharge planning protocols that support the implementation of best practices. The MCO shall participate in planning and implementation of these initiatives with OBH, and collaborate to develop an implementation monitoring plan and provide assistance to providers in collecting and reporting on best practice-related performance indicators (performance indicators may include reducing restraints and seclusions, increased employment of peer professionals, increased family involvement concurrent with the youth's residential stay [family involvement includes family voice in treatment planning], family support/skills training/therapy to support the family's ability to receive the youth home, frequent and ongoing contact with family in the form of phone calls and visits; and 6-12 month post-discharge outcomes data regarding successful integration into the home and community).

14.8 Adverse Incident Reporting

14.8.1 The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by DHH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents.

14.8.2 The MCO, as directed by DHH, may be required to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management.

14.8.3 The MCO shall submit reports to DHH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.

14.9 Provider Monitoring Plan and Reporting

14.9.1 The MCO shall develop and implement a plan for monitoring specialized behavioral health providers and facilities across all levels of care, which

incorporates onsite reviews and member interviews. The MCO shall submit the plan to LDH for approval within 30 calendar days of contract execution and at least 60 days prior to revision. The MCO's plan shall comply with all the requirements as specified by LDH:

14.9.1.1 Review criteria for each applicable provider type/level of care;

14.9.1.2 Sampling approach including number and percent of onsite audits by provider type, number and percent of desktop audits, and number of charts to be reviewed at each provider location;

14.9.1.3 Member interview criteria;

~~**14.8.3.1**~~**14.9.1.4** Random audit selection criteria;

14.9.1.5 Tools to be used;

14.9.1.6 Frequency of review, including schedule of reviews by provider type;

14.9.1.7 Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis;

14.9.1.8 Plan for ensuring corrective actions are implemented appropriately and timely by providers; and

14.9.1.9 Inter-rater reliability testing methods.

14.9.2 At a minimum, the MCO's sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The sample shall be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient/residential. Additional levels of care may be added at the discretion of LDH.

14.9.3 The MCO's review criteria shall address the following areas at a minimum:

14.9.3.1 Adherence to clinical practice guidelines;

14.9.3.2 Member rights and confidentiality, including advance directives and informed consent;

14.9.3.3 Cultural competency;

14.9.3.4 Patient safety;

14.9.3.5 Compliance with adverse incident reporting requirements;

14.9.3.6 Appropriate use of restraints and seclusion, if applicable;

14.9.3.7 Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment plan is individualized and appropriate for

the enrollee and includes goals, Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective; individualized crisis plan; members'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the member changes; the treatment plan includes the involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member; and

14.9.3.8 Continuity and coordination of care, including adequate discharge planning

14.9.4 The MCO shall take steps to require adoption of clinical practice guidelines by specialized behavioral health providers and measure compliance with the guidelines until such point that 90% or more of providers consistently achieve at least 80% compliance based on MCO measurement findings.

14.9.5 The MCO shall ensure that an appropriate corrective action is taken when a provider furnishes inappropriate or substandard services as determined by the MCO, when a provider does not furnish a service that should have been furnished, or when a provider is out of compliance with federal and state regulations. The MCO shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.

14.9.6 The MCO shall submit quarterly reports which summarize monitoring activities, findings, corrective actions, and improvements for Specialized Behavioral Health Services.

14.10 Outcome Assessment for Specialized Behavioral Health Services

14.10.1 The MCO shall assess the treatment progress and effectiveness of Specialized Behavioral Health Services for both children and adults using standardized clinical outcome tools and measures, according to the guidelines specified by LDH.

14.10.2 The MCO shall ensure providers and appropriate MCO staff are adequately trained/certified in the use of such tools and such training/certification is current.

14.10.3 The MCO shall be responsible for data collection of outcome data, data validation activities, and reporting to the LDH.

INTENTIONALLY LEFT BLANK

15.0 FRAUD, ABUSE, AND WASTE PREVENTION

15.1. General Requirements

15.1.1. The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812; ~~and~~ La. R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235 ; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

15.1.2. The MCO's Program Integrity Officer and CEO or COO shall meet with DHH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly~~, annually,~~ and at DHH's request, to discuss fraud, abuse, waste, neglect and overpayment issues. For purposes of this Section, the MCO's Program Integrity Officer shall serve as the primary point of contact for the MCO on issues related to Fraud, Abuse, and Waste Prevention.

15.1.3. The MCO and its subcontractors 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, CMS, the Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, 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 ten~~six~~ (10~~6~~) years from the expiration date of the Contract (including any extensions to the Contract) or from the date of completion of any audit, whichever is later, 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. MFCU shall be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hour admission will be allowed.

15.1.4. The MCO and its providers and subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above upon request. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above 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 MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract.

15.1.5. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained.

15.1.6. The MCO and its providers and subcontractors 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.

15.1.7. The MCO's employees, consultants, and its subcontractors 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.

15.1.8. The MCO and its subcontractors shall provide access to DHH and/or its designee to all information related to grievances and appeals files by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.~~226~~ 228.

15.1.9. The MCO shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The MCO 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.

15.1.10. The MCO will report to DHH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, subcontractor, or subcontractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program ~~to their~~ via the designated LDH Program Integrity contact.

15.1.11. The MCO and its subcontractors shall have ~~surveillance and utilization control~~ programs and procedures pursuant to (42 CFR §~~456.3, §456.4, §456.23~~438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The MCO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.

15.1.12. The MCO, as well as its subcontractors and providers, ~~whether contract or non-contract,~~ shall comply with all federal requirements (42 CFR ~~Part §~~455.104 and 42 CFR §438.610) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

15.1.13. The MCO, as well as its subcontractors and providers, ~~whether contract or non-contract,~~ shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

15.1.14. The MCO shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the MCO

in preventing and detecting potential fraud, waste, and abuse. At a minimum the MCO shall have one (1) full-time investigator physically located within Louisiana for every ~~10~~50,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state. LDH may approve written requests with detailed justification to substitute another SIU position in place of an investigator position.

15.1.15. DHH or its designee will notify ~~T~~the MCO when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

15.1.15.1. The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or

15.1.15.2. The improperly paid funds have already been recovered by the State's Recovery Audit Contractor (RAC) contractor; or

15.1.15.3. When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.

15.1.16. The~~e~~is prohibition described above in Section 15.1.15~~3~~ shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims.~~.~~ In the event that the MCO obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the MCO will return the funds to DHH.

15.1.17. The MCO shall confer with LDH before initiating any recoupment or withhold of any program integrity-related funds as defined in 15.1.15 (see 15.7 for audit coordination procedure) to ensure that the recovery, recoupment, or withhold is permissible.~~comply with all federal and state requirements regarding fraud waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.~~

15.1.18. Reporting and Investigating Suspected Fraud and Abuse

15.1.18.1. The MCO and its subcontractors shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.

15.1.18.2. The MCO shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.

15.1.18.3. The MCO shall notify MFCU and DHH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates

to MFCU and DHH when the concerns and/or allegations of any tips are authenticated.

15.1.18.4. The MCO shall report all tips, confirmed or suspected fraud, waste and abuse to DHH and the appropriate agency as follows:

15.1.18.4.1. All tips (regarding any ~~program integrity case opened~~ potential billing or claims issue identified through either complaints or internal review received within the previous two (2) weeks) shall be reported to DHH Program Integrity monthly~~and MFCU~~;

15.1.18.4.2. Suspected fraud and/or abuse in the administration of the program shall be reported to DHH Program Integrity and MFCU;

15.1.18.4.3. All confirmed or suspected provider fraud and abuse shall immediately be reported to DHH Program Integrity and MFCU; ~~and~~

15.1.18.4.4. All confirmed or suspected enrollee fraud and abuse shall be reported immediately, in writing, to DHH Program Integrity and local law enforcement of the enrollee's parish of residence.

15.1.18.5. When making a referral of suspected fraud, ~~T~~the MCO shall utilize a Fraud Reporting Form deemed satisfactory by ~~the agency to whom the report is to be made~~ DHH under the terms of this Contract. The MCO shall report suspected provider fraud using the DHH Provider Fraud Referral Form (Appendix EE).

15.1.18.6. The MCO shall be subject to a civil penalty, to be imposed by the DHH, for willful failure to report fraud and abuse by ~~recipients~~employees, subcontractors, beneficiaries, enrollees, applicants, or providers to DHH MFCU, as appropriate.

15.1.18.7. The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCO shall not take any of the following actions as they specifically relate to Medicaid claims:

15.1.18.7.1. Contact the subject of the investigation about any matters related to the investigation

15.1.18.7.2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

15.1.18.7.3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

15.1.18.8. The MCO shall promptly provide the results of its preliminary investigation to DHH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

15.1.18.9. The MCO and its subcontractors shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

15.1.18.10. The MCO and/or is subcontractors are~~is~~ to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.

15.1.19. The State shall not transfer its law enforcement functions to the MCO.

~~16.1.5 The MCO, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make available to the MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by this Contract or state and/or federal law, be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.~~

15.1.20. The MCO and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.

15.1.21. The MCO shall notify DHH when the MCO or its subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

~~16.1.6 Except as described in Section 15 of this Contract, nothing herein shall require the MCO to ensure non-contract providers are compliant with Louisiana Medicaid contracts or state and/or federal law.~~

15.1.22. ~~In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, t~~The MCO shall report overpayments made by DHH to the MCO ~~as well as overpayments made by the MCO to a provider and/or subcontractor~~within 60 calendar days from the date the overpayment was identified.

15.1.23. Unless prior written approval is obtained from DHH, the MCO shall not employ extrapolation methods to derive an overpayment in a provider audit.

~~16.1.7 The MCO shall have at least one (1) full-time investigator or full-time equivalent per 100,000 enrollees or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.~~

15.2. Fraud, Waste, and Abuse Compliance Plan

15.2.1. In accordance with 42 CFR §438.608(a), the MCO and its subcontractors, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between the MCO and the state, shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud, Waste, and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.

15.2.2. In accordance with 42 CFR §438.608(~~a~~b)(~~1~~2)(ii), the MCO's compliance program shall designate a ~~Program Integrity~~ Contract Compliance Officer~~ and Program Integrity committee that have the responsibility~~ who is responsible for developing and implementing written policies, procedures, and ~~authority for carrying out the provisions of the compliance program~~standards to ensure compliance with the requirements of this contract and all applicable Federal and State requirements, and who reports directly to the CEO and board of directors.~~ These individuals shall be accountable to the MCO's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management.~~

15.2.3. The MCO shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer.

15.2.4. The MCO shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly, including coordinating with law enforcement agencies if issues are suspected to be criminal in nature, to reduce the potential for recurrence, and conduct ongoing compliance with the requirements under the contract.

15.2.5. In accordance with 42 CFR 438.608(a)(1)(iii), the compliance program shall establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with oversight of the compliance program and its compliance with the requirements under this contract.

~~15.2.4.~~**15.2.6.** The MCO shall submit the Fraud, Waste, and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed, annually thereafter, and upon updates or modifications to DHH for approval at least thirty (30) days in advance of making them effective. DHH, at its sole discretion, may require that the MCO modify its compliance plan. The MCO compliance program shall incorporate the policy and procedures as follows:

~~15.2.4.1.~~**15.2.6.1.** Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;

~~15.2.4.2.~~**15.2.6.2.** Effective lines of communication between the ~~Program Integrity~~Contract Compliance Officer and the MCO's employees, providers and subcontractors;

~~15.2.4.3.~~15.2.6.3. ~~e~~Enforce~~d~~ment of standards through well publicized disciplinary guidelines;

~~15.2.4.4.~~15.2.6.4. Procedures for ongoing monitoring and auditing of the MCO's systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;

~~15.2.4.5.~~15.2.6.5. Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the ~~Program Integrity~~ Contract 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;

~~15.2.4.6.~~15.2.6.6. Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4)-(6);

~~15.2.4.7.~~15.2.6.7. Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.

~~15.2.4.8.~~15.2.6.8. Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to DHH and/or the U.S. Office of Inspector General;

15.2.6.9. Procedures for prompt notification to LDH when the MCO receives information about changes in a member's circumstance that may affect the member's eligibility including changes in the member's residence and death of a member.

15.2.6.10. Procedures for prompt notification to LDH when the MCO receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the program.

~~15.2.4.9.~~15.2.6.11. Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);

~~Well-publicized disciplinary procedures that shall apply to employees who violate the MCO compliance program;~~

~~15.2.4.10.~~15.2.6.12. Effective training and education system for the ~~Program Integrity~~Contract Compliance Officer, senior management, program integrity investigators, managers, ~~employees, providers~~ and members to ensure that they know and understand the federal and state standards and requirements ~~provisions~~ of the MCO's ~~compliance plan~~contract;

~~15.2.4.11.~~15.2.6.13. Fraud, Waste and Abuse Training shall include, but not be limited to:

- Annual training of all employees;
- New hire training within thirty (30) days of beginning date of employment.

~~15.2.4.12.~~15.2.6.14. The MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws:

- MCO Code of Conduct Training
- Privacy and Security - Health Insurance Portability and Accountability Act
- Fraud, waste, and abuse identification and reporting procedures
- Federal False Claims Act and employee whistleblower protections
- Procedures for timely consistent exchange of information and collaboration with DHH;
- Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and
- Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' ***Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks***) issued by 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.

15.2.7. The MCO shall require and have procedures for a network provider to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within sixty (60) calendar days of the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.

~~15.2.5.~~15.2.8. The MCO shall have procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential fraud.

15.3. Prohibited Affiliations

15.3.1. In accordance with 42 CFR §438.610, the MCO ~~is~~ and its subcontractors are prohibited from knowingly having a relationship with: An individual or entity that ~~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.

15.3.2. The MCO may not knowingly have a relationship with an individual or entity that is an affiliate of an individual or entity that is debarred, suspended or excluded from participating in any federal health care program, in accordance with 48 CFR §2.101 and 42 CFR §438.610.

15.3.3. If LDH finds the MCO is not in compliance with 42 CFR §438.610(a) and (b), LDH:

15.3.3.1. Shall notify the Secretary of the US Department of Health and Human Services (HHS) of the noncompliance;

15.3.3.2. May continue an existing agreement with the MCO unless the Secretary of HHS directs otherwise;

15.3.3.3. May not renew or otherwise extend the duration of an existing agreement with the MCO unless the Secretary of HHS provides to LDH and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations; and

15.3.3.4. Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under Section 1128, 1128A, or 1128B of the Social Security Act.

~~15.3.2.~~15.3.4. The MCO and its subcontractors shall comply with all applicable provisions of 42 CFR §438.608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. The MCO and its subcontractors shall screen all employees, ~~and~~ contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screenings to comply with the requirements ~~re~~ set forth at 42 CFR §455.436.

~~15.3.3.~~15.3.5. The MCO shall search the following websites:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE):
- Louisiana Adverse Actions List Search;
- The System of Award Management (SAM); and
- ~~The National Practitioner Data Bank (NPDB); and~~
- Other applicable sites as may be determined by DHH

~~15.3.4.~~15.3.6. The MCO and its subcontractors 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 reported to DHH within three (3) business days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).

~~15.3.4.1.~~15.3.6.1. An individual who is an affiliate of a prohibited person or entity described above c~~an~~d include:

- A director, officer, or partner of the MCO;
- A subcontractor of the MCO;
- A person with beneficial ownership of five (5%) percent or more of the MCO's equity; ~~or~~
- A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations under this contract; or~~.~~
- A network provider.

~~15.3.4.2.~~15.3.6.2. The MCO shall notify DHH in writing within three (3) days of the time it receives notice that action is being taken against the MCO 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 MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

~~15.3.5.~~15.3.7. The MCO, through its Contract Compliance Officer, shall attest monthly to LDH that a search of the websites reference in Section 15.3.4 has been completed to capture all exclusions.

15.4. Payments to Excluded Providers

15.4.1. Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services as specified in 42 CFR §1001.1901; and

15.4.2. The MCO is responsible for the return to the State of any money paid for services provided by an excluded provider.

15.5. Reporting

15.5.1. ~~In accordance with 42 CFR §455.1(a)(1) and §455.17, t~~The MCO and its subcontractors shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state's Office of Attorney General MFCU, and DHH within three (3) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s).

15.5.2. ~~Additionally, t~~The MCO shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers, subcontractor or subcontractor 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 MCO, network provider, or a subcontractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

15.5.3. Reporting shall include, but is not limited to, as set forth at 42 CFR §455.17:

15.5.3.1. Number of complaints of fraud, abuse, waste, neglect and overpayments made to the MCO that warrant preliminary investigation (~~defined at~~ under 42 CFR §455.14);

15.5.3.2. Number of complaints reported to the ~~Program Integrity~~Contract Compliance Officer; and

15.5.3.3. For each complaint that warrants full investigation (defined at 42 CFR §455.15 and §455.16), the MCO shall provide DHH, at a minimum, the following:

- Provider Name and ID number;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate range of dollars involved if applicable; and
- Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

~~The MCO, through its compliance officer, shall attest monthly to DHH that a search of the websites referenced in Section 15.3.3 has been completed to capture all exclusions.~~

15.5.4. The MCO shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the MCO and all of its subcontractors. [See 42 CFR §438.608(d)(3)].

15.5.5. The MCO shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.

15.5.6. LDH shall utilize MCO overpayment and recovery data in calculating future capitation rates per 42 CFR §438.608(d)(4).

15.6. Medical Records

15.6.1. The MCO shall have a method to verify that services for which reimbursement was made~~,~~ wereas provided to members as billed. The MCO shall have policies and procedures to maintain, or require MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:

15.6.1.1. Accurate and legible;

15.6.1.2. 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

15.6.1.3. Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.

15.6.2. The MCO shall ensure the medical record includes, minimally, the following:

15.6.2.1. Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);

15.6.2.2. Primary language spoken by the member and any translation needs of the member;

15.6.2.3. Services provided through the MCO, date of service, service site, and name of service provider;

15.6.2.4. 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 MCO;

15.6.2.5. Referrals including follow-up and outcome of referrals;

15.6.2.6. Documentation of emergency and/or after-hours encounters and follow-up;

15.6.2.7. Signed and dated consent forms (as applicable);

15.6.2.8. Documentation of immunization status;

15.6.2.9. Documentation of advance directives, as appropriate;

15.6.2.10. Documentation of each visit must include:

- Date and begin and end times of service;
- Chief complaint or purpose of the visit;
- Diagnoses or medical 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.* MD, DO, OD) and the signature or initials of the provider; and
- Initials of providers must be identified with correlating signatures.

15.6.2.11. Documentation of EPSDT requirements including but not limited to:

- Comprehensive health history;
- Developmental history;
- Unclothed physical exam;
- Vision, hearing and dental screening;
- Appropriate immunizations;
- Appropriate lab testing including mandatory lead screening; and
- Health education and anticipatory guidance.

15.6.3. The MCO is required to provide one (1) free copy of any part of member's record upon member's request.

15.6.4. All documentation and/or records maintained by the MCO, its subcontractors, and ~~or~~ any and all of its network providers related to all services, charges, operations and agreements under this contract shall be maintained for at least ~~six (6)~~ ten (10) calendar 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.

15.7. Rights of Review and Recovery by MCO and DHH

15.7.1. ~~Each~~ The MCO and its subcontractors are~~is~~ responsible for investigating and reporting possible acts of provider fraud, abuse, and waste for all services under this contract~~, including those services that the MCO subcontracts to outside entities~~.

15.7.2. The MCO and its subcontractors shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. The collected funds from these reviews are to remain with the MCO. ~~has the exclusive right of review and recovery for 365 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment, by delivering notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment.~~ The MCO shall report to DHH on a quarterly basis the results of all reviews, and include instances of suspected fraud, identified overpayments, and collection status.

15.7.3. All reviews shall be completed within eight months (240 calendar days) of the date the case was opened unless an extension is authorized by DHH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.

~~**15.7.3.**~~**15.7.4.** The MCO shall confer with DHH before initiating a post-payment provider-focused review to ensure that review and recovery is permissible. Notification of intent to review and/or recover shall include at a minimum: provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or

National Drug Codes (NDCs) under review, date range for dates of service under review, and amount paid. DHH shall respond within ten business days to each review notification. In the event DHH does not respond, the MCO may proceed with the review. The MCO and its subcontractors shall not pursue recovery until approved by DHH.

~~15.7.4.~~15.7.5. ~~Notice to the provider~~ Contact with a provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and ~~referred~~ submitted a referral of fraud to the Department, MFCU, or other appropriate law enforcement agency, unless approved by DHH.

~~All "complex" reviews must be completed within one hundred and twenty (120) days of the date of the notice to the provider unless an extension is authorized by the Department. This review period is inclusive of all provider notification, health plan document review, and including any provider appeal or rebuttal process. The MCO shall notify the Department, at least on a monthly basis, the results of "complex" reviews that include as well as instances of suspected fraud and/or a collection status.~~

15.7.6. If the MCO fails to collect at least a portion of an identified recovery after 365 days from the date of notice to the Department, unless an extension or exception is authorized by the Department, the Department or its agent may recover the overpayment from the provider and said recovered funds will be retained by the State.

15.7.7. DHH or its agent shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. DHH may recover from the provider any overpayments identified by DHH or its agent, and said recovered funds will be retained by the State.

15.7.8. DHH shall not initiate its own review on the same claims for a network provider which has been identified by the MCO as under a review approved by DHH per Section 15.7.4. DHH shall track open DHH and MCO reviews to ensure audit coordination. DHH shall not approve MCO requests to initiate reviews when the audit lead and timeframe is already under investigation by DHH or its agents.

~~16.1.8 The MCO shall not retain the exclusive right of review and/or recovery beyond 365 days from the original date of service of a claim for a "complex" review, but the MCO may conduct audits of providers' claims for a five (5) year period from the date of service of a claim. Results of the audit reviews must be communicated to the Department at least monthly in instances of suspected fraud or requiring collection. The collected funds from those reviews are to remain with the MCO.~~

~~16.1.9 If the MCO does not initiate action through official notification to a provider with respect to a "complex" claim review within 365 days from the original date of service of the claim or fails to collect at least a portion of the "complex" claim review recovery after 365 days from the date of notice to the Department of the collection status, unless in either scenario an extension is authorized by the Department or its agent may recover from the provider any overpayments which they identify and said recovered funds will be returned to the State.~~

~~16.1.10 The MCO shall not retain the exclusive right of review and/or recovery from the initial date of service of a claim for which the Department or its agent identifies improper payment(s) as a result of "automated" claims reviews. An "automated" review is one for which an analysis of the paid claims is sufficient to determine~~

~~the existence of an improper mispayment(s) where as no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.~~

~~16.1.11 DHH may recover from the provider any overpayments which they identify through an "automated" review and said recovered funds will be returned to the State.~~

~~15.7.5.~~**15.7.9.** ~~DHH must notify the MCO of an identified improper payment from a "complex" or "automated" review prior to notifying any provider(s). The MCO shall have thirty (30) calendar days from the date of notification of potential improper payments(s)~~ In the event DHH or its agent initiates a review on a network provider, a notification shall be sent to the MCO Special Investigation Unit (SIU) designee. The DHH notification of the intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The MCO shall have ten business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department ~~or its agent~~. If the State does not receive a response from the MCO within ten business days, the State may proceed with its review.

15.7.10. In the event the State or its agent investigates or audits a provider or member within the MCO's Network, the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the MCO and State. Document requests do not include medical records that shall be obtained from the provider.

15.7.11. DHH shall notify the MCO and the network provider concurrently of overpayments identified by the State or its agents.

~~15.7.6.~~**15.7.12.** The MCO shall not correct the claims nor initiate an audit on the claims upon notification ~~by~~ of the identified overpayment by the Department or its agent unless directed to do so by the Department.

~~15.7.7.~~**15.7.13.** In the event the provider does not refund overpayments identified by the Department or its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department ~~or its agent~~ will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. Upon DHH request, ~~T~~the MCO shall ~~collect and~~ refund to the State any amounts collected ~~to the Department~~. Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.

15.7.14. In the event DHH or its agent recovers funds from a provider due to an overpayment, the MCO shall submit corrected encounter data within thirty (30) calendar days upon notification by DHH, and shall not seek additional recovery from the provider for the claims the DHH or its agent audited, unless approved by DHH.

15.7.15. The MCO and its subcontractors shall enforce DHH directives regarding sanctions on MCO network providers and members, up to termination or exclusion from the network.

~~**15.7.8.**~~**15.7.16.** There will be no DHH provider improper payment recovery request of the MCO applicable for the dates of service occurring before the start of the Bayou Health Contract period or for providers for which no MCO relationship existed.

INTENTIONALLY LEFT BLANK

16.0 SYSTEMS AND TECHNICAL REQUIREMENTS

16.1. General Requirements

16.1.1. The MCO 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 and pre-certification that complies with DHH and federal reporting requirements. The MCO shall ensure that its System meets the requirements of the Contract, state issued Guides (~~***See***~~ including, but not limited to the ***MCO*** ~~***Encounter Data***~~***System*** ***Companion Guide*** ~~***and OBH Client Level Data Standards and Procedures Manual***~~) 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.

16.1.2. The MCO application systems foundation shall employ a relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. It is important that the MCO'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.

16.1.3. All MCO 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.

16.1.4. The MCO'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.

16.1.5 The Contractor must be capable of transmitting all non-proprietary data which is relevant for analytical purposes to DHH on a regular schedule in XML format. Final determination of relevant data will be made by DHH based on collaboration between both parties. The schedule for transmission of the data will be established by DHH and dependent on the needs of the Department related to the data being transmitted. XML files for this purpose will be transmitted via Secure File Transfer Protocol (SFTP) to the Department. Any other data or method of transmission used for this purpose must be approved via written agreement by both parties.

16.1.6 Proposer must clearly outline the solution's technical approach as it relates to a service oriented architecture. Details should include a description of capability and potential strategy for integration with future DHH-wide enterprise components as they are established, specifically making use of an enterprise service bus for managing touch points with other systems, integration with a master data management solution and flexibility to utilize a single identity and access management solution.

16.1.7 The contractor is responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in this RFP.

16.1.8 The contractor should adhere to state and federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this RFP.

16.1.9 The contractor shall clearly identify any systems or portions of systems outlined in the proposal which are considered to be proprietary in nature.

16.1.10 Unless explicitly stated to the contrary, the contractor is responsible for all expenses required to obtain access to DHH systems—including systems maintained by other DHH contractors including but not limited to the Medicaid fiscal intermediary and Medicaid enrollment broker--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.

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

~~16.1.11~~16.1.12 Any confidential information must be encrypted to FIPS 140-2 standards when at rest or in transit.

~~16.1.12~~16.1.13 Contractor owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA part 164).

~~16.1.13~~16.1.14 Any contractor use of flash drives or external hard drives for storage of Medicaid data must first receive written approval from the Department and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

~~16.1.14~~16.1.15 All contractor utilized computers and devices must:

~~16.1.14.1~~16.1.15.1 Be protected by industry standard virus protection software which is automatically updated on a regular schedule;

~~16.1.14.2~~16.1.15.2 Have installed all security patches which are relevant to the applicable operating system and any other system software; and

~~16.1.14.3~~16.1.15.3 Have encryption protection enabled at the Operating System level.

~~16.1.15~~16.1.16 The contractor must have:

~~16.1.15.1~~16.1.16.1 Capabilities of interagency electronic transfer to and from the participating state agencies (DHH-OBH, DCFS, and OJJ) as needed to support the operations as determined by DHH;

~~16.1.15.2~~16.1.16.2 Electronic storage and retrieval of individualized Plans of Care (POC), treatment plans, crisis plans, and advance directives;

~~16.1.15.3~~16.1.16.3 An MCO Data Warehouse that supports the timely submission of valid data, including but not limited to encounter data,

~~16.1.15.4~~16.1.16.4 A secure online web-based portal that allows providers and state agencies (DCFS, LDOE, DHH, and OJJ) to submit and receive responses to referrals and prior authorizations for services.~~;~~

~~16.1.15.5~~16.1.16.5 The MIS will regularly (e.g., bi-weekly) electronically transfer client/episode-level recipient, assessment, service, and provider data as directed by DHH for purposes of state and federal reporting (e.g., SAMHSA National Outcome Measures (NOMS), Treatment Episode Data Sets (TEDS), Government Performance Reporting Act (GPRA)), and for ad hoc reporting as needed by the state for service quality monitoring and performance accountability.

16.2 HIPAA Standards and Code Sets

16.2.1. 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 MCO ~~Encounter Data~~System Companion Guide.

16.2.2. All HIPAA-conforming exchanges of data between DHH, its contractors, and the MCO shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The **HIPAA Business Associate Agreement** (Appendix C) shall become a part of the Contract.

16.2.3. The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance;
- ASC X12N 835 Claims Payment Remittance Advice Transaction;
- ASC X12N 837I Institutional Claim/Encounter Transaction;
- ASC X12N 837P Professional Claim/Encounter Transaction;
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;
- ASC X12N 276 Claims Status Inquiry;
- ASC X12N 277 Claims Status Response;
- ASC X12N 278Utilization Review Inquiry/Response;
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products; and
- NCPDP Pharmacy Claims.

16.2.4. The MCO shall not revise or modify standardized forms or formats.

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

16.2.6. The MCO 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.

16.3 Connectivity

16.3.1 DHH is requiring that the MCO interface with DHH, the Medicaid Fiscal Intermediary (FI), the Enrollment Broker (EB), and its trading partners. The MCO must have capacity for real time connectivity to all DHH approved systems. The MCO must have the capability to allow and enable authorized DHH personnel to have real-time connectivity to the MCO's system as remote connections from DHH offices.

16.3.2 The System shall conform and adhere to the data and document management standards of DHH and its FI, inclusive of standard transaction code sets as outlined in the MCO Systems Companion Guide.

16.3.3. The MCO's Systems shall utilize mailing address standards in accordance with the United States Postal Service.

16.3.4. The MCO shall encourage all hospitals, physicians, and other providers in its network to adopt certified electronic health ~~information~~ record technology (CEH~~I~~RT) and comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC). ~~, with specific emphasis on connection to the Louisiana Health Information Exchange (LaHIE) and development of a secure, web-accessible health record for members, such as personal health record (PHR). The MCO shall participate in the planning and implementation of a single, all-payer PHR at such time that DHH requires.~~

16.3.5. The MCO shall require all emergency departments (EDs) in its network to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE)~~LaHIE's~~ ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and chronic disease management. The visit registry would consist of three basic attributes: 1) the ability to capture and match patients based on demographics information, 2) the ability to identify the facility at which care is being sought, and 3) at minimum, the chief complaint of the visit. These three pieces of information are commonly available through the HL7 ADT message standard and in use by most ED admission systems in use today across the country. This data should be available in real-time in order to assist providers and systems with up-to-date information for treating patients appropriately.

16.3.6. The MCO shall require all network hospitals to comply with the data submission requirements of Louisiana Revised Statues Section 1300.111-114. Including, but not limited to, syndromic surveillance data under the Sanitary Code of the State

of Louisiana (LAC 51:II.105). MCOs shall encourage the use of ~~La~~HIEs where direct connections to public health reporting information systems are not feasible or are cost prohibitive.

16.3.7. 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 MCO 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.

16.3.8. The Medicaid Management Information System (MMIS) processes claims and payments for covered Medicaid services within the fee-for-service Medicaid program. DHH's current MMIS contract expires December 31, 2015.DHH anticipates twelve month extension of the existing FI contract until such time that a reprocurement for Medicaid fiscal intermediary services is completed. DHH will require the MCO to comply with all transitional requirements as necessary should DHH contract with a new FI during the Contract at no cost to DHH or its FI.

16.3.9. The MCO shall be responsible for all initial and recurring costs required for access to DHH system(s), as well as DHH access to the MCO'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, the Fiscal Intermediary (FI) and the Enrollment Broker.

16.3.10. DHH may require the MCO to 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 MCO signs the Contract DHH.

16.3.11. Hardware and Software

The MCO must maintain hardware and software compatible with current DHH requirements which are as follows. This includes, but is not limited to, call center operations, claims EDI operations, authorized services operations, and member services operations:

16.3.11.1. Desktop Workstation Hardware:

- IBM-compatible, networked PC running Microsoft Windows 7 or later operating system.

16.3.11.2. Desktop Workstation Software:

- Operating system should be Microsoft Windows 7 or later,
- Web browser that is equal to or surpasses Microsoft Internet Explorer v7.0 and is capable of resolving JavaScript and ActiveX scripts;
- An e-mail application that is compatible with Microsoft Outlook 2007 or later~~,~~. The e-mail application should have the ability to send secure messages in the case that Protected Health Information (PHI) is present. E-mail users should be periodically (at least annually) trained in the appropriate use of secure e-mail functionality with respect to PHI;

- An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 or later;

- Each workstation should be networked and have access to high speed Internet;

- Each workstation connected to the Internet should have anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered;

- A desktop compression/encryption application that is compatible with WinZIP v11.0;

- All contractor-utilized workstations, laptops and portable communication devices shall be:

    - Protected by industry standard virus protection software which is automatically updated on a regular schedule;
    - Have installed all security patches which are relevant to the applicable operating system and any other system software; and
    - Have encryption protection enables at the Operating System level.

- Compliant with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).

16.3.11.3. Network and Back-up Capabilities

- Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs);

- Establish appropriate hardware firewalls, routers, and other security measures so that the MCO's computer network is not able to be breached by an external entity;

- Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval/recovery of mainframe (when applicable), network server data and desktop workstation data;

- 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

- The MCO shall establish independent generator back-up power capable of supplying necessary power for a minimum of four (4) days.

16.4. Resource Availability and Systems Changes

16.4.1. Resource Availability

The MCO shall provide Systems Help Desk services to DHH, its FI, and Enrollment Broker staff that have direct access to the data in the MCO's Systems.

16.4.1.1. The Systems Help Desk shall:

- Be available via local and toll-free telephone service, and via e-mail from 7a.m. to 7p.m., Central Time, Monday through Friday, with the exception of DHH-designated holidays. Upon request by DHH, the MCO shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;

- Answer questions regarding the MCO'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;

- Ensure individuals who place calls after hours have the option to leave a message. The MCO's staff shall respond to messages left between the hours of 7p.m. and 7a.m. by noon that next business day;

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

- 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.

16.4.2. Systems Quality Assurance Plan

16.4.2.1. The MCO shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems. The Systems Quality Assurance Plan information systems documentation requirements must be submitted to DHH for approval no later than thirty (30) days from the date the Contract is signed. At a minimum, the Systems Quality Assurance Plan must address the following:

16.4.2.1.1. The MCO 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.

16.4.2.1.2. The MCO shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.

16.4.2.1.3. The MCO shall ensure when a System change is subject to DHH prior written approval, the MCO will submit revision to the appropriate manuals before implementing said Systems changes.

16.4.2.1.4. The MCO shall ensure all aforementioned manuals and reference Guides are available in printed form and on-line; and

16.4.2.1.5. The MCO shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.

16.4.2.1.6. The MCO shall provide to DHH documentation describing its Systems Quality Assurance Plan.

16.4.3. Systems Changes

16.4.3.1. The MCO'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~~ unless otherwise directed by CMS or DHH.

16.4.3.2. If a system update and/or change are necessary, the MCO 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.

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

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

- Claims processing;
- Eligibility and enrollment processing;
- Service authorization management;
- Provider enrollment and data management; and
- Conversions of core transaction management Systems.

16.4.3.4. The MCO shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes:

- Within five (5) calendar days of receiving notification from DHH, the MCO shall respond in writing to notices of system problems.
- Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.

- The MCO shall correct the deficiency by an effective date to be determined by DHH.

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

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

16.4.3.5. Unless otherwise agreed to in advance by DHH, the MCO 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.

16.4.3.6. The MCO 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 MCO's System.

16.5. Systems Refresh Plan

16.5.1. The MCO shall provide to DHH a~~n annual~~ Systems Refresh Plan within thirty (30) days from the date the Contract is executed~~, annually thereafter,~~ and prior to implementation of revisions. The plan shall outline how Systems within the MCO'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.

16.5.2. The systems refresh plan shall also indicate how the MCO 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.

16.6. Other Electronic Data Exchange

16.6.1. The MCO's system shall scan, house, and retain indexed electronic images of documents to be used by members and providers to transact with the MCO 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 MCO 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.

16.6.2. The MCO shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.

16.7. Electronic Messaging

16.7.1. The MCO shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with DHH. This e-mail system shall be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office (currently 2007) and any subsequent upgrades as adopted.

16.7.2. As needed, the MCO shall be able to communicate with DHH over a secure Virtual Private Network (VPN).

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

16.8. Eligibility and Enrollment Data Exchange

The MCO shall:

- Receive, process and update enrollment files sent daily by the Enrollment Broker;
- Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;
- Transmit to DHH, in the formats and methods specified by DHH, member address changes and telephone number changes;
- Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control; and
- 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.

16.9. Provider Enrollment

16.9.1. At the onset of the MCO Contract and periodically as changes are necessary, DHH shall furnish to the MCO a list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. In order to coordinate provider enrollment records, the MCO shall utilize the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with DHH and the Enrollment Broker. The MCO shall provide the following:

- A weekly Provider Registry File to include provider name, address, licensing information, Tax ID, National Provider Identifier (NPI), taxonomy, contract information, and other data as detailed in the MCO Systems Companion Guide;
- A weekly Provider Site File as described in the MCO Systems Companion Guide;

- A weekly Primary Care Provider Linkage file as described in the MCO Systems Companion Guide;

- All relevant provider ownership information as prescribed by DHH, federal or state laws; and

16.9.1.1. 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.

16.9.2. Provider enrollment systems shall include, at minimum, the following functionality:

- Audit trail and history of changes made to the provider file;

- Automated interfaces with all licensing and medical boards;

- Automated alerts when provider licenses are nearing expiration;

- Retention of NPI requirements;

- System generated letters to providers when their licenses are nearing expiration;

- Linkages of individual providers to groups;

- Credentialing information;

- Provider office hours; and

- Provider languages spoken.

16.10. Information Systems Availability

The MCO shall:

16.10.1. Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the MCO's span of control;

16.10.2. Allow 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;

16.10.3. Allow DHH personnel, direct, real-time, read-only access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) calendar days of LDH request;

16.10.3.1. Access shall be provided to the following MCO (including subcontractors) systems (this is not an exclusive list);

16.10.3.1.1. Prior authorization;

16.10.3.1.2. Claims processing;

16.10.3.1.3. Provider portal;

16.10.3.1.4. Third party liability;

16.10.3.1.5. Fraud, waste, and abuse;

16.10.3.1.6. Pharmacy benefits manager point of sale;

16.10.3.1.7. Pharmacy benefits manager prior authorization; and

16.10.3.1.8. Provider contracting and credentialing.

16.10.3.2. Satisfaction of this Section by the MCO shall not constitute constructive compliance with nor relieve the MCO of any duty to satisfy any other provision of this Contract, including, but not limited to, the MCO's obligation to provide information at the request of DHH.

16.10.4. Query ability using Microsoft SQL Server Management Studio®, or similar enterprise-grade technology subject to DHH approval, shall also be provided to a SQL based production like reporting environment to be updated no less than weekly. This reporting environment shall include all data from the systems referenced in Section 16.10.3.1 or any additional data upon DHH request;

16.10.5. Training of DHH staff shall be provided by the contractor on-site at the MCO's location upon request by DHH;

~~16.10.3.~~16.10.6. 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 MCO. Unavailability caused by events outside of the MCO's span of control is outside of the scope of this requirement;

~~16.10.4.~~16.10.7. 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;

~~16.10.5.~~16.10.8. Ensure that the systems and processes within its span of control associated with its data exchanges with DHH's FI and/or Enrollment Broker and its contractors are available and operational;

~~16.10.6.~~16.10.9. Ensure that in the event of a declared major failure or disaster, the MCO'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;

~~16.10.7.~~16.10.10. Notify designated DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the MCO'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 MCO and DHH or DHH's FI. In its notification, the MCO shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;

~~16.10.8.~~16.10.11. 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;

~~16.10.9.~~16.10.12. 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;

~~16.10.10.~~16.10.13. 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 MCO's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the MCO's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability;

~~16.10.11.~~16.10.14. Cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the MCO's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period; and

~~16.10.12.~~16.10.15. Within five (5) business days of the occurrence of a problem with system availability, the MCO shall provide DHH with full written documentation that includes a corrective action plan describing how the MCO will prevent the problem from reoccurring.

16.11. Contingency Plan

16.11.1. The MCO, 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.

16.11.2. 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.

16.11.3. The MCO shall have a Contingency Plan that must be submitted to DHH for approval no later than thirty (30) days from the date the Contract is signed.

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

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

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

16.11.4.3. 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;

16.11.4.4. 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

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

16.11.5. The MCO shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to DHH that it can restore Systems functions.

16.11.6. In the event the MCO fails to demonstrate through these tests that it can restore Systems functions, the MCO 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.

16.12. Off Site Storage and Remote Back-up

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

16.12.2. The data back-up policy and procedures shall include, but not be limited to:

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

16.12.2.2. Documented back-up procedures;

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

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

16.12.2.5. Any change in back-up procedures in relation to the MCO's technology changes.

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

16.13. Records Retention

16.13.1. The MCO shall have online retrieval and access to documents and files for ten (10) years, six (6) years in live systems for audit and reporting purposes and an additional four (4) ~~, ten (10)~~ years in archival systems. Services which have a once in a life-time indicator (i.e., appendix removal, hysterectomy) 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 MCO shall provide forty-eight (48) hour turnaround or better on requests for access to information that is less than 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.

16.13.2. The historical encounter data submission shall be retained for a period not less than ~~six (6)~~ ten (10) years, following generally accepted retention guidelines.

16.13.3. 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.

16.14. Information Security and Access Management

The MCO's system shall:

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

16.14.1.1 Establish unique access identification per MCO employee;

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

16.14.1.3 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 MCO; and

16.14.1.4 Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

16.14.2 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.

16.14.3 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 MCO and DHH.

16.14.4 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:

16.14.4.1 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;

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

16.14.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

16.14.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and

16.14.4.5 Facilitate auditing of individual records as well as batch audits.

16.14.5 Have inherent functionality that prevents the alteration of finalized records;

16.14.6 Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The MCO shall provide DHH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;

16.14.7 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;

16.14.8 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;

16.14.9 Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of an MCO’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;

16.14.10 Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by DHH no later than fifteen (15) calendar days after the Contract award; and

16.14.11 Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the MCO 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.

INTENTIONALLY LEFT BLANK

17.0 CLAIMS MANAGEMENT

17.1 Functionality

17.1.1 The MCO shall maintain an electronic claims management system that will:

17.1.1.1 Uniquely identify the attending and billing provider of each service;

17.1.1.2 Identify the date of receipt of the claim (the date the MCO receives the claim as indicated by the date stamp on the claim);

17.1.1.3 Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, pended, adjusted, voided, appealed, etc., and follow up information on disputed claims;

17.1.1.4 Identify the date of payment, (the date of the check or other form of payment), and the number of the check or electronic funds transfer (EFT);

17.1.1.5 Identify all data elements as required by DHH for encounter data submission as stipulated in this Section of the RFP and the ***MCO Systems Companion Guide***;

17.1.1.6 Accept submission of paper-based claims and electronic claims by contracted providers, and non-participating providers according to the MCO policies as approved by DHH;

17.1.1.7 Accept submission of electronic adjustment and void transactions;

17.1.1.8 Accept submission of paper adjustment and void transactions;

17.1.1.9 Have capability to pay claims at $0.00; and

17.1.1.10 For the purpose of this Section, identify means to capture, edit and retain.

17.1.2 The MCO shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the MCO 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.

17.1.3 The MCO shall assume all costs associated with claims processing, including costs for reprocessing encounters due to errors caused by the MCO, or due to systems within the MCO's span of control.

17.1.4 The MCO shall provide on-line and phone-based capabilities to providers to obtain claim processing status information.

17.1.5 The MCO shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

17.1.6 The MCO shall have procedures approved by DHH, available to providers in written and web form for the acceptance of claim submissions which include:

17.1.6.1 The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims;

17.1.6.2 The process for reviewing claims for accuracy and acceptability;

17.1.6.3 The process for prevention of loss of such claims, and

17.1.6.4 The process for reviewing claims for determination as to whether claims are accepted as clean claims.

17.1.7 The MCO shall not employ off-system or gross adjustments when processing corrections for payment errors, unless the MCO requests and receives prior written approval from DHH.

17.1.8 For purposes of network management, the MCO shall notify all contracted providers to file claims associated with covered services directly to the MCO, or its sub-contractors, on behalf of Louisiana Medicaid members.

17.1.9 The MCO agrees that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, the MCO shall comply with said recommendations within ninety (90) calendar days from notice by DHH.

17.2 Claims Processing

17.2.1 The MCO shall ensure that all provider claims are processed according to the following timeframes:

17.2.1.1 Within five (5) business days of receipt of a claim, the MCO shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.

17.2.1.2 Process and pay or deny, as appropriate, at least Ninety percent (90%) of all clean claims for each claim type, within fifteen (15) business days of the receipt.

17.2.1.3 Process and pay or deny, as appropriate, at least ninety-nine percent (99%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.

17.2.1.4 Fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

17.2.2 Rejected Claims

17.2.2.1 The MCO may reject claims because of missing or incomplete information. Paper claims that are received by the MCO that are screened and rejected prior to scanning must be returned to the provider with a letter notifying them of the rejection. Paper claims received by the MCO that are scanned prior to screening and then rejected, are not required to accompany the rejection letter.

17.2.2.2 A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system.

17.2.2.3 The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, must include the following:

- The date the letter was generated;
- The patient or member name;
- Provider identification, if available, such as provider ID number, TIN or NPI;
- The date of each service;
- The patient account number assigned by the provider;
- The total billed charges;
- The date the claim was received; and
- The reasons for rejection.

17.2.3 Pended Claims

17.2.3.1 If a clean claim is received, but additional information is required for adjudication, the MCO may pend the claim and request in writing (notification via e-mail, Web site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all necessary information such that the claim can be adjudicated within established timeframes.

17.2.4 Claims Reprocessing

~~17.2.3.2~~17.2.4.1 If the MCO or LDH or its subcontractors discover errors made by the MCO when a claim was adjudicated, the MCO shall make corrections and reprocess the claim within thirty (30) calendar days of discovery, or if circumstances exist that prevent the MCO from meeting this time frame, a specified date shall be approved by LDH. The MCO shall automatically recycle the impacted claims and shall not require the provider to resubmit the impacted claims.

~~17.2.4~~17.2.5 Adjustments and Voids

~~17.2.4.1~~17.2.5.1 Incorrect claims payments may be adjusted or voided either electronically or hard copy. Adjustments/Voids must be submitted on the correct adjustment/void forms.

~~17.2.4.2~~17.2.5.2 Only one internal control number (ICN) should be adjusted or voided on each form.

~~17.2.4.3~~17.2.5.3 Only a paid claim can be adjusted or voided.

~~17.2.4.4~~17.2.5.4 Incorrect provider numbers, incorrect member Medicaid ID numbers, or incorrect claim types cannot be adjusted. The encounter record

must be voided and re submitted as an original. All other adjustments to an encounter record shall be done as an adjustment record.

~~17.2.5~~17.2.6 Timely Filing Guidelines

~~17.2.5.1~~17.2.6.1 Medicaid-only claims must be filed within three hundred sixty five (365) days of the date of service. Electronic submission of pharmacy claims (reversals and resubmittals) shall be allowed to process electronically within three hundred sixty five (365) days of service.

~~17.2.5.2~~17.2.6.2 Claims involving third party liability shall be submitted within 365 days from the date of service. Medicare claims shall be submitted within six (6) months of Medicare adjudication.

~~17.2.5.3~~17.2.6.3 The MCO must deny any claim not initially submitted to the MCO by the three hundred and sixty-fifth (365) calendar day from the date of service, unless DHH, the MCO or its sub-contractors created the error. The MCO shall not deny claims solely for failure to meet timely filing guidelines due to error by DHH or its subcontractors.

~~17.2.5.4~~17.2.6.4 For purposes of MCO reporting on payment to providers, an adjustment to a paid claim shall not be counted as a claim and electronic claims shall be treated as identical to paper based claims.

~~17.2.5.5~~17.2.6.5 The MCO shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claim~~s~~ is submitted within one hundred and eighty (180) days from the member's linkage to the MCO.

The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted to the MCO by the latter of the three hundred and sixty-fifth (365) calendar day from the date of service or one hundred and eighty (180) days from the member's linkage to the MCO.

~~17.2.6~~17.2.7 Claim System Edits

~~17.2.6.1~~17.2.7.1 The MCO shall perform system edits, including, but not limited to:

~~17.2.6.1.1~~17.2.7.1.1 Confirming eligibility on each member;

~~17.2.6.1.2~~17.2.7.1.2 Validating member name;

~~17.2.6.1.3~~17.2.7.1.3 Validating unique member identification number;

~~17.2.6.1.4~~17.2.7.1.4 Validating date of service - 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;

~~17.2.6.1.5~~17.2.7.1.5 Determination of medical necessity - by a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity;

~~17.2.6.1.6~~17.2.7.1.6 Prior Approval – The system shall determine whether a covered service required prior authorization and if so, whether the MCO granted such approval;

~~17.2.6.1.7~~17.2.7.1.7 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;

~~17.2.6.1.8~~17.2.7.1.8 Covered Services - Ensure that the system verifies that a service is a covered service and is eligible for payment;

~~17.2.6.1.9~~17.2.7.1.9 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 and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4; and

~~17.2.6.1.10~~17.2.7.1.10 Quantity of Service - Ensure that the System shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied.

~~17.2.6.2~~17.2.7.2 Perform post-payment review on a sample of claims to ensure services provided were medically necessary.

~~17.2.6.3~~17.2.7.3 The MCO shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CMS, and move to future versions as required by CMS or DHH. Updates to code sets are to be complete no later than 30 days after notification, unless otherwise directed by DHH. This includes annual and other fee schedule updates.

~~17.2.6.3.1~~17.2.7.3.1 Providers must be notified as to when the updates will be in production and of the MCO process for the recycling of denied claims that are due to the system update delays. The recycle of these denied claims shall be complete no later than 15 days after the system update.

~~17.2.6.4~~17.2.7.4 The MCO shall use only national standard code sets such as CPT/HCPS, ICD-10-CMS, etc. (unless it conflicts with DHH policy or state regulations). The MCO shall also comply with deadlines for communication, testing and implementation of code sets established by CMS and/or DHH.

~~17.2.6.5~~17.2.7.5 In addition to CPT, ICD-9-CM, ICD-10-CM, ICD-10-PCS and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the MCO and DHH to evaluate performance measures.

~~17.2.6.6~~17.2.7.6 The MCO shall perform internal audit reviews to confirm claim edits are functioning properly and provide DHH with confirmation of this process. DHH shall be provided the results of internal audit reviews upon request.

17.3 Payment to Providers

17.3.1 At a minimum, the MCO shall run one (1) provider payment cycle per week, on the same day each week, as determined by the MCO.

17.3.2 The MCO 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).

17.3.3 The MCO shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) day claims processing deadline. Interest owed to the provider must be paid the same date that the claim is adjudicated, and reported on the encounter submission to the FI as defined in the MCO Systems Companion Guide.

17.3.4 The MCO shall pay pharmacy providers no less than the DHH specified dispensing fee. In addition, any state imposed provider fees for pharmacy services, shall be added on top of the minimum dispensing fee required by DHH.

17.4 Remittance Advices

In conjunction with its payment cycles, the MCO shall provide:

17.4.1 Each remittance advice generated by the MCO to a provider shall comply with the provisions of LA-R.S. 46:460.71.

17.4.2 Adjustments and Voids shall appear on the RA under "Adjusted or Voided claims" either as Approved or Denied.

17.4.3 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."*

17.4.4 The MCO shall submit a sample of remittance advices that were sent to independent, chain and specialty pharmacies by the PBM to DHH pharmacy staff quarterly. This sample shall include at least 10 RAs from each pharmacy type (independent, chain, and specialty).

17.5 Sampling of Paid Claims

17.5.1 On a monthly basis, the MCO shall provide individual explanation of benefits (EOB) notices to a sample group of members, not more than 45 days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:

- Description of 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.

17.5.2 The MCO shall stratify the paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the contract. To the extent that the MCO or DHH considers a particular specialty (or provider) to warrant closer scrutiny, the MCO may over sample the group. The paid claims sample should be a minimum of two (2%) percent of claims per month to be reported on a quarterly basis.

17.5.3 Surveys may be performed at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.

17.5.4 The MCO shall track any grievances received from members and resolve the grievances according to its established policies and procedures. The resolution may be member education, provider education, or referral to DHH. The MCO shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

17.5.5 Within three (3) business days, results indicating that paid services may not have been received, shall be referred to the MCO's fraud and abuse department for review and to the DHH ~~through the following url: http://new.dhh.louisiana.gov/index.cfm/page/219 or DHH prior approved method~~Program Integrity contact.

17.5.6 Reporting shall include the total number of survey notices sent out to members, total number of surveys completed, total services requested for validation, number of services validated, analysis of interventions related to grievance resolution, and number of surveys referred to DHH for further review.

17.6 Claims Dispute Management

17.6.1 The MCO shall develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process must be submitted to DHH for approval within thirty (30) days of the date the Contract is signed by the MCO.

17.6.2 The Claims Dispute process shall allow providers the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the MCO and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless the MCO and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

17.6.3 The MCO shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.

17.6.4 The MCO shall adjudicate all disputed claims to a paid or denied status within thirty (30) business days of receipt of the dispute claim.

17.6.5 The MCO shall resolve all disputed claims, no later than twenty-four (24) months from the date of service.

17.7 Claims Payment Accuracy Report

17.7.1 On a monthly basis, the MCO shall submit a claims payment accuracy percentage report to DHH. The report shall be based on an audit conducted by the MCO. 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.

17.7.2 The minimum attributes to be tested for each claim selected shall include:

- Claim data is correctly entered into the claims processing system;
- Claim is associated with the correct provider;
- Proper authorization was obtained for the service;
- Member eligibility at processing date correctly applied;
- Allowed payment amount agrees with contracted rate;
- Duplicate payment of the same claim has not occurred;
- Denial reason is applied appropriately;
- Co-payments are considered and applied, if applicable;
- Effect of modifier codes correctly applied; and
- Proper coding.

17.7.3 The results of testing at a minimum should be documented to include:

- Results for each attribute tested for each claim selected;
- Amount of overpayment or underpayment for each claim processed or paid in error;
- Explanation of the erroneous processing for each claim processed or paid in error;

- 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

- Claims processed or paid in error have been corrected.

17.7.4 If the MCO sub-contracted for the provision of any covered services, and the MCO's sub-contractor is responsible for processing claims, then the MCO shall submit a claims payment accuracy percentage report for the claims processed by the sub-contractor.

17.8 Encounter Data

17.8.1 The MCO's System shall be able to transmit to and receive encounter data from the DHH FI's system as required for the appropriate submission of encounter data.

17.8.2 Each MCO shall create a unique Processor Control Number (PCN) or Group number for Louisiana Medicaid. The health plan shall submit the PCN or group number and the Bank Identification Number with the encounter claims data submission.

17.8.3 For encounter data submissions, the MCO shall:

17.8.3.1 Submit complete and accurate encounter data at least monthly;

17.8.3.2 Due in accordance with the encounter reconciliation schedule published by DHH or its contracted review organization, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the MCO or its subcontractor has a capitation arrangement with a provider. If the MCO fails to submit complete encounter data, including encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) as measured by a comparison of encounters to cash disbursements within a five (5) percent error threshold (at least ninety-five (95) percent complete), the plan may be penalized as outlined in Section 20 of the RFP.

17.8.3.3 DHH's current FI accepts HIPAA compliant 837 encounters for Institutional, Professional and Dental. DHH"s FI accepts Pharmacy encounters using the NCPDP D.0 format in a batch processing method. The MCO shall be able to transmit encounter data to the FI in this manner sixty (60) days after the contract start date. Inpatient Hospital services (Institutional encounters indicating Facility Type Code of 11, 12, 18, 21 or 86) are adjudicated at the document level. All other encounters are adjudicated at the line level

17.8.4 Within sixty (60) days of operation, the MCO's System shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format. The MCO 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 **MCO Systems Companion Guide.**

- All encounters shall be submitted electronically in the standard HIPAA 5010 transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (P – Professional, I – Institutional and NCPDP Pharmacy). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

- The MCO shall provide DHH with weekly encounter data on all prior authorization requests. The data shall be reported electronically to DHH in a mutually agreeable format as specified in the MCO Systems Companion Guide. Contractor shall report prior authorization requests on all services which require prior authorization. The information reported shall contain but not be limited to:
  - Plan ID
  - Plan Authorization Number
  - Authorization Type
  - Medicaid Recipient ID
  - Provider NPI
  - Provider Taxonomy
  - CPT / NDC/HICL/THERP CLASS
  - CPT Modifiers 1
  - CPT Modifiers 2
  - CPT Modifiers 3
  - CPT Modifiers 4
  - Referring Provider NPI
  - Plan Authorization Status
  - Authorization begin date
  - Authorization end date
  - Authorization Units
  - Authorization amount ($)
  - Authorization received date
  - Authorization notice date
  - Authorization Denied Reason

17.8.5 The MCO shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided, including all claims paid, denied or adjusted directly by the MCO or indirectly through a subcontractor.

17.8.6 The MCO shall have the capability to convert, all information that enters its claims system via hard copy paper claims, to electronic encounter data, for submission in the appropriate HIPAA compliant formats to DHH's FI.

17.8.7 The MCO shall ensure that all encounter data from an MCO sub-contractor is incorporated into files submitted by the MCO to the FI. The MCO shall not submit separate encounter files from MCO sub-contractors.

17.8.8 The MCO shall ensure the level of detail associated with encounters from providers with whom the MCO has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the MCO received and settled a fee-for-service claim.

17.8.9 The MCO shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The MCO 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.

17.8.10 The MCO shall adhere to federal and/or DHH 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 MCOs.

17.8.11 The MCO shall submit paid, denied, adjusted, and voided claims as encounters to the FI. DHH will establish the appropriate identifiers to indicate these claims as encounters, and information will be provided in the MCO Systems Companion Guide.

17.8.12 The MCO shall ensure that encounter files contain settled claims, adjustments, denials or voids, including but not limited to adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the MCO has a capitation arrangement.

17.8.13 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 a batch submission by the MCO. 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 MCO for correction and resubmission to the FI in the next payment cycle.

17.8.14 DHH has authorized their FI to edit MCO encounters using a common set of edit criteria, that might cause denials, and MCOs should resolve denied encounters when appropriate. Encounter denial codes shall be deemed "repairable" or "non-repairable". An example of a repairable encounter is "provider invalid for date of service". An example of a non-repairable encounter is "exact duplicate". The MCO is required to be familiar with the FI edit codes and dispositions for the purpose of repairing encounters denied by the FI. A list of encounter edit codes is located in the **MCO Systems Companion Guide.**

17.8.15 In order to maintain integrity of processing, the MCO 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.

17.8.16 The MCO CEO, CFO or their designee shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

17.8.17 MCO must make an adjustment to encounter claims when MCO discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If DHH or its subcontractors discover errors or a conflict with a previously adjudicated encounter claim MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH. MCO must obtain prior approval from DHH for any submission to DHH's Fiscal Intermediary that numbers greater than one hundred thousand (100,000) encounter claims.

17.9 Claims Summary Report

17.9.1 The MCO must submit monthly, Claims Summary Reports of paid and denied claims, to DHH by claim type. Instructions are provided in the **MCO Systems Companion Guide**.

17.10 Pharmacy Claims Processing

17.10.1 System Requirements

17.10.1.1 The MCO shall have an automated claims and encounter processing system for pharmacy claims that will support the requirements of this contract and ensure the accurate and timely processing of claims and encounters. The MCO shall allow pharmacies to back bill electronically (reversals and resubmissions) for 365 days from the date of the original submission of the claim.

17.10.1.2 Transaction standards: The MCO shall support electronic submission of claims using most current HIPAA compliant transaction standard (currently NCPDP D.0)

17.10.1.3 Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits.

17.10.1.4 The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription and pricing information. The system shall provide online access to reference file information. The system should maintain a history of the pricing schedules and other significant reference data. The drug file for both retail and specialty drugs, including price, must be updated at a minimum every seven (7) calendar days, at the MCO's discretion they may update the file more frequently.

17.10.1.5 The MCO must comply with the claims history requirements in Section 16.13. The historical encounter data submission shall be retained for a period not less than ~~six (6)~~ten (10) years, following generally accepted retention guidelines.

17.10.1.6 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.

17.10.1.7 The MCO shall ensure that the manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia.

17.10.1.8 Provisions should be made to maintain permanent history by service date for those services identified as “once-in-a-lifetime.”

17.10.2 Pharmacy Rebates

The MCO shall submit all drug encounters, with the exception of inpatient hospital drug encounters, to DHH pursuant to the requirements of Section 17.10.3 of this contract. DHH or its vendor shall submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the DHH Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (PPACA).

17.10.3 Pharmacy Encounters Claims Submission

17.10.3.1 The MCO shall submit a weekly claim-level detail file of pharmacy encounters to DHH which includes individual claim-level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This weekly submission must comply with Section 17.8~~8~~ requirements. See the MCO Systems Companion Guide for a complete listing of claim fields required.

17.10.3.2 The overlap of the 340B Drug Pricing Program and the Medicaid Drug Rebate program creates the possibility of duplicate discounts. States are federally mandated by Section 2501(c) of the Patient Protection and Affordable Care Act (ACA) to seek drug rebates on Managed Care Medicaid claims, meaning that the potential for duplicate discounts exists for managed care claims. Louisiana uses the Health Resources and Services Administration’s (HRSA) Medicaid Exclusion File (MEF) for both Fee for Service (FFS) and Managed Care Medicaid claims in order to prevent duplicate discounts.

17.10.3.3 Due to this duplicate discount potential, Louisiana requires that covered entities utilize the same carve-in or carve-out designation for Managed Care Medicaid patients as for FFS Medicaid recipients. If a covered entity appears on the Medicaid Exclusion File, Louisiana will exclude that provider’s FFS and MCO claims from rebate invoicing. Claims for FFS Medicaid and Managed Care Medicaid recipients are treated identically in regards to exclusion from rebate invoicing.

17.10.3.4 In order to allow covered entities to distinguish Managed Care Medicaid patients from an MCO's private insurance patients, Louisiana requires its MCOs to utilize a unique Processor Control Number (PCN) or Group Number for Louisiana Medicaid. This unique PCN or group number shall be submitted to DHH before processing any pharmacy claims.

17.10.3.5 Contract pharmacies are not permitted to bill Medicaid for drugs purchased at 340B pricing. This includes both FFS and Managed Care Medicaid.

17.10.3.6 340B Billing Per Covered Entity

17.10.3.6.1 MCOs shall include in their contracts with 340B providers billing instructions on how to identify 340B claims/encounters.

17.10.3.7 340B Claim Level Indicators

17.10.3.7.1 Carve In Pharmacy Claims: On 340B claims, a value of "20" in NCPDP field 420-DK (Submission Clarification Code) and a value of "8" in NCPDP field 423-DN (Basis of Cost Determination) shall be submitted in the pharmacy claim segment of a billing transaction.

17.10.3.7.2 Professional Services Claims (Physician- Administered Drug Claims): Physician-Administered drug claims should use the UD modifier to identify 340B drugs on outpatient physician-administered drug claims.

17.10.3.7.3 Carve-Out Claims: Covered entities who carve out Medicaid recipients should bill according to guidelines provided in each plan's provider manual.

17.10.4 Disputed Pharmacy Encounter Submissions

17.10.4.1 On a weekly basis, DHH will review the MCO's pharmacy encounter claims and send a file back to the MCO of disputed encounters that were identified through the drug rebate invoicing process.

17.10.4.2 Within 60 calendar days of receipt of the disputed encounter file from DHH, the MCO shall, if needed, correct and resubmit any disputed encounters and send a response file that includes 1) corrected and resubmitted encounters as described in the Rebate Section of the **MCO Systems Companion Guide**, and/or 2) a detailed explanation of why the disputed encounters could not be corrected including documentation of all attempts to correct the disputed encounters at an encounter claim level detail, as described in the Rebate Section of the **MCO Systems Companion Guide**.

17.10.4.3 In addition to the administrative sanctions in Section 20 of this contract, failure of the MCO to submit weekly pharmacy encounter claims files and/or a response file to the disputed encounters file within sixty (60) calendar days as detailed above for each disputed encounter will result in a quarterly offset to the capitation payment equal to the value of the rebate assessed on the disputed encounters being deducted from the MCO's capitation payment.

17.10.5 Use of a Pharmacy Benefits Manager (PBM)

17.10.5.1 The MCO must use a PBM to process prescription claims. The PBM must pay claims in accordance with Section 17 of this contract.

17.10.5.2 The MCO must identify the proposed PBM and the ownership of the proposed PBM. Before entering into a subcontract with a PBM, the MCO shall obtain DHH approval. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store or pharmaceutical manufacturer, the MCO will submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The MCO must provide a plan documenting how it will monitor such Subcontractors. These assurances and procedures must be transmitted to DHH for review and approval prior to the date pharmacy services begin.

17.10.5.3 The MCO must submit a plan for oversight of the PBM's performance prior to the implementation of the MCO's PBM. The plan must be approved by DHH and comply with this contract and all DHH requirements.

17.11 Audit Requirements

The MCO shall ensure that their Systems facilitate the auditing of individual claims. Adequate audit trails shall be provided throughout the Systems. DHH may require the Contractor and/or subcontractors, if performing a key internal control, to submit to financial and performance audits from outside companies to assure both the financial viability of the program and the operational viability, including the policies and procedures placed into operation.

The MCO 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.

17.11.1 State Audits

17.11.1.1 The MCO shall provide to state auditors (including legislative auditors), or their designee, 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 MCO shall provide information necessary to assist the state auditor in processing or utilizing the files.

17.11.1.2 If the auditor's findings point to discrepancies or errors, the MCO shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report.

17.11.2 Louisiana Legislative Auditor Authority

17.11.2.1 The parties agree and acknowledge that the Louisiana Legislative Auditor ("LLA") has the authority pursuant to La. R.S. 24:513 et seq., subject to state and federal laws and privileges protecting the confidentiality of information, to conduct oversight and audit of the Louisiana Department of Health,

including the Medicaid managed care program, and subject thereto LDH, LLA and MCOs have entered into a Data Sharing Agreement (DSA) to facilitate the sharing of data and information requested by the LLA. Pursuant to the DSA, LLA may, in coordination with LDH and MCOs:

17.11.2.1.1 Attend quarterly meetings between the MCOs, LDH, and the DOJ MFCU;

17.11.2.1.2 Evaluate the effectiveness of the MCOs program integrity outcomes;

17.11.2.1.3 Audit, evaluate and inspect the books, records, and contracts related to the performance of the MCO contracts; and

17.11.2.1.4 Access all audit information relating to the performance of the MCO contracts obtained by LDH related to the Medicaid managed care program.

17.11.2.2 Contemporaneous with the execution of any emergency contract, the DSA will be amended to extend its term to coincide with the term of the emergency contract

17.11.3 Independent Audits of Systems

17.11.3.1 The MCO shall submit an independent SOC 2 Type II system audit. The audit should review system security, system availability, system confidentiality and processing integrity for the Louisiana Medicaid line of business. The audit period shall be 12 consecutive months, aligning with the MCO's fiscal year, with no breaks between subsequent audit periods.

~~17.11.1.3~~17.11.3.2 The MCO shall supply the Department with an exact copy of the SOC 2 Type II independent audit no later than six (6) months after the close of the MCO's fiscal year.

17.11.3.3 The MCO shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of the MCO's receipt of the audit report.

~~17.11.1.4~~17.11.3.4 These audit requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the Contractor. The cost of the audit shall be borne by the MCO or subcontractor.

~~17.11.2~~17.11.4 Audit Coordination and Claims Reviews

~~17.11.2.1~~17.11.4.1 The MCO shall coordinate audits with the Department or designee and respond within thirty (30) calendar days of a request by the Department regarding the MCO's review of a specific provider and/or claim(s), and the issue reviewed.

~~17.11.2.2~~17.11.4.2 In the event the Department or its designee identifies ~~a mispayment~~an overpayment, the MCO shall have ~~thirty (30) calendar~~ ten (10) business days from the date of notification of ~~mis~~overpayments to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or designee. The MCO shall not correct the

claims upon notification by the Department or designee, unless directed to do so by the Department.

~~17.11.2.3~~17.11.4.3 DHH reserves the right to review any claim paid by the MCO or designee. The MCO has the right to collect or recoup any overpayments identified by the MCO from providers of service in accordance with existing laws or regulations. If an overpayment is identified by the State or its designee ~~after a one year period from date of service of the claim~~, and the provider fails to remit payment ~~et~~to the state, DHH may require the MCO ~~will~~ to collect and remit the overpayment to DHH. ~~In the event the MCO does not collect mispayments from the provider within thirty (30) calendar days of notification of the overpayment, t~~The MCO shall refund the overpayment to the Department within thirty (30) calendar days. Failure by the MCO to collect from the provider does not relieve the MCO from remitting the identified overpayment to DHH.

17.12 Louisiana Health Insurance Premium Payment (LaHIPP) program is a Louisiana Medicaid program that pays all or part of the health insurance premium for an employee and their family if: (a) health insurance is available from their job (i.e. Employer Sponsored Insurance); (b) someone in the family has Medicaid; and (c) it is determined that it would cost less for Louisiana Medicaid to pay the health insurance premium for the person who receives Medicaid than it would be for Louisiana Medicaid to pay the cost of the same person's per member per month payment for physical health coverage through the enrollee's managed care organization. The goal of LaHIPP is to reduce the number of the uninsured and lower Medicaid spending by establishing a third party resource as the primary payer of the Medicaid enrollee's medical expenses.

17.12.1 DHH is responsible for determining if an individual qualifies for LaHIPP participation. LaHIPP is not an eligibility category. LaHIPP participants are identified in the TPL file.

17.12.2 DHH is responsible for issuing payment for all or part of LaHIPP participants' health insurance premium.

17.12.3 LaHIPP members are mandatorily enrolled in Bayou Health for specialized behavioral health services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified under Section 3.6.

17.12.4 The MCO is responsible for payment of LaHIPP participants' total member liability (co-payments, co-insurance and deductibles) if the participant uses a provider that accepts the insurance as primary payer and Medicaid as secondary payer. If the provider does not accept this payment arrangement, the participant will be responsible for the member liability. The MCO pays only after the third party has met the legal obligation to pay. The MCO is always the payer of last resort, except when the MCO is responsible for payment as primary payer for mental health services and transportation services not covered by commercial insurance as primary payer.

17.12.5 The mental health services listed below are typically not reimbursed by commercial health plans. MCOs should accept the following claims billed directly

from the mental health provider without requiring an explanation of benefits from the primary carrier and pay as primary payer.

- H0018-Therapeutic Group Home
- H0039-Assertive Community Treatment per diem
- H0045-Crisis Stabilization
- H2017-Psychosocial Rehabilitation Services
- H0036-Community psychiatric support and treatment
- H2033-Multi-systemic Therapy
- H2011-Crisis Intervention Service, per 15 minutes
- S9485-Crisis Intervention Mental Health Services

INTENTIONALLY LEFT BLANK

18.0 REPORTING

The MCO shall comply with all the reporting requirements established by this Contract and in accordance with any DHH issued companion and reporting guide(s). As per 42 CFR §438.242~~(a)(b)(1) (3)~~, the MCO 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, claims, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.

The MCO shall create deliverables which may include documents, manuals, files, plans, and reports 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.

The MCO shall provide DHH with a sample of all reports within forty-five (45) calendar days following the date the Contract is signed.

In the event that there are no instances to report, the MCO shall submit a report so stating.

The MCO shall submit all data ~~As~~ required in~~by~~ 42 CFR §438.604~~(a) and (b), and 42 CFR §438.606~~, including any additional data, documentation, or information relating to the performance of its obligations as required by DHH and ~~the MCO~~ shall certify all submitted data, documents and reports per 42 CFR §438.606. All ~~. The~~ data ~~that~~ reported must be certified includinge~~,~~ but ~~are~~ not limited to, enrollment information, financial reports, encounter data, and other information as specified within the Contract and 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 MCO must submit the certification concurrently with the certified data and documents. DHH will identify specific data that requires certification.

The data shall be certified by one of the following:

- MCO's Chief Executive Officer (CEO);
- MCO's Chief Financial Officer (CFO); or
- An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

The MCO shall provide the necessary data extracts to the DHH or its designee ~~Data Warehouse~~ as required by this contract or specified in one of the MCO Companion Guides.

18.1 Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.106.) The **Medicaid Ownership and Disclosure Form** (Appendix VV) is to be submitted to DHH with the proposal; then resubmitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the MCO's management, ownership or control occurs.

18.2 Information Related to Business Transactions

18.2.1 The MCO shall furnish to DHH and/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.

18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about:

18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and

18.2.3 Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of this request.

18.2.4 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 (5%) percent of the MCO's total operating expenses whichever is greater.

18.3 Report of Transactions with Parties in Interest

18.3.1 The MCO shall report to DHH all "transactions" with a "party in 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.

18.3.2 The MCO shall make the information reported pursuant to Section 18.3.1 available to its members upon reasonable request.

~~**18.3.2**~~**18.3.3** Federally qualified MCOs are exempt from this requirement. DHH may require that the information on business transactions be accompanied by a consolidated financial statement for the MCO and the party in interest.

~~**18.3.3**~~**18.3.4** If the MCO 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.

~~**18.3.4**~~**18.3.5** The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the MCO's business transactions must be reported.

~~**18.3.5**~~**18.3.6** If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.

18.4 Key Staff Reporting

18.4.1 The MCO must submit to the DHH the following staff-related items annually:

18.4.1.1 An updated organization chart complete with the Key Staff 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.

18.4.1.2 A functional organization chart of the key program areas, responsibilities and the areas that report to that position.

18.4.1.3 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.

18.5 Encounter Data

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

18.5.2 DHH may change the Encounter Data Transaction requirements, current specifications are included in the ***MCO Systems Companion Guide***, with ninety (90) calendar days written notice to the MCO. The MCO shall, upon notice from DHH, provide notice of changes to subcontractors.

18.6 Financial Reporting

18.6.1 The MCO shall submit to DHH unaudited quarterly financial statements and an annual audited financial statement, using the required format provided by DHH. Quarterly financial statements shall be submitted no later than sixty (60) days after the close of each calendar quarter. Audited annual statements shall be submitted no later than six (6) months after the close of the MCO's fiscal year.

18.6.2 The financial statements shall be specific to the operations of the MCO rather than to a parent or umbrella organization. Audited annual statements of a parent organization, if available, shall be also submitted.

18.6.3 All financial reporting shall be based on Generally Accepted Accounting Principles (GAAP).

18.6.4 In order to evaluate and monitor the performance and operations of the MCO relative to the provision of specialized behavioral health services, to report to CMS as required for the behavioral health services federal authorities, and to assist in any future actuarial rate development, the MCO shall provide financial and utilization data in a format prescribed and provided by DHH to include, but not be limited to, detailed administrative and service costs broken out by defined Medicaid eligibility group, provider type, and service and utilization reporting inclusive of average lengths of stay and costs per person.

18.7 Information on Persons Convicted of Crimes

The MCO shall furnish DHH information related to any person employed or contracted with the MCO convicted of a criminal offense under a program relating to Medicare (Title XVIII), ~~and~~ Medicaid (Title XIX), and Title XX as set forth in 42 CFR §455.106

and including SCHIP (Title XXI). Failure to comply with this requirement may lead to termination of this Contract.

18.8 Errors

18.8.1 The MCO agrees to prepare complete and accurate reports for submission to DHH. If after preparation and submission, an MCO error is discovered either by the MCO or DHH; the MCO shall correct the error(s) and submit accurate reports as follows:

18.8.1.1 For encounters – In accordance with the timeframes specified in the Contract Monitoring and Sanctions Sections of this RFP.

18.8.1.2 For all reports – Fifteen (15) calendar days from the date of discovery by the MCO or date of written notification by DHH (whichever is earlier). DHH may at its discretion extend the due date if an acceptable plan of correction has been submitted and the MCO can demonstrate to DHH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.

18.8.2 Failure of the MCO to respond within the above specified timeframes may result in a loss of any money due the MCO and the assessment of liquidated damages as provided in Contract Monitoring and Sanctions Sections of this RFP.

18.9 Submission Timeframes

18.9.1 The MCO shall ensure that all required deliverables, which may include documents, manuals, files, plans, and reports, as stated in this RFP, are submitted to DHH in a timely manner for review and approval. The MCO's failure to submit the deliverables as specified may result in the assessment of liquidated damages, as stated in the Contract Monitoring and Sanctions Sections of this RFP.

18.9.2 DHH may, at its discretion, require the MCO to submit additional deliverables both *ad hoc* and recurring. If DHH requests any revisions to the deliverables already submitted, the MCO shall make the changes and re-submit the deliverables, according to the time period and format required by DHH. A sixty (60) day notice will be given on changes to all on-going reports.

18.9.3 Unless otherwise specified in the contract, deadlines for submitting deliverables are as follows:

18.9.3.1 Monthly deliverables shall be submitted no later than the fifteenth (15) calendar day of the following month;

18.9.3.2 Quarterly deliverables shall be submitted by April 30, July 30, October 30, and January 30, for the calendar quarter immediately preceding the due date;

18.9.3.3 Annual reports and files, and other deliverables due annually, shall be submitted within thirty (30) calendar days following the twelfth (12th) month of the contract year; except those annual reports that are specifically exempted from this 30-calendar-day deadline by this Contract. This Contract will specify the due date of any annual report it

exempts from this 30-calendar-day deadline; and

18.9.3.4 If a due date falls on a weekend or State-recognized holiday, deliverables will be due the next business day.

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

18.10 Recurring Reports

The MCO shall prepare and submit deliverables in the report format prescribed by DHH.

18.10.1 A list of recurring deliverable reports is summarized and posted to the DHH webpage for Medicaid MCOs: http://new.dhh.louisiana.gov/index.cfm/page/1700

18.10.2 The DHH webpage indicated above will serve as the definitive source of all required recurring deliverable reports and will be updated by DHH when changes are made as stipulated.

18.11 *Ad Hoc* Reports

18.11.1 The MCO shall prepare and submit any other reports as required and requested by DHH, any of DHH's designees, Legislature and/or CMS, that is related to the MCO's duties and obligations under this Contract. Information considered to be of a proprietary nature shall be clearly identified as such by the MCO at the time of submission.

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

18.12 Pharmacy Reporting

18.12.1 The MCO shall provide reporting specific to the pharmacy program.

18.13 PASRR Reporting

18.13.1 The MCO shall report to DHH indicators relative to individual evaluations on a monthly basis with information available by region, type of placements, results of recommendations, location of individuals and referral sources as outlined in the Behavioral Health Companion Guide.

18.14 Court-Ordered Reporting

The MCO shall comply with all court-ordered reporting requirements currently including but not limited to the *Wells v. Kliebert* and *Chisholm v. Kliebert* cases in the manner determined by DHH.

18.15 Substance Abuse and Mental Health Block Grant Data Collection Requirements

18.15.1 The MCO may be required to provide DHH-OBH reliable and valid data to meet federal reporting requirements for the SAMHSA-funded SABG and MHBG Block Grants for populations and services covered in this contract as detailed in the Behavioral Health Companion Guide.

18.16 Report Submission

18.16.1 For quality measures and administrative measures, MCOs shall use the Quality Reporting Document Architecture – Category III document format that provides a standard structure with which to report aggregated quality measure data.

18.16.2 Reports will be submitted in electronic format as structured data only using Health Level 7 messaging at such time as DHH requests.

18.17 Health Information System Requirements

18.17.1 The MCO shall comply with Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.

18.17.2 The MCO shall collect data on enrollee and provider characteristics as specified by the State, and on all services furnished to enrollees through an encounter data system or other methods as may be specified by the State.

18.17.3 The MCO shall ensure that data received from providers is accurate and complete by:

18.17.3.1 Verifying the accuracy and timeliness of reported data, including data from network providers the MCO, PIHP, or PAHP is compensating on the basis of capitation payments;

18.17.3.2 Screening the data for completeness, logic, and consistency; and

18.17.3.3 Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

18.17.4 The MCO shall make all collected data available to the State and upon request to CMS.

18.18 Transparency Report

18.18.1 The MCO shall designate one staff member to serve as the single point of contact for all Transparency Report requests.

18.18.2 The MCO shall comply with all data requests and independent surveys from LDH or its designee.

18.18.3 The MCO shall comply with all instructions and definitions as disseminated by LDH for transparency reporting.

18.18.3.1 Failure to comply with reporting instructions will require resubmission of data by the MCO to LDH.

18.18.3.2 To validate that the reports are submitted correctly, the MCO may be required to supply its data code upon request of LDH or its designee.

~~**18.16.1.1**~~**18.18.3.3** Repeat deficiencies may subject the MCO to a penalty under Section 20 at the discretion of LDH.

INTENTIONALLY LEFT BLANK

19.0 CONTRACT MONITORING

BHSF will be responsible for the primary oversight of the Contract, including Medicaid policy decision-making and Contract interpretation. As appropriate, BHSF will provide clarification of MCO requirements and Medicaid policy, regulations and procedures and will schedule meetings as necessary with the MCO.

19.1. Contract Personnel

~~**19.1.1.** Liaisons~~

~~**19.1.2.**~~

~~**19.1.3.**~~**19.1.1.** The Contract Compliance Officer, described in Section 4.2.10, shall facilitate the establishment and maintenance of direct relationships between LDH business owners and MCO employees with corresponding responsibilities for the duration of the Contract. The Contract Compliance Officer shall introduce MCO employees newly placed in a position relevant to the duties of an LDH business owner within five (5) business days of the placement. ~~MCO shall designate an employee of its administrative staff to act as the primary liaison between the MCO and DHH for the duration of the Contract. DHH's Medicaid Managed Care Section will be MCO's principal 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 MCO shall also designate a member of its senior management who shall act as a liaison between the MCO'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.~~

~~**19.1.4.**~~**19.1.2. Contract Monitor**

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

Medicaid Health Plan Relations
Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th St., 7th floor
Baton Rouge, LA 70821

19.2. 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 or email 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 Bureau of Health Services Financing
Medicaid Health Plan Relations Director
628 North 4th St., 7th floor
Baton Rouge, LA 70821

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 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 to provide written notice to the MCO, such notice will be signed by the Medicaid Director or his/her designee

19.3. Notification of MCO Policies and Procedures

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

19.4. Required Submissions

Within thirty (30) calendar days from the date the Contract is signed by the MCO, the MCO 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 MCO's responsibilities under the terms of the Contract. Refer to Appendix JJ, **Transition Requirements** for a listing of submission requirements.

19.5. Readiness Review Prior to Operations Start Date

DHH will assess the performance of the selected MCOs prior to and after the begin date for operations in accordance with 42 CFR §438.66(d). DHH will start at least three (3) months prior and complete readiness reviews of MCOs prior to implementation. This includes evaluation of all MCOs' program components including IT, administrative services and medical management. Each readiness review for entities that did not contract with DHH as a prepaid entity will be performed on site at the MCO's Louisiana administrative offices. Refer to Appendix JJ, **Transition Period Requirements**. Readiness reviews for entities that were previously contracted with DHH to serve as prepaid entities will be conducted via desk audit.

The results of the Readiness Review will be submitted to CMS by LDH for CMS to make a determination that the contract or associated contract amendment is approved under 42 CFR §438.3(a).

19.5.1. Specialized Behavioral Health Implementation

DHH shall conduct a readiness review with each MCO prior to specialized behavioral health integration. The purpose of the readiness review is to demonstrate each plan's ability to provide covered specialized behavioral health

benefits and services to all assigned members. The review may consist of a desk review of policies and implementation plans, as well as, an onsite review for follow up and demonstration. Work plans, policies and capacities to be addressed may include but are not limited to:

- tasks, activities and timelines for transition
- member outreach and communication;
- member services and provisions for continuing all management and administrative services;
- plan to review authorizations;
- provider transition which shall include provider outreach;
- a dedicated plan for transitioning high risk/high need populations;
- MCO staffing and training plan;
- reporting readiness including CMS required reports;
- acceptance into its system any and all necessary data files and information available from DHH;
- assurances that member services are not interrupted or delayed during the transition;
- demonstrate its system capabilities and adherence to contract specifications during readiness review;
- systems edit review;
- proof of required staffing plan;
- hiring plan if not fully staffed and organizational charts for approval;
- proof of network adequacy;
- operations readiness;
- appropriate HIPAA and 42 CFR requirements are in place; and
- provider readiness review by MCOs

19.6. Ongoing Contract Monitoring

DHH will monitor the MCO's performance to assure the MCO is in compliance with the Contract provisions. However this does not relieve the MCO of its responsibility to continuously monitor its providers' performance in compliance with the Contract provisions.

19.6.1. DHH or its designee shall coordinate with the MCO to establish the scope of review, the review site, if on site, relevant time frames for obtaining information, and the criteria for review.

19.6.2. DHH or its designee will monitor the operation of the MCO for compliance with the provisions of this Contract, and applicable federal and state laws and regulations. Inspection may include the MCO's facilities, as well as auditing and/or review of all records developed under this Contract including, but not

limited to, periodic medical 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.

19.6.3. The MCO shall provide access to documentation, medical records, premises, and staff as deemed necessary by DHH.

19.6.4. The MCO 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 MCO 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.

19.7. MCO On-Site Reviews

DHH will conduct on-site readiness reviews for entities that did not contract with DHH previously as prepaid entities prior to member enrollment under this contract and as an ongoing activity during the Contract period. The MCO's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of MCO 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
- PCP assignments and changes
- Enrollee grievances and appeals
- Health education and promotion
- Quality improvement
- Utilization review
- Data reporting
- Coordination of care
- Claims processing
- Encounter data
- Fraud and abuse

DHH will assess and communicate feedback on overall plan performance through routine meetings with MCO leadership, including but not limited to:

- ~~Weekly~~ Monthly in person or telephonic meetings between the Medicaid Director, Medicaid Deputy Director responsible for Bayou Health, and MCO Administrator/CEO.
- Quarterly Business Reviews wherein MCO leadership present to DHH leadership on overall MCO performance relative to DHH goals and requirements of the Contract. The reviews will take place in person at DHH headquarters on a schedule determined by DHH. DHH will notify the MCO of the schedule and any format or content requirements at (30) days prior to the Review date. Unless otherwise specified by DHH, in person attendance by key staff as follows is mandatory:
    - Administrator/Chief Executive Officer (CEO);
    - Medical Director/Chief Medical Officer;
    - Behavioral Health Medical Director;
    - Chief Operating Officer (COO);
    - Chief Financial Officer/CFO;
    - Quality Management Coordinator;
    - Provider Services Manager;
    - Case Management Administrator/Manager; and
    - Other staff as designated by DHH based on content.

Monthly combined meetings of all contracted MCOs with the Medicaid Deputy Director responsible for Bayou Health and key DHH program staff will be held in person at DHH headquarters to discuss program updates and issues, options for resolution, and action steps for implementation. Depending on the agenda, MCO staff required to attend, may vary at the discretion of DHH. Unless otherwise excused by the Deputy Director, the attendance by the following key staff is mandatory:

- Administrator/Chief Executive Officer (CEO);
- Chief Financial Officer/CFO;
- Chief Operating Officer (COO); and
- Other staff as designated by DHH based on content.

INTENTIONALLY LEFT BLANK

20.0 CONTRACT NON-COMPLIANCE

When DHH identifies that the MCO is not compliant with the terms of the contract, DHH may pursue administrative actions, corrective action plans, and/or monetary penalties.

20.1. Administrative Actions

20.1.1. Administrative actions exclude monetary penalties, corrective action plans, intermediate sanctions and termination and include, but are not limited to:

- A warning through written notice or consultation;
- Education requirement regarding program policies and procedures;
- Review of MCO business processes;
- Referral to the Louisiana Department of Insurance for investigation;
- Referral for review by appropriate professional organizations; ~~and/or~~
- Referral to the Office of the Attorney General for fraud investigation; and/or~~.~~
- Exclusion from Automatic Assignment – LDH may exclude the MCO from any or all components of the automatic assignment process described in Section 11 for the duration of the noncompliance or thirty calendar days, at the discretion of LDH. During this period of exclusion, members shall be automatically assigned under the terms of Section 11 as if the excluded MCO were not a participant in the assignment process. Upon determining that the noncompliance has been satisfactorily cured and the thirty-day minimum exclusion period has lapsed, LDH shall return the MCO to the assignment process but shall not take any action to return the MCO to the position it would have been in had it not been excluded.

20.2. Corrective Action Plans (CAP)

20.2.1. DHH may require the MCO to develop a Corrective Action Plan that includes the steps to be taken by the MCO to obtain compliance with the terms of the contract.

20.2.2. DHH shall approve and monitor implementation of the CAP through available reporting resources, on-site evaluations, or requested status reports.

20.2.3. The CAP must include a timeframe for anticipated compliance and a date certain for the correction of the occurrence.

20.2.4. DHH may impose monetary penalties if the terms of the CAP are not met. Monetary penalties will continue until satisfactory correction of the occurrence has been made as determined by DHH.

20.3. Monetary Penalties

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.

20.3.1. 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 MCO'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 MCO in attempting to stay in compliance.

20.3.2. For purposes of this Section, violations involving different individual, unrelated enrollees shall not be considered as arising out of the same action.

20.3.3. The Table of Monetary Penalties, below, specifies permissible monetary penalties for certain violations of the contract. For any violation not explicitly described in the table, LDH may impose a monetary penalty of up to $5,000 per occurrence per calendar day.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Operations Start Date	Ten thousand dollars ($10,000.00) per calendar day for each day beyond the Operations Start Date that the MCO is not operational until the day that the MCO is operational, including all systems.
Provider Registry Accuracy	Two thousand dollars ($2,000) per calendar day for each day for that one or more non-contracted providers remain listed as contracted in the Electronic Provider Registry submitted by the MCO.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
System Readiness Review Contingency Plan • Disaster Recovery Plan • Business Continuity Plan • Systems Quality Assurance Plan	MCO must submit to DHH or the Readiness Review Contractor the subject plans no later than 30 days after the announcement of recommendation of contract award. One thousand ($1,000.00) per calendar day for each day a deliverable is late, inaccurate, or incomplete.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
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 MCO 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 MCO, 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 medical record review by DHH or its designee where the MCO 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 MCO members have begun to permit time for development and implementation of a system for exchanging data and training of staff and health care providers.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Pharmacy Claims Data At the request of DHH or its fiscal intermediary, plans shall submit pharmacy claims information in an electronic format that is suited to allow for integration with the State's pharmacy rebate program. DHH shall establish the frequency of these information requests, and the plans shall comply. The pharmacy rebate process is a quarterly process and claims information is usually required before the end of the month that follows the end of the quarter.	The MCO may be subject to a sanction of $10,000 per calendar day for each day the information is late; or incomplete, deficient and/or inaccurate until the information has been submitted and accepted by DHH as complete, accurate and containing no deficiencies.
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 MCO shall pay providers interest at 12% per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid the same date that the claim is paid.	Five thousand dollars ($5,000.00) for the each month that an MCO's claims performance percentages by claim type fall below the performance standard. Twenty-five thousand dollars ($25,000.00) for each additional month that the claims performance percentages by claim type, by MCO fall below the performance standards. One thousand dollars ($1,000.00) per claim if the MCO fails to timely pay interest.
Claims Summary Report	One thousand dollars ($1,000.00) per calendar day the report is late, inaccurate, or incomplete.
Incentive Based Performance Measure	Amounts withheld for MCO Incentive Based Performance Measure outcomes may be permanently retained upon validation of calculated rate by DHH's contracted external quality review organization.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
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 *MCO Quality Companion Guide*.
Member Services Activities	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.
Member Call Center • Operate a member call center 24/7 • Answer 95% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5% • No more than 1% of incoming calls receive a busy signal	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. One hundred dollars ($100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period per MCO. One hundred dollars ($100.00) for each 30 second time increment, or portion thereof, by which the MCOs average hold time exceeds the maximum acceptable hold time per MCO.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Provider ~~Demographics~~Directory	~~Fifteen~~ Fifty thousand dollars ($~~1~~50,000.00) per audit conducted by LDH wherein the MCO is found to have not ~~calendar day for failure to provide and validate~~ maintained an accuracy rate of at least 90%. ~~provider demographic data on a semi-annual basis to ensure current, accurate, and clean data is on file for all contracted providers~~ One thousand dollars ($1,000) per calendar day for failure to correct inaccurate provider directory data within 14 days of notification by LDH.
Provider Service Activities	Fifteen thousand dollars ($15,000.00) 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. Fifteen thousand dollars ($15,000.00) per calendar day for failure to furnish provider services functions from 7 a.m. to 7 p.m. Central Time, Monday through Friday to address non-emergency issues encountered by providers.
Provider Call Center • Operate a provider call center 24/7 • Answer 95% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5% • No more than 1% of incoming calls receive a busy signal	One hundred dollars ($100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period per MCO. One hundred dollars ($100.00) for each thirty (30) second time increment, or portion thereof, by which the MCOs average hold time exceeds the maximum acceptable hold time per MCO.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Covered Services	Failure to provide a MCO 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. Fifteen thousand dollars ($15,000.00) per calendar day for each incident of non-compliance per MCO.
Appropriate Care Alternatives for Inpatients	One thousand dollars ($1,000) for each incident of non-compliance with Section 8.4.3 wherein the MCO denies continuation of higher level services (*e.g.,* inpatient hospital) for failure to meet medical necessity when the service can be provided through an in-network or out-of-network provider for a lower level of care.
Appropriate Care Alternatives for Members in a TGH or PRTF	One thousand dollars ($1,000) for each incident of non-compliance with Section 6.30.3 wherein the MCO denies continuation of higher level services (e.g., TGH or PRFT) for failure to meet medical necessity when the service can be provided through an in-network or out-of-network provider for a lower level of care.
Management Information System	In the event of a declared major failure or disaster, the MCO'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. Fifteen thousand dollars ($15,000.00) per calendar day of non-compliance per MCO.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**PENALTY**
Emergency Management Plan	Ten thousand dollars ($10,000.00) per calendar day for each day the Emergency Management Plan as specified in this RFP is received after the due date or up to one hundred thousand dollars ($100,000) for failure to submit timely. However DHH may assess an additional two hundred thousand dollars ($200,000) for failure to submit the plan prior to the beginning of the Atlantic hurricane season (June 1st).
Termination Transition Plan	Failure to submit 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 Ten thousand dollars ($10,000.00) per calendar day the plan is late, inaccurate, or incomplete.
Standing and *Ad Hoc* Reports	Two thousand dollars ($2,000.00) per calendar day that a report is late or incorrect.
Annual Recertification for Adult Mental Health Rehabilitation Services Failure to complete greater than or equal to 95% of annual recertifications for Adult mental health rehabilitation services within 365 days of most recent certification.	Ten thousand dollars ($10,000) per month when MCO's performance is below 95%.
PASRR Within 4 working days or receipt of referral, the MCO will submit a completed Level II evaluation to DHH-OBH.	Five thousand dollars ($5,000) per month when MCO performance for this indicator is below 95% of the total within that month.

~~20.3.3.~~20.3.4. DHH shall utilize the following guidelines to determine whether a report is correct and complete:

~~20.3.3.1.~~20.3.4.1. The report must contain 100% of the MCO's data; and

~~20.3.3.2.~~20.3.4.2. 99% of the required items for the report must be completed; and

~~20.3.3.3.~~20.3.4.3. 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DHH.

~~25.1 Other Reporting and/or Deliverable Requirements~~

~~25.1.1 For each day that a deliverable is late, incorrect or deficient, the MCO 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 expressly written elsewhere in this Contract.~~

~~25.1.2 Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Contract.~~

~~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~~

20.4. Employment of Key and Licensed Personnel

20.4.1. A penalty of seven hundred dollars ($700.00) per calendar day shall be imposed for failure to have a full-time acting or permanent Administrator/CEO for more than seven (7) consecutive calendar days for each day the Administrator/CEO has not been appointed;

20.4.2. A penalty of seven hundred dollars ($ 700.00) per calendar day shall be imposed for failure to have a full-time acting or permanent Medical Director OR Behavioral Health Medical Director for more than seven (7) consecutive calendar days for each day the medical director has not been appointed.

20.4.3. A penalty of two hundred fifty dollars ($250.00) per calendar day shall be imposed for each day that personnel are not licensed as required by applicable state and federal laws and/or regulations.

20.5. Excessive Reversals on Appeal

A penalty of twenty-five thousand dollars ($25,000.00) shall be imposed for exceeding ten percent (10%) member appeals over a twelve month period (January-December or the first twelve months that the Contract is in effect) which have been overturned in a final appeal outcome for each occurrence over 10%; or for each occurrence in which the MCO does not provide the medical services or requirements set forth in a final outcome of the administrative decision by DHH or the appeals decision of the State Fair Hearing.

20.6. Marketing and Member Education Violations

20.6.1. Whenever DHH determines that the MCO or any of its agents, subcontractors, volunteers or providers has engaged in any unfair, deceptive, or prohibited marketing or member education practices in connection with proposing, offering, selling, soliciting, and providing any health care services, one or more of the remedial actions as specified in Section 20.8 shall apply.

20.6.2. Unfair, deceptive, or prohibited marketing practices shall include, but are not limited to:

- Failure to secure written approval before distributing marketing or member materials;
- Failure to secure written approval for events where marketing or member materials may be distributed;
- Engaging in, encouraging or facilitating prohibited marketing by a provider;
- Directly marketing to enrollees or potential enrollees;
- Failure to meet time requirements for communication with new members (distribution of welcome packets, welcome calls);
- Failure to provide interpretation services or make materials available in required languages;
- Engaging in any of the prohibited marketing and member education practices detailed in this RFP;
- 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 MCO potential enrollees or enrollees with respect to any health care services, MCO or health care provider; or the DHH Bayou Health Program;
- Representation that an MCO or network provider offers any service, benefit, access to care, or choice which it does not have;
- Representation that an MCO or health care provider has any status, certification, qualification, sponsorship, affiliation, or licensure which it does not have;
- Failure to state a material fact if the failure deceives or tends to deceive;
- Offering any kickback, bribe, award, or benefit to any Medicaid eligible as an inducement to select, or to refrain from selecting any health care service, MCO, or health care provider, unless the benefit offered is medically necessary health care; and

- Use of the Medicaid eligible's or another 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:
    - Medical records information;
    - 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; and
    - Use of any device or artifice in advertising an MCO or soliciting a Medicaid eligible which misrepresents the solicitor's profession, status, affiliation, or mission.

20.6.2.1. In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which the MCO represents or agrees that it will not contract with another provider. The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

20.6.2.2. If DHH determines the MCO or its subcontractors has steered potential members to join the MCO, DHH may impose the following sanctions:

- The member(s) shall be disenrolled from the MCO at the earliest effective date allowed;
- PMPMs for the months(s) the member(s) was enrolled in the MCO will be recouped;
- The MCO shall be assessed an additional $5,000 monetary sanction per member; and
- The MCO shall submit a letter to each member notifying the member of the imposed sanction and of their right to choose another MCO.

20.6.2.3. If DHH determines the MCO has violated any of the marketing and/or outreach activities outlined in the Contract, the MCO may be subject to remedial sanctions specified in Section 20.8 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.

20.7. Remedial Action(s) for Marketing Violations

20.7.1. DHH shall notify the MCO 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 MCO must perform;

20.7.2. DHH may require the MCO to recall the previously authorized marketing material(s);

20.7.3. DHH may suspend enrollment of new members to the MCO for an amount of time specified by DHH;

20.7.4. DHH may deduct the amount of capitation payment for members enrolled as a result of non-compliant marketing practices from the next monthly capitation payment made to the MCO and shall continue to deduct such payment until correction of the failure;

20.7.5. DHH may require the MCO to contact each member who enrolled during the period while the MCO was out of compliance, in order to explain the nature of the non-compliance and inform the member of his or her right to transfer to another MCO; or

20.7.6. DHH may prohibit future marketing activities by the MCO for an amount of time specified by DHH.

20.8. Cost Avoidance Requirements

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

20.9. Failure to Provide Core Benefits and Services

In the event that DHH determines that the MCO failed to provide one or more core benefits and services, DHH shall direct the MCO to provide such service. If the MCO continues to refuse to provide the core benefit or service(s), DHH shall authorize the members to obtain the covered service from another source and shall notify the MCO in writing that the MCO shall be charged the actual amount of the cost of such service. In such event, the charges to the MCO shall be obtained by DHH in the form of deductions of that amount from the next monthly capitation payment made to the MCO or a future payment as determined by DHH. 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.

20.10. Failure to Maintain an Adequate Network of Contract Providers

In the event that DHH determines that the MCO: (1) failed to maintain an adequate network of mandatory contract provider types as specified in Section 7 of this RFP, (2) failed to comply with the requirement to make three documented attempts to contract with the provider, or (3) failed to pay for medically necessary services to a non-network provider as required, a monetary penalty of up to $10,000 per incident may be assessed.

20.11. Failure to Have Subject Appropriate Staff Member(s) Attend Onsite Meeting

In the event that DHH determines that the MCO failed to provide subject appropriate staff member(s) to attend an onsite meeting, and their onsite absence jeopardizes the smooth and efficient operation of the Bayou Health Program, a monetary penalty of up to $1,000 per appropriate staff person per meeting may be assessed.

INTENTIONALLY LEFT BLANK

21.0 INTERMEDIATE SANCTIONS

21.1 Acts or Failures to Act Subject to Intermediate Sanctions

Pursuant to 42 CFR §438.700, et seq., DHH may impose on the MCO intermediate sanctions if it determines that an MCO acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under the Contract, to a member covered under the Contract;

- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid MCO Program;

- Acts to discriminate among members on the basis of their health status or need for health care services; this includes termination of enrollment or refusal to reenroll a member, except as permitted in Section 11.12.2 or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.

- Misrepresents or falsifies information that it furnishes to CMS or to DHH;

- Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider;

- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §422.208 and §422.210;

- 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

- 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.

21.2. Other Misconduct Subject to Intermediate Sanctions

DHH also may impose sanctions against any MCO if it finds any of the following non-exclusive actions/occurrences:

- The MCO has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH;

- The MCO has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;

- The MCO 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 MCO's member;

- The MCO 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;

- The MCO 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;

- The MCO has rebated or accepted a fee or portion of fee or charge for a patient referral;

- The MCO has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

- The MCO has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

- The MCO has failed to furnish any information requested by DHH regarding payments for providing goods or services;

- The MCO 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;

- The MCO has furnished goods or services to a member which at the sole discretion of DHH, and based on competent medical 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.

21.3. Sanction Types

The types of intermediate sanctions that DHH may impose on the MCO shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §438.702-708 and may include any of the following:

- Civil monetary penalties in the amounts specified in 42 CFR §438.704

- Appointment of temporary management for an MCO as provided in 42 CFR §438.706;

- Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

- Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction;

- 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 in accordance with 42 CFR §438.730; and

- Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

- DHH may require the MCO to develop a Corrective Action Plan, as described in Section 20.2, to address areas of non-compliance subject to intermediate sanctions.

- Except as provided in Section 21.6.3 before imposing any intermediate sanctions, DHH shall give the MCO timely written notice that explains the basis and nature of the sanction and any other due process protections.

21.4. Notice to CMS

DHH will give the CMS Regional Office written notice whenever it imposes or lifts an intermediate sanction for one of the violations listed in 42 CFR §438.700, specifying the affected MCO, 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.

21.5. Payment of Monetary Penalties and Sanctions

21.5.1. Monetary penalties or sanctions assessed by DHH that cannot be collected through the withhold specified in Section 5.3 shall be due and payable to DHH within thirty (30) calendar days after the MCO's receipt of the notice of monetary penalties or sanctions.

21.5.2. In the event an appeal by the MCO results in a decision in favor of the MCO, the amount specified in the decision will be returned to the MCO.

21.5.3. DHH has the right to recovery of any amounts overpaid as the result of deceptive practices by the MCO and/or its contractors, and may consider trebled damages, civil penalties, and/or other remedial measures.

21.5.4. A monetary penalty or sanction may be applied to all known affiliates, subsidiaries and parents of an MCO, 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 MCO 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.

21.6. Termination of MCO Contract

21.6.1. Nothing in this Section shall limit DHH's right to terminate the Contract or to pursue any other legal or equitable remedies.

21.6.2. Pursuant to 42 CFR §438.708, DHH may terminate the Contract and enroll that MCO's members in other MCOs or provide their benefits through other options included in the state plan if DHH, at its sole discretion, determines that the MCO has failed to: (1) carry out the substantive terms of the Contract, or (2) meet applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

21.6.3. DHH will provide the MCO with a timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the penalty or sanction and pre-termination hearing rights.

21.6.4. The termination will be effective no less than thirty (30) calendar days from the date of the Notice of Intent to Terminate. The MCO may, at the discretion of DHH, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

21.6.5. In accordance with 42 CFR §438.710, DHH will conduct a pre-termination hearing upon the request of the MCO as outlined in the Notice to provide MCO the opportunity to contest the nature and basis of the sanction.

21.6.5.1. The request must be submitted in writing to the Undersecretary prior to the determined date of termination stated in the Notice.

21.6.5.2. The MCO shall receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

21.6.6. The decision by the DHH Undersecretary shall be final and La. R.S. 49:950-999.25, the Administrative Procedure Act, does not apply. The Notice of Termination will state the effective date of termination.

21.6.7. DHH will notify the Medicaid members enrolled in the MCO in writing, consistent with 42 CFR §438.710 and §438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately without cause.

21.7. Payment of Outstanding Monies or Collections from MCO

The MCO will be paid for any outstanding monies due less any assessed monetary penalties or sanctions. If monetary penalties exceed monies due, collection can be made from the MCO Fidelity Bond, Performance Bond, Retainage, Errors and Omissions Insurance, or any insurance policy or policies required under this Contract. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

21.8. Provider Sanctions

Nothing contained herein shall prohibit DHH from imposing sanctions, including civil monetary penalties, license revocation and Medicaid termination, upon a health care provider for its violations of federal or state law, rule, or regulations.

21.9. Independent Assurances

When required by DHH, the contractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

21.9.1. These audits will require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the independent audit. The audit firm will submit to the State

Agency and/or Contractor a final report on controls placed in operations for the project and includes a detailed description of the audit firm's tests of the operating effectiveness of controls.

21.9.2. The Contractor shall supply the Department with an exact copy of the report within thirty (30) calendar days of completion. When required by Office of Public Health, such audits may be performed annually during the term of the contract. The Contractor shall agree to implement recommendations as suggested by the audits within three months of report issuance at no cost to the State. If cost of the audit is to be borne by the Contractor, it was included in the response to the RFP.

INTENTIONALLY LEFT BLANK

22.0 PROPOSAL AND EVALUATION

22.1. General Information

This Section outlines the provisions which govern determination of compliance of each proposer's response to the RFP.

22.1.1. DHH shall determine, at its sole discretion, whether or not the requirements have been reasonably met.

22.1.2. Omissions of required information shall be grounds for rejection of the proposal by DHH.

22.2. Blackout Period

The Blackout Period is a specified period of time during a competitive sealed procurement process in which any proposer, bidder, or its agent or representative, is prohibited from communicating with any state employee or contractor of the State involved in any step in the procurement process about the affected procurement. The Blackout Period applies not only to state employees, but also to any contractor of the State. “Involvement” in the procurement process includes but may not be limited to project management, design, development, implementation, procurement management, development of specifications, and evaluation of proposals for a particular procurement. All solicitations for competitive sealed procurements will identify a designated contact person. All communications to and from potential proposers, bidders, vendors and/or their representatives during the Blackout Period must be in accordance with this solicitation’s defined method of communication with the designated contact person. The Blackout Period will begin upon posting of the solicitation. The Blackout Period will end when the contract is awarded.

In those instances in which a prospective vendor is also an incumbent vendor, the State and the incumbent vendor may contact each other with respect to the existing contract only. Under no circumstances may the State and the incumbent vendor and/or its representative(s) discuss the blacked-out procurement.

Any bidder, proposer, or state contractor who violates the Blackout Period may be liable to the State in damages and/or subject to any other remedy allowed by law.

Any costs associated with cancellation or termination will be the responsibility of the proposer or bidder.

Notwithstanding the foregoing, the Blackout Period shall not apply to:

- A protest to a solicitation submitted pursuant to La. R.S. 39:1671 or LAC 34:V.145.A.8;
- Duly noticed site visits and/or conferences for bidders or proposers;
- Oral presentations during the evaluation process; and
- Communications regarding a particular solicitation between any person and staff of the procuring agency provided the communication is limited strictly to matters of procedure. Procedural matters include deadlines for decisions or submission of proposals and the proper means of communicating regarding the procurement, but

shall not include any substantive matter related to the particular procurement or requirements of the RFP.

22.3. Rejection and Cancellation

22.3.1. Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts. The Department reserves the right to reject all proposals received in response to this solicitation.

22.3.2. In accordance with the provisions of R.S. 39:2182, 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 laws governing public contracts under the provisions of Chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950, professional, personal, consulting, and social services procurement under the provisions of Chapter 16 of this Title, or the Louisiana Procurement Code under the provisions of Chapter 17 of this Title.

22.4. 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 a contract. The Louisiana Board of Ethics is the only entity which can officially rule on ethics issues. Each proposal must include 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.

22.5. Award Without Discussion

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

22.6. 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 shall be included in the proposal. In addition, written commitments from any subcontractors or joint ventures shall be included as part of the proposal. All assignments must be approved by DHH.

22.7. Proposer Prohibition

A proposer shall not submit multiple proposals in different forms. This restriction does not prohibit different proposers from offering the same subcontractor as a part of their proposals, provided that the subcontractor does not also submit a proposal as a prime contractor and the subcontractor has the capacity to provide services as a subcontractor to two prime contractors.

22.8. Determination of Responsibility

22.8.1. Determination of the proposer's responsibility relating to this RFP shall be made according to the standards set forth in LAC 34:V.136. The State must find that the selected proposer:

22.8.1.1. Has adequate financial resources for performance, or has the ability to obtain such resources as required during performance;

22.8.1.2. Has the necessary experience, organization, technical qualifications, skills, and facilities, or has the ability to obtain them;

22.8.1.3. Is able to comply with the proposed or required time of delivery or performance schedule; Has a satisfactory record of integrity, judgment, and performance; and

22.8.1.4. Is otherwise qualified and eligible to receive an award under applicable laws and regulations.

22.8.2. Proposers should ensure that their proposals contain sufficient information for the State to make its determination by presenting acceptable evidence of the above to perform the contracted services.

22.9. 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.

22.10. Ownership of Proposal

All proposals become the property of DHH and will not be returned to the proposer. DHH 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.

22.11. Procurement Library/Resources Available To Proposer

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

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

http://www.makingmedicaidbetter.com; and

http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/dspBid.cfm?search=department&term=4 (official site)

22.11.2. Potential proposers may receive historical Medicaid claims data at the parish of residence level for SFY 12 and SFY 13 for MCO core benefits and services as well as pharmacy data, for mandatory and voluntary MCO populations under the following conditions:

22.11.2.1. Submit the non-binding Letter of Intent to Propose to the RFP Coordinator;

22.11.2.2. Sign and submit the **MCO Data Use Agreement** (Appendix P) to the RFP Coordinator; and

22.11.2.3. Mail or deliver to the RFP Coordinator listed in Section 1.4 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 from the RFP Coordinator at the DHH Bienville Building, 628 North 4th Street, 5th Floor, Baton Rouge, LA. The storage drive and request for routing should be routed to the RFP Coordinator (See Section 1.4.1).

22.11.2.4. The claims data that is loaded onto the flash drive or hard drive will be password protected. DHH will give the password to the potential proposer by some means separate from the delivery of the flash drive or hard drive, such as by mail, fax, or telephone call.

22.11.2.5. The historical Medicaid claims data will be in SAS7BDAT format.

22.12. Proposal Submission

22.12.1. 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.

22.12.2. The Proposer shall submit one (1) original hard copy and two (2) additional hard copies of each proposal. Two (2) electronic copies of the proposal, each on a separate flash drive or CD(s) shall be submitted. No facsimile or emailed proposals will be accepted. Proposer should provide one electronic copy of the Redacted version (cd or flash drive).

22.12.3. The evaluation team will utilize both the hard copies and the electronic copy to evaluate the proposal. It is the proposer's responsibility to assure that all copies are complete and contain all required components for the evaluation.

22.12.4. 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

22.13. Proprietary and/or Confidential Information

22.13.1. The designation of certain information as trade secrets and/or privileged or confidential proprietary information is applicable to this proposal. Any proposal copyrighted or marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

22.13.2. For the purposes of this RFP, the provisions of the Louisiana Public Records Act (La. R.S. 44:1, et seq.) will be in effect. Pursuant to this Act, all proceedings, records, contracts, and other public documents relating to this RFP shall be open to public inspection. Proposers are reminded that while trade secrets and other proprietary information submitted in conjunction with this RFP may not be subject to public disclosure, protections must be claimed by the proposer at the time of submission of its proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.

22.13.3. The proposer must clearly designate the part of the proposal that contains a trade secret and/or privileged or confidential proprietary information as "confidential" in order to claim protection, if any, from disclosure. The proposer shall mark the cover sheet of the proposal with the following legend, specifying the specific section(s) of the proposal sought to be restricted in accordance with the conditions of the legend: "The data contained in pages _____ of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this proposer as a result of or in connection with the submission of this proposal, the state of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the state of Louisiana's right to use or disclose data obtained from any source, including the proposer, without restrictions."

22.13.4. Further, to protect such data, each page containing such data shall be specifically identified and marked **"CONFIDENTIAL."**

22.13.5. Proposers must be prepared to defend the reasons why the material should be held confidential. If a competing proposer or other person seeks review or copies of another proposer's confidential data, DHH will notify the owner of the asserted data of the request. If the owner of the asserted data does not want the information disclosed, it must take legal action as necessary to restrain DHH from releasing information DHH believes to be public record.

22.13.6. If the proposal contains confidential information, a redacted copy of the proposal must be submitted. If a redacted copy is not submitted, DHH may consider the entire proposal to be public record. When submitting the redacted copy, it should be clearly marked on the cover as - "**REDACTED COPY."** The redacted copy should also state which section(s) or information has been removed.

22.13.7 Any proposal marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse. Additionally, any proposal that fails to follow this sections and/or La. R.S. 44:3.2(D)(1) shall have failed to properly assert the designation of trade secrets and/or privileged or confidential proprietary information and the information may be considered public records.

22.14. 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.

22.15. Proposal Clarifications

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.

22.16. Interpretive Conventions

22.16.1. Whenever the terms "must," or "is required" are used in this RFP in conjunction with a specification or performance requirement, the specification or requirement is mandatory. A proposer's failure to address or meet any mandatory requirement in a proposal may be cause for DHH's rejection of the proposal.

22.16.2. Whenever the terms "can," "may," or "should" are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is a desirable, but not mandatory, requirement. Accordingly, a proposer's failure to address or provide any items so referred to will not be the cause for rejection of the proposal, but will likely result in a less favorable evaluation.

22.17. Proposal Content

22.17.1. The proposal shall address all requirements listed in Appendix KK **MCO Proposal Submission and Evaluation Requirements** of this RFP and should provide, in sequence, the information and documentation as required. The Proposer shall also complete the form provided in Appendix KK and include the completed form as the table of contents of the proposal.

22.17.2. 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.

22.17.3. 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, as outlined in the RFP.

22.17.4. The Proposer may not submit the Proposer's own contract terms and conditions or other requirements in a response to this RFP.

22.17.5. The Proposer must submit an original, signed Certification Statement (see Appendix A). The signed Certification Statement should be included in your response to Part I: Mandatory Requirements Section A.1. (see Appendix KK).

22.18. Proposal Format

22.18.1. Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and should be typed on standard 8 1/2" x 11" paper with recommended margins of one inch. It should be single spaced with text no smaller than 11-point font; pages may be single sided or double sided. All proposal pages should be numbered and identified with the Proposer's name. Materials should be sequentially filed in three ring binders no larger than three inches in thickness.

22.18.2. The specific requirements and for making a Proposal in response to this RFP are detailed in **Appendix KK – MCO Proposal Submission and Evaluation Requirements**.

22.18.3. All information included in a Proposal should be relevant to a specific requirement detailed in the RFP and Appendix KK. All information should be incorporated into a response to a specific requirement and clearly referenced.

22.18.4. The Proposer should duplicate the Appendix KK ***MCO Proposal Submission and Evaluation Requirements*** form and use as the Table of Contents of each binder. The response to each Part and Section should be clearly labeled and tabbed.

22.18.5. The response to the **Appendix KK Part I. Mandatory Requirements** must be in a separate binder and clearly labeled. The response to Appendix KK Part II. Financial Requirements must be in a separate binder and clearly labeled. The response to Appendix KK Part IX. Veteran Initiative and Hudson Initiative must be in a separate binder and clearly labeled.

22.18.6. The response Parts III. through X. can be in the same binder or multiple binders as needed, but each Part and Section should be separated by an appropriately labeled tab.

22.18.7. Attachments should only be provided as requested in the ***MCO Proposal Submission and Evaluation Requirements*** and should be clearly labeled, including the Section number from the Requirements. Any information not meeting these criteria will be deemed extraneous.

22.19. Evaluation Criteria

The following criteria will be used to evaluate proposals:

22.19.1. The DHH Proposal Review Team will be comprised of state employees.

22.19.2. Proposal Review Team members will be required to sign disclosure forms to establish that they have no personal or financial interest in the outcome of the proposal review and contractor selection process.

22.19.3. Each Proposal Evaluation Team member shall evaluate each proposal against the evaluation criteria in this RFP as specified in Appendix KK, rather than against other proposals, and scoring will be done by consensus of the PRT assigned to each Section.

22.19.4. Proposals containing assumptions, lack of sufficient detail, poor organization, lack of proofreading and unnecessary use of self-promotional claims will be evaluated accordingly.

22.19.5. DHH reserves the right, at its sole discretion, to request Proposer clarification of a Proposal provision or to conduct clarification discussions with any or all Proposers. Any such clarification or discussion shall be limited to specific Sections of the proposal identified by DHH. The subject Proposer shall put any resulting clarification in writing as may be required by DHH.

22.19.6. DHH reserves the right, at its sole discretion, to conduct its own research and/or consult with contracted subject matter experts in order to verify and assess the information presented.

22.19.7. Scoring will be based on a possible total of 1,000-points, and the three (3) to five (5) proposals with the highest total scores may be recommended for award.

22.20 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.

22.21 Withdrawal of Proposal

A proposer may withdraw a proposal that has been submitted at any time up to the date and time the proposal is due. To accomplish this, a written request signed by the authorized representative of the proposer must be submitted to the RFP Coordinator.

INTENTIONALLY LEFT BLANK

23.0 EVALUATION CATEGORIES AND MAXIMUM POINTS

In the evaluation of proposals, DHH will consider each of the factors in the table below, which shows the maximum points that can be awarded for each category. There will be a maximum of 1,000 points available.

Ten percent (10%) of the total evaluation points for 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 entrepreneurships as subcontractors (see Appendix D.)

Proposer Status and Reserved Points:

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

i. Proposer is a certified small entrepreneurship: Full amount of the reserved points

ii. Proposer is not a certified small entrepreneurship but has engaged one or more certified small entrepreneurships to participate as subcontractors or distributors. Points will be allocated based on the following criteria:

- The number of certified small entrepreneurships to be utilized
- The experience and qualifications of the certified small entrepreneurship(s)
- The anticipated earnings to accrue to the certified small entrepreneurship(s)

Evaluation Components	Possible Points
Part I. Mandatory Requirements	Included/not included
Part II. Financial Requirements	35
Part. III Organizational Requirements	85
Part IV. Provider Network	70
Part V. Member Management	220
Part VI. Marketing and Member Materials	30
Part VII. Quality Management	75
Part VIII. Program Integrity	60
Part IX. Systems and Technical Requirements	100
Part X. Added Value to Louisiana Members and Providers	225
Part XI. Veteran/Hudson Initiative	100
Total Possible Points	**1,000**

23.1 Announcement of Awards

DHH will recommend contract awards to between three and five proposers with the highest graded proposals and that are deemed to be in the best interest of DHH. DHH reserves the right not to award a contract or award fewer than three (3) contracts.

23.2 Notice of Contract Awards

The notice of intended contract award shall be sent by carriers that require signature upon receipt, by fax with voice confirmation, or by email with reply confirmation to the winning proposers. No proposer shall infer or be construed to have any rights or

interest to a contract with DHH until both the proposer and DHH have executed a valid contract and final approval is received from all necessary entities.

23.2.1. The State will notify the successful Proposer and proceed to negotiate terms for final contract. Unsuccessful proposers will be notified in writing accordingly.

23.2.2. The proposals received (except for that information appropriately designated as confidential in accordance with R.S. 44.1 et seq), selection memorandum along with list of criteria used along with the weight assigned each criteria; scores of each proposal considered along with overall scores of each proposal considered, and a narrative justifying selection shall be made available, upon request, to all interested parties after the “Notice of Intent to Award” letter has been issued.

23.2.3. Any Proposer aggrieved by the proposed award has the right to submit a protest in writing to the head of the agency issuing the proposal within 14 days after the award has been announced by the agency.

23.2.4. The award of a contract is subject to the approval of the Division of Administration, Office of Contractual Review.

INTENTIONALLY LEFT BLANK

24.0 TURNOVER REQUIREMENTS

24.1 Introduction

Turnover is defined as those activities that the MCO is required to perform upon termination of the Contract in situations in which the MCO must transition contract operations to DHH or a third party. The turnover requirements in this Section are applicable upon any termination of the Contract 1) initiated by the MCO, 2) initiated by DHH, or 3) at the expiration of the Contract period and any extensions.

24.2 General Turnover Requirements

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

24.2.1. Comply with all terms and conditions stipulated in the Contract, including continuation of core benefits and services under the Contract, until the termination effective date;

24.2.2. Promptly supply all information necessary for the reimbursement of any outstanding claims; and

24.2.3. 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.

24.3. Turnover Plan

24.3.1. In the event of written notification of termination of the Contract by either party, the MCO shall submit a Turnover Plan within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the MCO and DHH. The Plan shall address the turnover of records and information maintained by the MCO relative to core benefits and services provided to Medicaid members. 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.

24.3.2. If the Contract is not terminated by written notification as provided in 22.3.1 above, the MCO 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.

24.3.3. As part of the Turnover Plan, the MCO must provide DHH with copies of all relevant member and core benefits and services data, documentation, or other pertinent information necessary, as determined by DHH, for DHH or a subsequent MCO to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan will describe the MCO'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.

24.4. Transfer of Data

The MCO shall transfer all data regarding the provision of member core 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.

All relevant data must be received and verified by DHH or the subsequent MCO. If DHH determines that not all of the data regarding the provision of member core benefits and services to members was transferred to DHH or the subsequent MCO, 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 MCO.

24.5. Post-Turnover Services

Thirty (30) days following turnover of operations, the MCO 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.

If the MCO does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for DHH or the subsequent MCO to assume the operational activities successfully, the MCO 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.

The MCO also must pay any and all additional costs incurred by DHH that are the result of the MCO's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

The MCO must maintain all files and records related to members and providers for six (6) 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 MCO agrees to repay any valid, undisputed audit exceptions taken by DHH in any audit of the Contract.

24.6. Transition to Managed Long-Term Supports and Services

It is the state's intent to enter into a managed care contract(s) which shall offer holistic healthcare to dual eligible members and members requiring long-term supports and services, including behavioral health services. The MCO shall cooperate with any transition of populations or services to other healthcare delivery systems.

The MCO shall be responsible for coordinating with the new contractor for any records or service management data required for the transition of members and services to and from the new contractor's systems and care management.

Transitions may result in the loss of Per Member Per Month (PMPM) payments to the MCO for members transitioning out of the Bayou Health into the new system of care for long-term supports and services and may result in adjustments to the monthly capitated rate in order to maintain an actuarially sound rate range.

The MCO shall adhere to all transition requirements provided by DHH upon implementation of any new managed care contract(s).

INTENTIONALLY LEFT BLANK

25.0 TERMS AND CONDITIONS

The Contract effective date is anticipated to be February 1, 2015. DHH reserves the right to revise the anticipated effective date and/or dates of the enrollment phases to a later date. DHH will provide the Contractor sixty (60) days prior notice of such change to provide the Contractor the opportunity to prepare for the on-site Readiness Review.

The term of the contract shall be thirty-six (36) months from the effective date or unless terminated prior to that date in accordance with state or federal law or terms of the Contract.

The MCO shall successfully complete a readiness review as specified in Section 19.2 of this RFP prior to the effective date in the time frame specified by the Department. If the MCO does not pass the readiness review the Contract shall be terminated by DHH.

Subject to Section 25.1 of this RFP, with all proper approvals and concurrence with the successful contractor, DHH 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.

The MCO agrees to comply with all state and federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Contract, not specifically mentioned in this Section, including those in the DHH pro forma contract (Appendix B). Any provision of this Contract which is in conflict with federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the contract will be effective on the effective date of the statutes, regulations, or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The MCO may request DHH to make policy determinations required for proper performance of the services under this Contract.

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

~~25.2~~25.1 Amendments

The Contract may be amended at any time as provided in this paragraph. The Contract may be amended whenever appropriate to comply with state and federal requirements or state budget reductions; provided, however, that rates must be certified as actuarially sound. No modification or change of any provision of the Contract shall be made or construed to have been made unless such modification is mutually agreed to in writing by the MCO and DHH, and incorporated as a written amendment to the Contract. Any amendment to the Contract shall require approval by DHH, the Division of Administration Office of Contractual Review and may require approval of the CMS Regional Office prior to the amendment implementation.

DHH reserves the right to provide written clarification for non-material changes of

contract requirements whenever deemed necessary, at any point in the contract period, to ensure the smooth operations of the Bayou Health Program. Such clarifications shall be implemented by the MCO and will not require an amendment to the Contract.

~~25.3~~25.2 Applicable Laws and Regulations

~~25.3.1~~25.2.1 The MCO agrees to 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:

25.2.1.1. Title 42, Code of Federal Regulations (CFR), Chapter IV, Subchapter C (Medical Assistance Programs);

25.2.1.2. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 U.S.C. §7401, et seq.) the Clean water Act (33 U.S.C. §1251 et seq.) and 20 U.S.C. §6082(2) of the Pro-Children Act of 1994 (P.L. 103-227);

25.2.1.3. Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d) and regulations issued pursuant thereto, 45 CFR Part 80; In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d, et seq.) and its implementing regulations at 45 CFR Part 80, the MCO must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract;

25.2.1.4. Title VII of the Civil Rights Act of 1964 (42 U.S.C. §2000e) in regard to employees or applicants for employment;

25.2.1.5. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;

25.2.1.6. The Age Discrimination Act of 1975, 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;

25.2.1.7. The Omnibus Budget Reconciliation Act of 1981, 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;

25.2.1.8. The Balanced Budget Act of 1997, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, P.L. 106-113;

25.2.1.9. The Americans with Disabilities Act, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;

25.2.1.10. Sections 1128 and 1156 of the Social Security Act, relating to exclusion of MCOs for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

25.2.1.11. The Federal Drug Free Workplace Act of 1988, P.L. 100-690, as implemented in 45 CFR Part 82;

25.2.1.12. Title IX of the Education Amendments of 1972 regarding education programs and activities;

25.2.1.13. The 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 §3).

25.2.1.14. The Equal Opportunity Act of 1972;

25.2.1.15. Federal Executive Order 11246;

25.2.1.16. The Federal Rehabilitation Act of 1973;

25.2.1.17. The Vietnam Era Veteran's Readjustment Assistance Act of 1974;

25.2.1.18. Title IX of the Education Amendments of 1972;

25.2.1.19. The Age Act of 1975; and

25.2.1.20. The Americans with Disabilities Act of 1990.

25.2.1.21. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR §146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.

~~25.2.1.21.~~**25.2.1.22.** Section 1557 of the Patient Protection and Affordable Care Act (ACA).

~~25.3.2~~**25.2.2** Notwithstanding Section 2.4 of this RFP, the contractor agrees not to discriminate in its employment practices, and will render services under this contract without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this contract.

25.3 Assessment of Fees

The Contractor and DHH agree that DHH may elect to deduct any assessed fees from payments due or owing to the MCO or direct the MCO to make payment directly to DHH for any and all assessed fees. The choice is solely and strictly DHH's choice.

The Contractor 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.

25.4 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 MCO 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.

25.5 Board Resolution/Signature Authority

The MCO, if a corporation, shall secure and attach to the Contract a formal Board Resolution indicating the signatory to the Contract is a corporate representative and authorized to sign said Contract.

25.6 Confidentiality of Information

25.6.1 All financial, statistical, personal, technical and other data and information relating to the State's operation which are designated confidential by DHH and made available to the contractor in order to carry out this contract, or which become available to the contractor in carrying out this contract, shall be protected by the contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to DHH. The identification of all such confidential data and information as well as DHH's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by DHH in writing to the contractor. If the methods and procedures employed by the contractor for the protection of the contractor's data and information are deemed by DHH to be adequate for the protection of DHH's confidential information, such methods and procedures may be used, with the written consent of DHH, to carry out the intent of this paragraph. The contractor shall not be required under the provisions of the paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the contractor's possession, is independently developed by the contractor outside the scope of the contract, or is rightfully obtained from third parties.

25.6.2 Under no circumstance shall the contractor discuss and/or release information to the media concerning this project without prior express written approval of the Department of Health and Hospitals.

25.6.3 The MCO shall assure that medical records and any and all other health and enrollment information an relating to members or potential members, which is provided to or obtained by or through the MCO's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and other state and federal laws, DHH policies or this Contract. The MCO 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.

25.6.4 All information as to personal facts and circumstances concerning members or potential members obtained by the MCO 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 otherwise permitted by HIPPA or required by applicable State or federal law regulations, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract.

25.7 Conflict of Interest

The MCO may not contract with Louisiana Medicaid unless such safeguards at least equal to federal safeguards (41 U.S.C. §423) 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.

25.8 Contract Controversies

Any claim or controversy arising out of the contract shall be resolved by the provisions of Louisiana Revised Statutes 39:1524-26.

25.9 Contract Language Interpretation

Subject to Section 25.31 of the RFP, the MCO 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.

25.10 Cooperation with Other Contractors

25.10.1 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 enrollment broker services, the MCO agrees to cooperate fully with such other contractors. The MCO shall not commit any act that will interfere with the performance of work by any other contractor.

25.10.2 The MCO's failure to cooperate and comply with this provision shall be sufficient grounds for DHH to halt all payments due or owing to the MCO 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.

25.11 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.

25.12 Corporation Requirements

If the MCO is a corporation, the following requirement must be met prior to execution of the Contract:

25.12.1 If a for profit corporation whose stock is not publicly traded-the MCO must file a Disclosure of Ownership form with the Louisiana Secretary of State.

25.12.2 If the MCO is a corporation not incorporated under the laws of the state of Louisiana-the MCO must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.

25.12.3 The MCO must provide written assurance to DHH from the MCO's legal counsel that the MCO 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.

25.13 Debarment/Suspension/Exclusion

25.13.1 The MCO agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to nonprocurement debarment and/or suspension. As a condition of enrollment, the MCO 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 health care programs. To help make this determination, the MCO may search the following websites:
Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp;

the Health Integrity and Protection Data Bank (HIPDB)
http://www.npdb-hipdb.hrsa.gov/index.jsp;

the Louisiana Adverse Actions List Search (LAALS)
https://adverseactions.dhh.la.gov;

and/or the System for Award Management, http://www.sam.gov.

25.13.2 The MCO shall conduct a screen, as described in Section 25.13.1 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).

25.14 Effect of Termination on MCO's HIPAA Privacy Requirements

25.14.1 Upon termination of this Contract for any reason, the MCO shall return or destroy all Protected Health Information received from DHH, or created or received by

the MCO on behalf of DHH. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of the MCO. The MCO shall not retain any copies of the Protected Health Information.

25.14.2 In the event that the MCO determines that returning or destroying the Protected Health Information is not feasible, the MCO 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 MCO 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 MCO maintains such Protected Health Information.

25.15 Emergency Management Plan

25.15.1 The MCO shall submit an emergency management plan within forty-five (45) days from the date the Contract is signed to DHH for approval. The emergency management plan shall specify actions the MCO 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 MCO 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.

25.15.2 At a minimum, the plan ~~should~~ shall include the elements contained in the ***Emergency Management Plan*** in Appendix OO.

25.16 Employee Education about False Claims Recovery

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

25.17 Employment of Personnel

25.17.1 In all hiring or employment made possible by or resulting from this Contract, the MCO agrees that:

- There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation; and

- Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable state and federal laws regarding employment of personnel.

25.17.2 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 MCO 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. All inquiries made to the MCO concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the MCO concerning employment made possible as a result of this Contract shall conform to federal, state, and local regulations.

25.18 Entire Contract

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.

The MCO shall comply with all provisions of the Contract and shall act in good faith in the performance of the provisions of said Contract. The MCO shall be bound by all applicable Department issued guides. The MCO 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. The MCO shall comply with all applicable DHH policies and procedures in effect throughout the duration of the Contract period. The MCO shall comply with all applicable DHH provider manuals, rules and regulations and guides.

DHH, at its discretion, will issue correspondence to inform the MCO of changes in Medicaid policies and procedures which may affect the Contract. Unless otherwise specified in the Medicaid correspondence the MCO will be given sixty (60) calendar days to implement such changes.

25.19 Force Majeure

The MCO 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 MCO shall, however, be responsible for the development and implementation of an Emergency Management Plan as specified in Section 25.14 of this RFP.

25.20 Fraudulent Activity

25.20.1 The MCO shall report to DHH any cases of suspected Medicaid fraud or abuse by its members, network providers, employees, or subcontractors. The MCO shall report such suspected fraud or abuse in writing as soon as practical after discovering suspected incidents, but no more than three (3) business days. The MCO shall report the following fraud and abuse information to DHH:

- The number of complaints of fraud and abuse made to the MCO that warrant preliminary investigation; and
- For each case of suspected provider fraud and abuse that warrants a full investigation:
    - the provider's name and number

- the source of the complaint
- the type of provider
- the nature of the complaint
- the approximate range of dollars involved
- the legal and administrative disposition of the case

25.20.2 The MCO shall adhere to the policy and process contained in this RFP for referral of cases and coordination with DHH for fraud and abuse complaints regarding members and providers.

25.21 Governing Law and Place of Suit

It is mutually understood and agreed that this Contract shall be governed by the laws of the state of Louisiana, except its conflict of laws provisions, as to both interpretation and performance. Any administrative proceeding, action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the administrative tribunals and courts of the state of Louisiana. Specifically, any state court suit shall be filed in the 19th Judicial District Court for East Baton Rouge Parish as the exclusive venue for same, and any federal suit shall be filed in the U.S. District Court for the Middle District of Louisiana as the exclusive venue for same. This Section shall not be construed as granting a right or cause of action to the MCO in any of the aforementioned Courts.

25.22 HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in the HIPAA Business Associate Addendum, Appendix C.

25.23 Confidentiality Compliance

25.23.1 The MCO shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) and the rules and regulations promulgated there under (45 CFR Parts 160, 162, and 164). The MCO shall ensure compliance with all HIPAA requirements across all systems and services related to this Contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

25.23.2 Confidentiality of Patient Records

- When applicable, the MCO shall agree to comply with the requirements of 42. U.S.C. 290dd-2 and its implementing regulations, 42 CFR Part 2 . The MCO shall also agree to strictly maintain the confidentiality of patient records of drug, alcohol, and other drug treatment programs in addition to treatment and assessment for pathological or compulsive gambling.

- The MCO shall ensure that every individual treated by a provider that is a covered “Part 2 program”, as defined in 42 CFR Part 2, is offered to sign a consent form for the disclosure of substance use treatment information to the

individual's PCP for the purpose of healthcare integration in accordance with 42 CFR Part 2, Subpart C.

- The MCO shall have the ability to track provider compliance with offering consent forms for members receiving substance use services from Part 2 programs, including the number of members receiving substance use services by each provider and the number of consent forms offered and signed. The MCO shall report this information to DHH upon request.

- The MCO shall educate contracted providers on protocols for requesting and receiving patient records in accordance with 45 CFR Parts 160 and 164 (HIPAA) and 42 CFR Part 2.

- When substance use information is subject to the requirements of 42 CFR Part 2, any disclosure of that information without the written consent of the patient must be compliant with 42 CFR Part 2 and must be accompanied by a statement notifying the recipient of the prohibition against re-disclosure.

- The MCO shall develop policies and procedures which outline HIPAA requirements and 42 CFR Part 2 requirements for the purpose of healthcare integration. These policies and procedures shall outline instances in which 42 CFR Part 2 overrides HIPAA requirements.

25.23.3 HIPAA Disclosure Process

MCOs shall protect confidential information and documents in accordance with 42 USC §671(a)(8), 42 USC §5106a, 42 USC §290dd-2, 45 CFR §1355.21, 45 CFR §205.50, 45 CFR §1355.30, 42 CFR Part 2, La. R.S. 46:56, and 45 CFR Parts 160 and 164, as applicable. MCOs shall disclose in writing any use or disclosure of PHI other than as permitted by the contract within three (3) days of becoming aware of the use or disclosure.

MCOs are required to submit incident reports affecting providers or member receiving services to DHH with a corrective action plan and timelines for implementation of correction for approval by DHH within ten (10) business days of the MCO's discovery of any HIPAA , breaches as defined at 45 CFR §164.402. The incident report shall include, at a minimum:

- Date of discovery;
- Date or date range of violation/potential violation;
- Cause of the incident including sequence and mechanisms;
- Number of unauthorized individuals who viewed PHI;
- Number of affected individuals whose PHI was compromised;
- Steps taken to correct this incident to date, and planned steps to correct incident;
- Steps taken to prevent reoccurrence from happening in the future;
- Steps taken to mitigate any harmful effects caused by the unauthorized disclosure;
- Any training or other corrective action targeted to the MCOs;

- Staff or providers subsequent to this incident;
- Plans for notification of CMS/HHS; and,
- Notification plan to individuals.
- A risk assessment which includes the following:
  - The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
  - The unauthorized person who used the PHI or to whom the disclosure was made;
  - Whether the PHI was actually acquired or viewed; and
  - The extent to which the risk to the PHI has been mitigated.

25.24 Hold Harmless

25.24.1 The MCO shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:

- 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 MCO in connection with the performance of this Contract;
- 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 MCO, its agents, officers, employees, or subcontractors in the performance of this Contract;
- Any claims for damages or losses resulting to any person or firm injured or damaged by the MCO, its agents, officers, employees, or subcontractors by MCO'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;
- Any claims for damages or losses arising from failure ~~of~~by the MCO, its agents, officers, employees, or subcontractors to ~~observe the~~comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;
- Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to the MCO by LDH;
- 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

- 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 MCO, its agents, officers, employees or subcontractors.

25.24.2 In the event of circumstances not reasonably within the control of the MCO or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the MCO, 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 MCO shall be liable for the core benefits and services required to be provided or arranged for in accordance with this Contract.

25.24.3 DHH will provide prompt notice of any claim against it that is subject to indemnification by MCO under this Contract. The MCO 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 MCO, which shall not be unreasonably withheld.

25.25 Hold Harmless as to the MCO Members

25.25.1 Notwithstanding state plan approved cost sharing, ~~T~~the MCO 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, MCO members, or persons acting on their behalf, for health care services which are rendered to such members by the MCO and its subcontractors, and which are core benefits and services.

25.25.2 The MCO further agrees that the MCO member shall not be held liable for payment for core 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 MCO provided the service directly. The MCO agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by MCO and insolvency of the MCO.

25.25.3 The MCO further agrees that the MCO member shall not be held liable for the costs of any and all services provided by a provider whose service is not covered by the MCO or does not obtain timely approval or required prior-authorization.

25.25.4 The MCO further agrees that this provision shall be construed to be for the benefit of MCO members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the MCO and such members, or persons acting on their behalf.

25.26 Homeland Security Considerations

25.26.1 The MCO shall perform the services to be provided under this Contract entirely within the United States. The term “United States” includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the MCO 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.

25.26.2 If the MCO performs services, or uses services, in violation of the foregoing paragraph, the MCO 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 MCO shall be required to hold harmless and indemnify DHH pursuant to the indemnification provisions of this Contract.

25.26.3 The prohibitions in this Section shall also apply to any and all agents and subcontractors used by the MCO to perform any services under this Contract.

25.27 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.

25.28 Independent Provider

It is expressly agreed that the MCO and any subcontractors and agents, officers, and employees of the MCO 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 MCO or any subcontractor and DHH and the state of Louisiana.

25.29 Integration

This Contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The MCO also agrees to be bound by the Contract and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

25.30 Interest

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

25.31 Interpretation Dispute Resolution Procedure

25.31.1 The MCO may request in writing an interpretation of the issues relating to the Contract from the Medicaid MCO Program Director. In the event the MCO disputes the interpretation by the Medicaid MCO Program Director, the MCO shall submit a written reconsideration request to the Medicaid Director.

25.31.2 The MCO 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.

25.31.3 The Medicaid Director shall reduce the decision to writing and provide a copy to the MCO. The written decision of the Medicaid Director shall be the final decision of DHH. The Medicaid Director will render his final decision based upon the written submission of the MCO and the Medicaid MCO Program Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by the MCO and the Medicaid MCO Program Director or his/her designee. If such a presentation is allowed, the information presented will be considered in rendering the decision.

25.31.4 Pending final determination of any dispute over a DHH decision, the MCO shall proceed diligently with the performance of the Contract and in accordance with the direction of DHH.

25.32 Loss of Federal Financial Participation (FFP)

The MCO hereby agrees to be liable for any loss of FFP suffered by DHH due to the MCO'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.

25.33 Misuse of Symbols, Emblems, or Names in Reference to Medicaid

No person or MCO 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.

25.34 National Provider Identifier (NPI)

The HIPAA Standard Unique Health Identifier regulations (45 CFR Part 162, Subparts A & D) require that all covered entities (health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

25.35 Non-Discrimination

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

applicants, notices of non-discrimination. This provision shall be included in all provider contracts.

25.36 Non-Waiver of Breach

The failure of DHH at any time to require performance by the MCO of any provision of this Contract, or the continued payment of the MCO 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. 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.

25.37 Offer of Gratuities

By signing this Contract, the MCO 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.

25.38 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;
- MCO Systems Companion Guide;
- MCO Quality Companion Guide; and
- The Proposal submitted by the MCO in response to this RFP.

25.39 Physician Incentive Plans

25.39.1 The MCO shall comply with requirements for physician incentive plans, as required by 42 CFR §438.6(h) and set forth (for Medicare) in 42 CFR §422.208 and §422.210.

25.39.2 Assurances to CMS. Each organization will provide to DHH assurance satisfactory to the Secretary of HHS that the requirements of §422.208 are met.

25.40 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".

25.41 Prohibited Payments

Payment for the following shall not be made:

- Organ transplants, unless the state plan has written standards meeting coverage guidelines specified;
- Non-emergency 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;
- Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and
- Any amount expended for home health care services unless the MCO provides the appropriate surety bond.

25.42 Rate Adjustments

The MCO and DHH both agree that the monthly capitation rates identified in this RFP shall be in effect during the period identified on the MCO Rate Schedule that will be posted on DHH's website. Rates may be adjusted during the Contract period based on DHH and actuarial analysis, subject to CMS review and approval.

The MCO 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 the MCO refuse to accept the revised monthly capitation rate, Section 25.63 of the RFP and the provisions of the RFP for contract turnover and performance bond shall apply.

25.43 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:

- 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;
- Records for real property and equipment acquired with federal funds shall be retained for six (6) years after final disposition;

- When records are transferred to or maintained by DHH, the six (6) year retention requirement is not applicable to the recipient; and

- Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR §74.53(g).

25.44 References to Statutes, Rules, or Regulations

All references in this RFP to any statute, rule, or regulation shall be deemed to refer to the provisions of the statute, rule, or regulation as they exist at the time of the issuance of this RFP or as they may be hereafter amended. At any given time, the MCO shall comply with the provisions that are currently in effect at that time.

25.45 Release of Records

The MCO shall release medical 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. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to, La. R.S. 40:1299.96, La. R.S. 13:3734, and La. C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) and subject to reasonable charges. The MCO shall not charge DHH/BHSF or their designated agent for any copies of records requested.

25.46 Reporting Changes

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

- Change in business address, telephone number, facsimile number, and e-mail 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 e-mail address;
- Change in incorporation status;
- Change in federal employee identification number or federal tax identification number; or
- Change in MCO litigation history, current litigation, audits and other government investigations both in Louisiana and in other states.

25.47 Right to Audit

The State Legislative Auditor, agency, and/or federal auditors and internal auditors of the Division of Administration shall have the option to audit all accounts directly pertaining to the contract for a period of three (3) years from the date of the last payment made under this contract. Records shall be made available during normal working hours for this purpose.

25.48 Safeguarding Information

The MCO 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 MCO's written safeguards shall:

- Be comparable to those imposed upon the DHH by 42 CFR Part 431, Subpart F, and La. R.S. 46:56;
- State that the MCO 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.

25.49 Safety Precautions

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

25.50 Severability

If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void by a judgment or order of a court of competent jurisdiction, then both DHH and MCO shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically infeasible, both DHH and the MCO will be discharged from further obligations created under the terms of the Contract.

25.51 Software Reporting Requirement

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

25.52 Termination for Convenience

DHH may terminate this Contract for convenience and without cause upon sixty (60) calendar days written notice. DHH shall not be responsible to the MCO or any other party for any costs, expenses, or damages occasioned by said termination, i.e., this termination is without penalty.

25.53 Termination Due to Serious Threat to Health of Members

DHH may terminate this Contract immediately if it is determined that actions by the MCO or its subcontractor(s) pose a serious threat to the health of members enrolled

in the MCO. The MCO members will be given an opportunity to enroll in another MCO (if there is capacity) or move to Medicaid fee-for-service.

25.54 Termination for MCO Insolvency, Bankruptcy, Instability of Funds

25.54.1. The MCO's insolvency or the filing of a petition in bankruptcy by or against the MCO shall constitute grounds for termination for cause. If DHH determines the MCO has become financially unstable, DHH will immediately terminate this Contract upon written notice to the MCO effective the close of business on the date specified.

25.54.2. The MCO shall cover continuation of services to members for the duration of any period for which payment has been made, as well as for inpatient admissions up until discharge.

25.55 Termination for Ownership Violations

The MCO is subject to termination, unless the MCO can demonstrate changes of ownership or control, when:

- A person with a direct or indirect ownership interest in the MCO:
  - Has been convicted of a criminal offense under §1128(a) or 1128(b)(1) or (b)(3) of the Social Security Act, in accordance with 42 CFR §1002.203;
  - Has had civil liquidated damages or assessment imposed under §1128A of the Social Security Act; or
  - Has been excluded from participation in Medicare or any state health care program.
- Any individual who has a direct or indirect ownership interest or any combination thereof of 5% or more, or who is an officer (if the MCO is organized as a corporation), or who is a partner (if it is organized as a partnership), or who is an agent or a managing employee, is under temporary management as defined in Section 21.3.
- The MCO has a direct or indirect substantial contractual relationship with an excluded individual or entity. “Substantial contractual relationship” is defined as any direct or indirect business transactions that amount in a single fiscal year to more than $25,000 or 5% of the MCO’s total operating expenses, whichever is less.

25.56 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.

Any Proposer has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the state when requested. This applies even if an eventual contract is terminated and/or a lawsuit is filed. Specifically, the

proposer does not have the right to limit or impede the State's right to audit or to withhold State owned documents.

25.57 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.

25.58 Titles

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

25.59 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 MCO resulting from this Contract.

25.60 Waiver of Administrative Informalities

The Department of Health and Hospitals reserves the right, at its sole discretion, to waive minor administrative informalities contained in any proposal.

25.61 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.

25.62 Warranty to Comply with State and Federal Regulations

The MCO shall warrant that it shall comply with all state and federal laws and regulations as they exist at the time of the Contract or as subsequently amended.

25.63 Warranty of Removal of Conflict of Interest

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

25.64 Withholding in Last Month of Payment

During the transition to a new Contractor, for the last month of the Contract, the Department shall withhold seventy-five percent (75%) of the final payment to the Contractor for a maximum of ninety (90) days from the due date of such amount to ensure that the outgoing Contractor fulfills its contractual obligations and repays DHH for payments made on behalf of ineligible recipients, some of which may extend past the term of the Contract.

25.65 Termination for Failure to Accept Revised Monthly Capitation Rate

Should the MCO refuse to accept a revised monthly capitation rate as provided in Section 25.42 of the RFP, it may request DHH in writing to permit the Contract to be terminated effective at least sixty (60) calendar days from the date of DHH's receipt of the written request. DHH shall have sole discretion to approve or deny the request for termination and to impose such conditions on the granting of an approval as it may deem appropriate, but it shall not unreasonably withhold its approval.

INTENTIONALLY LEFT BLANK

1915(b) Waivers - one of several options available to states that allow the use of Managed Care in the Medicaid Program. When using 1915(b), states have four different options:

- 1915(b)(1) - Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits
- 1915(b)(2) - Allow a county or local government to act as a choice counselor or enrollment broker) in order to help people pick a managed care plan
- 1915(b)(3) - Use the savings that the state gets from a managed care delivery system to provide additional services
- 1915(b)(4) - Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation).

1915(c) Waivers - one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Abandoned Call – A call in which the caller selects a valid option and is either not permitted access to that option or disconnects from the system.

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

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 Sections 7.3 and 7.5 of this RFP; or the failure of the MCO to act within the timeframes provided in Section 13.7.1 of this RFP~~See Adverse Benefit Determination.

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.

Acute Care – Means preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

Acute Care Hospital – A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition).For purposes of determining network adequacy, acute care hospitals must include an emergency department.

Adequate Network/Adequacy of Network – Refers to the network of health care providers for an MCO 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 for primary care providers; 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.

Adjudicate – means 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.

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

Adverse Action – Any decision by the MCO to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.

Adverse Benefit Determination – Means ~~A~~any of the following: ~~admission, availability of care, continued stay or other health care service that has been reviewed by an MCO entity and based upon the information provided, does not meet the MCO's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed or terminated.~~

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Affiliate – means any individual or entity that meets any of the following criteria:

(1) owns or holds more than a five percent (5%) interest in the MCO (either directly, or through one (1) or more intermediaries);

(2) in which the MCO owns or holds more than a five percent (5%) interest (either directly, or through one (1) or more intermediaries);

(3) any parent entity or subsidiary entity of the MCO regardless of the organizational structure of the entity;

(4) any entity that has a common parent with the MCO (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 MCO; 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.

Age Discrimination Act of 1975 – prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements. The Age Discrimination Act is enforced by the Office for Civil Rights.

Aged/Blind/Disabled – means the categories of individuals who meet the Medicaid eligibility factor of age, blindness, or a mental and/or physical disability.

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.

Ambulatory Care – Preventive, diagnostic and treatment services provided on an outpatient basis.

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.

Ancillary Services – Those support services other than room, board, and medical and nursing services that are provided to hospital patients in the course of care. They include such services as laboratory, radiology, pharmacy, and physical therapy 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 an MCO entity, which results in the denial, reduction, suspension, termination or delay of health care benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Automatic Assignment – The process utilized to enroll into an MCO, using predetermined algorithms, a Medicaid eligible that (1) is not excluded from MCO participation and (2) does not proactively select an MCO within the DHH specified timeframe.

Basic Behavioral Health Services – Mental health and substance abuse services which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders that are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities. Basic Behavioral Health Services include, but are not limited to, screening, brief intervention and assessment, prevention, early intervention, medication management, treatment and Referral Services provided in the primary care setting and as defined in the Medicaid State Plan. Basic Behavioral Health Services may further be defined as those provided in the enrollee's PCP or medical office by the enrollee's (non-Specialist) physician (e.g., DO, MD, APRN, PA) as part of routine physician evaluation and management activities. These services shall be covered by the MCO for enrollees with both physical health and behavioral health coverage.

Benefits or Covered Services – Those health care services to which an eligible Medicaid recipient is entitled under Louisiana Medicaid State Plan.

Blocked Call – A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.

Bureau of Health Services Financing (BHSF) – 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.

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

CMS 1500 – Universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.

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 health care 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.

Capitation – A contractual agreement through which the MCO 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 makes to an MCO for each member covered under the Contract for the provision of core health benefits and services and assigned to the MCO. This payment is made regardless of whether the member receives core benefits and services during the period covered by the payment.

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

Capitated Service – Any core benefit or service for which the MCO receives an actuarially sound capitation payment.

Care Coordination – Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in the member's care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of member's care.

Care Management – Overall system of medical management encompassing Utilization Management, Referral, Case Management, Care Coordination, Continuity of Care and Transition Care, Chronic Care Management, Quality Care Management, and Independent Review.

Case Management – Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.

Case Manager – A person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case management manager shall not provide direct care services to members enrolled with the Contractor, but shall authorize appropriate services and/or refer members to appropriate services.

Cause – Specified reasons that allow mandatorily enrolled MCO members to change their MCO choice. Term may also be referred to as "good cause."

Centers for Disease Control/Advisory Committee on Immunization Practices (CDC/ACIP) – Federal agency and committee whose role is to provide advice that will lead to a reduction in the incidence of vaccine-preventable diseases in the United States and an increase in the safe use of vaccines and related biological products.

Centers for Medicare and Medicaid Services (CMS) – The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA).

Certified Nurse Midwife (CNM) – An advanced practice registered nurse educated in the disciplines of nursing and midwifery and certified according to a nationally recognized certifying body, such as the American College of Nurse Midwives Certification Council, as approved by the state board of nursing and who is authorized to manage the nurse midwifery care of newborns and women in the ante-partum, intra-partum, postpartum, and/or gynecological periods.

Children's Choice Waiver – Medicaid 1915(c) Home and Community Based Services program that offers supplemental support to children with developmental disabilities who currently live at home with their families or who will leave an institution to return home.

CHIP – Children's Health Insurance Program created in 1997 by Title XXI of the Social Security Act. Known in Louisiana as LaCHIP.

***Chisholm* Class Members** – All current and future recipients of Medicaid in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry.

Choice Counseling – Enrollment Broker activities such as answering questions and providing information in an unbiased manner on available MCOs and advising potential enrollees and enrollees on what factors to consider when choosing among them.

Chronic Condition – persistent or frequently recurring conditions of significant duration that may limit an individual's activities and require ongoing medical care to optimize the individual's quality of life.

Chronic Care Management – The concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic Care Management Program (CCMP) – A program that provides care management and coordination of activities for individuals determined to be at risk for high medical costs.

Claim – means (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.

Co-branding – a relationship between two or more separate legal entities, one of which is an MCO. The MCO's health plan displays the name(s) or brand(s) of the co-branding entity or entities on its marketing materials to signify a business arrangement. Co-branding arrangements allow an MCO and its co-branding partner(s) to promote enrollment in the MCO's health plan. Co-branding relationships are entered into independent of the contract that the MCO has with DHH.

Cold Call Marketing – Any unsolicited personal contact with a Medicaid eligible individual by the MCO, its staff, its volunteers or its vendors/contractors with the purpose of influencing the Medicaid eligible individual to enroll in the MCO or either to not enroll in or disenroll from another MCO.

CommunityCARE 2.0 – Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program which links Medicaid eligibles to a primary care provider as their medical home.

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

Contract Dispute – A circumstance whereby the MCO and DHH or the MCO 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.

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 health care services.

Coordinated System of Care (CSoC) – A component of the system of care for youth who have significant behavioral health challenges and who are in or at imminent risk of out-of-home placement, and their families; and is a collaborative effort among families, youth, the Department of Children and Family Services, the Department of Education, the Department of Health and Hospitals, and the Office of Juvenile Justice.

Co-payment – Any cost sharing payment for which the Medicaid MCO 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 Benefits and Services – A schedule of health care benefits and services required to be provided by the MCO to Medicaid members as specified under the terms and conditions of this RFP and Contract and the Louisiana Medicaid State Plan.

Corrective Action Period – the period of time between the acceptance by DHH of the Corrective Action Plan and the date of compliance as determined by DHH.

Corrective Action Plan (CAP) – A plan developed by the MCO 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

Cost-Based Reimbursement – A method of payment of medical care by third parties for services delivered to patients. The amount of payment is based on the allowable costs to the provider for delivering the service.

Cost Neutral – The mechanism used to smooth data, share risk, or adjust for risk that will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

Cost Settlement – Mechanism utilized within a cost based reimbursement system. The Medicaid claims are paid in the interim at a rate that approximates the actual cost of the claim. The actual final reimbursement is determined from the filed cost report and based on the cost reimbursement rules that are contained within the Medicaid State Plan.

Cost Sharing – Any copayment, coinsurance, deductible, or other similar charge.

Covered Drug List – A list maintained by the MCO giving details of generic and name brand medications payable by the MCO's health plan.

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

Crisis Mitigation Services - A provider's assistance to enrollees during a crisis that provides 24-hour on call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute Crisis Mitigation Services.

Critical Incident – The following are types of Critical Incidents:

- **Abuse** (child/youth) - any one of the following acts that seriously endanger the physical, mental, or emotional health and safety of the child.
    - The infliction, attempted infliction, or, because of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person.
    - The exploitation or overwork of a child by a parent or any other person
    - The involvement of a child in any sexual act with a parent or any other person

- The aiding or toleration by the parent of the caretaker of the child's sexual involvement with any other person or of the child's involvement in pornographic displays or any other involvement of a child in sexual activity constituting a crime under the laws of this state (Children's Code Article 603)

- **Abuse** (adult) - the infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value. (Louisiana Revised Statutes 15:403.2).
- **Chemical restraint** - consist of one time as needed medications which restricts the freedom of movement or causes incapacitation by sedation.
- **Death** - regardless of cause or the location where the death occurred.
- **Elopement** - Residential/Inpatient providers are to report an enrollee who is out of contact with staff, without prior arrangement, for more than 2 hours. A person may be considered to be in "immediate jeopardy" based on his/her personal history and may be considered "missing" before 24 hours elapse in a community setting. Additionally, it is considered a reportable incident whenever the police are contacted about a missing person, or the police independently find and return the enrollee, regardless of the amount of time he or she was missing.
- **Exploitation** (adult) - the illegal or improper use or management of the funds, assets, or property of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage (Louisiana Revised Statutes 15:503.7)
- **Extortion** (adult) - the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or Abuse of legal or official authority. (Louisiana Revised Statutes 15:503.8)
- **Mechanical/Physical Restraint** - Any physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body
- **Neglect** (child/youth) - the refusal or unreasonable failure of a parent of caretaker to supply the child with the necessary food, clothing, shelter, care, treatment, of counseling for any illness, injury, or condition of the child, as a result of which the child's physical, mental or emotional health and safety are substantially threatened or impaired. This includes prenatal illegal drug exposure caused by the parent, resulting in the Newborn being affected by the drug exposure and withdrawal symptoms. (Children's Code Article 603)
- **Neglect** (adult) - the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (Louisiana Revised Statutes 15:503.10)
- **Protective Hold** (Sometimes called "Personal Restraint") - the application of physical force using body pressure, without the use of any device, to an individual for the purpose of restraining the free movement of the individual's body.
- **Seclusion** - the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.
- **Suicide** - death resulting from the purposeful action of self.
- **Suicide attempt** - the intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an attempt that requires medical treatment, and/or where the enrollee suffers or could have suffered significant injury or death. Non-reportable events include: Threats of suicide that do not result in an actual attempt; gestures that clearly do not place the enrollee at risk for serious injury or death; and actions that may place the enrollee at risk, but where the enrollee is not attempting harm to himself/herself.

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

DHH Administrative Regions – The nine Louisiana geographic areas designated in state statute for administrative purposes. Each geographic area is comprised of specific parishes. For specific areas see:
http://www.dhh.louisiana.gov/offices/medialibrary/media-1/REG_MAP04.jpg

Deliverable – A document, manual, file, plan, or report submitted to DHH by the MCO to fulfill requirements of this Contract.

Denied Claim – A claim for which no payment is made to the network provider by the MCO 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.

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

Developmental Disability – As defined in La. R.S. 28:451.2:

- A severe, chronic disability of a person that:
  - Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.
  - Is manifested before the person reaches age twenty-two.
  - Is likely to continue indefinitely.
  - Results in substantial functional limitations in 3 or more of the following areas of major life activity:
    - Self-care
    - Receptive & expressive language
    - Learning
    - Mobility
    - Self-direction
    - Capacity for independent living
    - Economic self-sufficiency
  - Is not attributable solely to mental illness.
  - Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration & are individually planned & coordinated.

Direct Marketing/Cold Call – Any unsolicited personal contact with or solicitation of a Medicaid eligible in person, through direct mail advertising or telemarketing by an employee or agent of the MCO for the purpose of influencing an individual to enroll with the MCO.

Disease Management (DM) – see Chronic Care Management

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

Dispensing Fee – the fee paid by the MCO to reimburse the overhead and labor expense incurred by pharmacy providers and the professional services provided by a pharmacist when dispensing a prescription.

Documented Attempt – A *bona fide*, or good faith, attempt, in writing, by the MCO to contract with a provider, made on or after the date the MCO signs the Contract with DHH, and no sooner than 60 calendar days following any preceding attempt. Such attempts ~~may~~ shall include written correspondence via certified mail that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within ~~1~~30 calendar days following the receipt date, the potential network provider rejects the request or fails to respond either verbally or in writing, the MCO may consider the request for inclusion in the MCO's network denied by the provider. Provider responses are not limited to approval or rejection of the offer. This shall constitute one attempt.

Dual Diagnosis – The situation in which the same person is diagnosed with more than one condition, such as psychiatric disorders, neurodevelopmental disorders, substance-related and addictive disorders.

Duplicate Claim – A claim that is either a total or partial duplicate of services previously paid.

Durable Medical Equipment, Prosthetics, Orthotics and certain Supplies (DMEPOS) – DME is inclusive of equipment which 1) can withstand repeated use, 2) is primarily and customarily used to serve a medical purpose; 3) generally is not useful to a person in the absence of illness or injury, and 4) is appropriate for use in the home. POS is inclusive of prosthetics, orthotics and certain supplies. Certain supplies are those medical supplies that are of an expendable nature, such as catheters and diapers.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT-Eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act. This includes but is not limited to conditions which are discovered through EPSDT Well Child screening services, whether or not such services are outside of the Medicaid State Plan. [42 U.S.C. §1396d(r)(5)] and the CMS Medicaid State Manual. ~~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) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered [42 CFR §440.40(b)]. EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of "medical assistance".~~

E-Consultation – The use of electronic computing and communication technologies in consultation processes.

Electronic Health Records (EHR) – A computer-based record containing health care 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 the MCO.

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 Services – Emergency dental coverage is limited to the emergency treatment of injury to natural teeth. Treatment includes but is not limited to x-rays and emergency oral surgery to temporarily stabilize the enrollee. Dental services provided for the Routine Care, treatment, or replacement of teeth or structures are not covered.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Emergency Medical Transportation – Transportation provided for an unforeseen combination of circumstances that apparently demand immediate attention at a medical facility to prevent serious impairment or loss of life.

Emergency Room Care – Emergency services provided in an emergency department.

Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR §438.114(a) and §1932(b)(2) of the Social Security Act and that are needed to screen, evaluate, and stabilize an emergency medical condition. Services defined as such under Section 1867 (e) of the Social Security Act ("anti-dumping provisions"). If an emergency medical condition exists, the MCO is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the "prudent layperson" standard shall apply to both in-plan and out-of-plan coverage.

Encounter – A distinct set of health care services provided to a Medicaid member enrolled with an MCO on the dates that the services were delivered.

Encounter Data – Health care encounter data include: (i) All data captured during the course of a single health care 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 health care 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-04, KM-3 and NCPDP version D.0~~3.2~~ claim forms as specified in the ***MCO System~~s~~ Companion Guide*** or the ***MCO Batch Pharmacy Encounter Guide***.

Enrollee – Louisiana Medicaid or CHIP recipient who is currently enrolled in an MCO or other Medicaid managed care program.

Enrollment – The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of an MCO.

Enrollment Broker – The state's contracted or designated agent that performs functions related to choice counseling, enrollment and disenrollment of potential enrollees and enrollees into an MCO.

Evidence-Based Practice – Clinical interventions that have demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness.

Excluded Populations – Medicaid eligibles who are excluded from enrollment in an MCO and may not voluntarily enroll.

Excluded Services – those services which members may obtain under the Louisiana Medicaid State Plan and for which the MCO is not financially responsible.

Existing Provider-Beneficiary Relationship – The provider who has been the main source of Medicaid services for the enrollee during the previous year.

Expanded Services – A covered service provided by the MCO which is currently a non-covered service(s) in the Medicaid State Plan or is an additional Medicaid covered service furnished by the MCO to Medicaid MCO members for which the MCO 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 date may be relatively weak or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

External Quality Review (EQR) – The analysis and evaluation by an external quality review organization of aggregated information on quality, timeliness, and access to the health care services that an MCO or its subcontractors furnish to members and to DHH.

External Quality Review Organization (EQRO) – an organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs EQR and other related activities as set forth in federal regulations, or both.

Family Planning Services – Services that include examinations and assessments, diagnostic procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

Federal Financial Participation (FFP) – 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 capital income.

Federally Qualified Health Center (FQHC) – An entity that receives a grant under Section 330 of the Public Health Service Act (also see §1905(1)(2)(B) of the Social Security Act) to provide primary health care 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 which accepts payment in full for providing benefits, with the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Fidelity – the accuracy and consistency of an intervention to ensure it is implemented as planned and that each component is delivered in a comparable manner to all members over time.

Fiscal Intermediary (FI) – DHH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.

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

Formulary – a list maintained by the MCO giving details of medications payable by the MCO's health plan.

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 Equivalent Position (FTE) – Refers to the equivalent of one (1) individual full-time employee who works forty (40) hours per week; or a full-time primary care provider shall be defined as a one delivering outpatient preventive and primary (routine, urgent and acute) care for twenty (20) hours or more per week (exclusive of travel time).

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.

Go-Live Date – The date the MCO shall begin providing services to Medicaid members.

Good Cause – See "cause".

Grievance – An expression of member/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 procedure for addressing enrollee's grievances.

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

Habilitation Services and Devices – Health care services that help enrollees keep, learn, or improve skills and functioning for daily living.

Health Care Professional – A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other health care 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.

Health Care Provider – A health care professional or entity that provides health care services or goods.

Health Insurance – A type of insurance coverage that pays for medical and surgical expenses incurred by the insured. Health insurance can reimburse the insured for expenses incurred from illness or injury, or pay the care provider directly.

Healthcare Effectiveness Data and Information Set (HEDIS) – A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (*e.g.* MCO) performance.

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV – The legislation establishes a transparent and open process for the development of standards that will allow for the nationwide electronic exchange of information between doctors, hospitals, patients, health plans, the government and others by the end of 2009. It establishes a voluntary certification process for health information technology products. The National Institute of Standards and Technology will provide for the testing of such products to determine if they meet the national standards that allow for the secure electronic exchange and use of health information.

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

HIPAA Security Rule (45 CFR Parts 160 and 164) – Part of the rules promulgated pursuant to 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.

Historical Provider Relationship – The provider who has been the main source of Medicaid services for the member during the previous year (decided on by the most recent CommunityCARE 2.0 PCP, or if not previously enrolled in CommunityCARE 2.0, by the provider (PCP or specialist) in the previous 12 months with whom the member had the most visits.

Home and Community Based Services Waiver (HCBS) – Under Section 1915 (c) of the Social Security Act states may request waivers of state wideness, comparability of services, and community income and resource rules for the medically needy in order to develop Medicaid-financed community-based treatment alternatives. Non-state plan services that may be offered include case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. Current HCBS waivers in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Elderly and Disabled Adult Waiver, Adult Day Health Care, Supports Waiver, and Adult Residential Options.

Home Health Care – Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment, medical supplies, and other services.

Hospice – Services provided as described in Louisiana Medicaid State Plan and 42 CFR Part 418, which are provided to terminally ill individuals, with a prognosis of six (6) months or less, who elect to receive hospice services provided by a certified hospice agency.

Hospital Outpatient Care – Care in a hospital that usually doesn't require an overnight stay.

Hospitalization – Admission to a hospital for treatment.

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. MCOs shall move to ICD-10-CM as it becomes effective.

IEP Services – These are therapies included in a student's Individualized Education Plan (IEP). Included are physical therapy, occupational therapy, speech/language therapy, audiology and some psychological therapy. The enrolled provider must be a public school system and they certify the state match via Certified Public Expenditures (CPE). The school board does bill fee-for-service through the MMIS claims payment system which acts as an interim payment. At the end of the year there is a cost settlement process.

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

Implementation Date – The date DHH notifies the MCO that Network Adequacy has been certified by DHH, the MCO has successfully completed the Readiness Review and is approved to begin enrolling members.

Incentive Arrangement – Any payment mechanism under which a subcontractor may receive additional funds over and above the rate it was paid for meeting targets specified in the contract.

Incurred But Not Reported (IBNR) – Services rendered by a provider for which a claim/encounter has not been received by the MCO.

Indian – Any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined Eligible as an Indian, under 42 CFR 136.12.

Indian Health Care provider (IHCP) – A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Individual Practice – Independent primary care providers who work in their own private practices.

Individuals with Disabilities Education Act (IDEA) – A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

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.

Inpatient Facility – Hospital or clinic for treatment that requires at least one overnight stay.

Insolvency – A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets, or as determined by the Louisiana Department of Insurance pursuant to Title 22 of the Louisiana Revised Statutes.

Institutionalized – A patient in a nursing facility; an inpatient in a medical institution or institution for mental disease, whereby payment is based on a level of care provided in a nursing facility; or receives home and community-based waiver services.

Intellectual Disability – a type of developmental disability, formerly known as mental retardation, characterized by significantly impaired intellectual and adaptive functioning. It is defined by an IQ score under 70 in addition to deficits in two or more adaptive behaviors that affect every day, general living.

Interdisciplinary Team - a group that reviews information, data, and input from a person to make recommendations relevant to the needs of the person. The team consists of the person, his legal Representative if applicable, professionals of varied disciplines who have knowledge relevant to the person's needs, and may include his family enrollees along with others the person has designated.

Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/DD) – a facility licensed by the Louisiana Department of Health (LDH) Health Standards Section (HSS) to provide residential care for four or more individuals that meet the criteria for 24 hours per day of Active Treatment. ICF/DD facilities are considered “institutions” and not Home and Community Based Services by Centers of Medicare and Medicaid Services (CMS).

Intermediate Sanctions – those actions authorized by 42 CFR §438.700, et seq. for certain actions or omissions by a managed care organization.

Investigational Procedure/Service – See Experimental Procedure/Service.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO/Joint Commission) – An organization that operates accreditation programs to subscriber hospitals and other healthcare organizations.

Kick Payment – The method of reimbursing an MCO entity in the form of a separate one (1) time fixed payment for specific services in addition to the PMPM payment.

KIDMED – Louisiana’s name for the screening component of the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid eligible children under the age of 21 as required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).

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.

LaCHIP – Refers to the Louisiana's Medicaid expansion CHIP (Title XXI) Program that provides health coverage to uninsured children under age 19, whose families have a net income up to 200 percent of the Federal Poverty Level (FPL); and whose income exceeds the Medicaid limit. Phase I includes children ages 6-18 with income from 100% up to and including 133% FPL; Phase II includes children with income from 134% up to and including 150% FPL; Phase III includes children with income from 151% FPL up to and including 200% FPL; Phase IV provides prenatal coverage from conception to birth for children whose uninsured mothers are ineligible for Medicaid and have net family income at or below 200% FPL (referred to as the LaCHIP Prenatal Program); and Phase V includes children in families with income from 201% up to and including 250% FPL. LaCHIP Phase V (referred to as the LaCHIP Affordable Plan) is administered by the Louisiana Office of Group Benefits.

LaMOMS – Medicaid program for pregnant women with income up to and including 133% FPL and optional Medicaid program for pregnant women with income from 134% up to and including 185% FPL. With a 15% income disregard, the income limit is, in effect, 200% FPL. The program provides pregnancy-related services, delivery and post-partum care for 60 days after the pregnancy ends for women whose sole basis of eligibility is pregnancy.

Legend Drugs – drugs which bear the federal legend: "Caution: federal law prohibits dispensing without a prescription."

Licensed Mental Health Professional (LMHP) – an individual who is licensed in the state of Louisiana to diagnose and treat mental illness or substance disorder acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently as:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

Liquidated Damages – Damages that may be assessed whenever an MCO, its providers, and/or its subcontractors fail to achieve certain performance standards and other items defined in the terms and conditions of the Contract.

Local Governing Entity (LGE) – A system of independent healthcare districts and authorities. Within LGEs, services are provided through various arrangements including state operated, state contracted services, private comprehensive providers, rehabilitation agencies, community addiction and mental health clinics, Licensed Mental Health Professionals (LMHPs), and certified peer support specialists.

Louisiana Children's Health Insurance Program (LaCHIP) – Louisiana's name for the Children's Health Insurance Plan created by Title XXI of the Social Security Act in 1997. Provides **h**ealth care coverage for uninsured children up to age 19 through a Medicaid expansion program

for children at or below 200% FPL and a separate state CHIP program for the unborn prenatal option and for children with income from 200% up to and including 250% FPL.

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's Health Insurance Premium Payment Program (LaHIPP) – Louisiana Medicaid program that pays for some or all of the health insurance premiums for an employee and their family if they have insurance available through their job and someone in the family is enrolled in Medicaid.

Louisiana Medicaid State Plan – The binding written agreement between DHH and CMS which describes how the Medicaid program is administered and determines the services for which DHH will receive federal financial participation.

Major Subcontract – means any contract, subcontract, or agreement between the MCO and another entity that meets any of the following criteria:

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

Major Subcontractor – Means any entity with a major subcontract with the MCO. For the purposes of this Contract, major subcontractors do not include providers in the MCO's provider network. Major subcontractors may include, without limitation, affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Managed Care Organization (MCO) – A private entity that contracts with DHH to provide core benefits and services to Louisiana Medicaid MCO Program enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to La. R.S. 22:1016, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health and Hospitals.

Managed Care Program – Louisiana Medicaid program providing statewide leadership to most effectively utilize resources to promote the health and well-being of Louisianans in DHH's Bayou Health Program.

Mandatory Population/Enrollee – The groups of Medicaid eligibles who are required to enroll in a Medicaid MCO and whose participation is not voluntary.

Marketing – Means any communication, from an MCO to a Medicaid enrollee who is not enrolled in that MCO, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO's Medicaid product, or either to not enroll in, or to disenroll from, another MCO's Medicaid product.

Marketing Materials – Information produced in any medium, by or on behalf of an MCO, that can reasonably be interpreted as intended to market to potential enrollees or enrollees.

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

Material Changes – 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 MCO's complaint and grievance procedures; health care delivery systems, services, changes to ~~expanded services; benefits~~value-added benefits or services; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that require DHH approval prior to implementation; and the MCO's capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material.

MCO Administrative Services – means the performance of services or functions, other than the direct delivery of core benefits and services, necessary for the management of the delivery of and payment for core 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.

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

Measurable – Applies to an MCO objective and means the ability to determine definitively whether or not the objective has been met, or whether progress has been made toward a positive outcome.

Measurement Year – With regard to healthcare quality measure reporting, measurement year refers to the time frame during which healthcare services are provided. For example, for most HEDIS® measures, the previous calendar year is the standard measurement year. The healthcare quality measure steward defines the measurement year (or period) in the technical specifications for each measure.

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 health care providers for serving covered individuals.

Medicaid Eligibility Office – DHH offices located within select parishes of the state and centralized State Office operations that are responsible for initial and ongoing Medicaid financial eligibility determinations.

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

Medicaid FFS Provider – An institution, facility, agency, person, corporation, partnership, or association that has signed a PE-50 provider agreement, has been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

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 may make payments under the Medicaid or LaCHIP Program, who may or may not be currently enrolled in the Medicaid or LaCHIP Program**,** and on whose behalf payment has been made.

Medical Director – The licensed physician designated by the MCO to exercise general supervision over the provision of core benefits and services by the MCO.

Medical Home – Systems of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, nursing homes and home health agencies. Primary care providers are inclusive of physician-led and nurse-practitioner-led primary care practices.

Medical Information – means 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 Loss Ratio – The percentage of PMPM payments received by the MCO from DHH used to pay medical claims from providers and approved quality improvement and IT costs.

Medical Loss Ratio Year – The calendar year for which Medical Loss Ratio is being reported.

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 health care services whether provided by the MCO, 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 §456.211.

Medical Screening – An examination: (1) provided on hospital property, and provided for that patient for whom it is requested or required, (2) performed within the capabilities of the hospital, and provided for that patient for whom it is requested or required, (3) the purpose of which is to determine whether the patient has an Emergency Medical Condition, and (4) performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or physician assistant as permitted by state statutes and regulations and hospital bylaws.

Medical Vendor Administration (MVA) – Refers to the 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 health care 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) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, 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 Medical 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. Medicare is available to 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 an MCO under the provisions of this RFP and also refers to "enrollee" as defined in 42 CFR §438.10(a).

Member Materials – Means all written materials produced or authorized by the MCO and distributed to members or potential members containing information concerning the MCO Program(s). 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 MCO.

Mental Health/Substance Abuse (MH/SA) providers – behavioral health professionals engaged in the treatment of substance abuse, dependency, addiction, or mental illness

Methodology – The planned process, steps, activities or actions taken by an MCO to achieve a goal or objective, or to progress toward a positive outcome.

Monetary Penalties – Monetary sanctions that may be assessed whenever an MCO, its providers, and/or its subcontractors fail to achieve certain performance standards and other items defined in the terms and conditions of the Contract.

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 ~~subcontractual arrangements~~ Provider Network Agreements to an MCO to supply a range of primary and acute health care services. Also referred to as Provider Network.

Network Adequacy – Refers to the network of health care providers for an MCO 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. Network Adequacy will be assessed on the MCOs contracted network providers excluding single case agreements unless otherwise approved by LDH.

Network Provider – An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and Subcontractors, that has a contract with the MCO for the delivery of Core Benefits and Services to the MCO's enrollees.

Network Provider Agreements – A contract between the MCO and a Network provider for the delivery of Core Benefits and Services to members.

New Opportunities Waiver (NOW) – Medicaid 1915(C) Waiver designed to provide home and community based supports and services to beneficiaries with developmental disabilities who require the level of care of an intermediate care facility for people with intellectual / developmental disabilities (ICF/DD).

Newborn – A live infant born to an MCO member.

Non-Contracting Provider – A person or entity that provides hospital or medical care but does not have a contract or agreement with the MCO.

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

Non-Emergency – An encounter by an MCO member who has presentation of medical signs and symptoms, to a health care provider

Non-Emergency Medical Transportation (NEMT) – A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider. NEMT does not include transportation provided on an emergency basis, such as trips to the ED in life threatening situations.

Non-Participating Physician – A physician licensed to practice that has not contracted with or is not employed by the MCO to provide health care services.

Non-Participating Provider – A provider that does not have a signed network provider agreement.

Non-Urgent Sick Care – Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent sick visit include cold symptoms, sore throat, and nasal congestion; requires face-to-face medical attention within 48-72 hours of member notification of a non-urgent condition, as clinically indicated.

Nurse Practitioner (NP) – An advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency such as the American Nurses Association's American Nurses Credentialing Center, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, or the National Certification Board of Pediatric Nurse Practitioners and Nurses, or as approved by the state board of nursing and who is authorized to provide primary, acute, or chronic care, as an advanced nurse practitioner acting within his/her scope of practice to individuals, families, and other groups in a variety of settings including, but not limited to, homes, institutions, offices, industry, schools, and other community agencies.

OCDD Statement of Approval – indicates a person who has gone through a process and been determined to be Eligible for Developmental Disabilities services.

Open Enrollment – The period of time when an MCO member may change MCOs without cause *(once per year after initial enrollment)*.

Open Panel – means PCPs who are accepting new patients for the Louisiana Medicaid MCO program.

Operational Start Date – Means the first day on which an MCO is responsible for providing core benefits and services to MCO members and all related Contract functions. The Operational start date may vary per MCO. The Operational Start Date(s) applicable to this Contract are set forth in the Contract between DHH and the MCO (Appendix B of this RFP).

Oral and Maxillofacial Surgical Services - Medically necessary medical services, rendered by a physician (M.D. or D.O.) or dental professional, if performance of those services are within the scope of the dentist's license.

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

Outlier –- Additional payment that is made for catastrophic costs associated with services provided to 1) children under the age of six who received inpatient services in a disproportionate share hospital setting, and 2) infants who have not attained the age of one year who received inpatient services in any acute care setting.

Ownership Interest – The possession of stock, equity in the capital, or any interest in the profits of the MCO, for further definition see 42 CFR §455.101.

Participating Provider – A provider that has a signed network provider agreement with a MCO.

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

Performance Concern – The informal documentation of an issue. The MCO is required to respond to the performance concern by defining a process to detect, analyze and eliminate non-compliance and potential causes of non-compliance. This is a "warning" and failure to comply with the Corrective Action Plan and/or continued non-compliance may result in formal action against the MCO.

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.

Permanent Supportive Housing (PSH) - Consists of deeply affordable, community-integrated rental housing combined with supportive services that are designed to assist households in gaining and maintaining access to safe, good quality housing. In PSH, the service recipient is the tenant and leasee. Tenancy is not contingent upon continued receipt of services. The State of Louisiana's PSH program serves low income households in which a member has a substantial long term disability.

Personal Care Services (PCS) – Provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. Does not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters.

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

Pharmacy Benefits ~~– For the purposes of this RFP and exclusion from core benefits and services, pharmacy benefits are defined as p~~Prescription drugs that are dispensed by pharmacies.

Pharmacy Benefit Manager (PBM) – a third party administrator of prescription drug programs

Physician Assistant – A health care professional who is a graduate of a program accredited by the Committee on Allied Health Education and Accreditation or its successors and who has successfully passed the national certificate examination administered by the National Commission on the Certification of Physicians' Assistants or its predecessors and who is approved and licensed by the Louisiana State Board of Medical Examiners to perform medical services under the supervision of a physician or group of physicians who are licensed and registered with the board to supervise such assistant. A physician assistant may perform certain duties such as history taking, diagnosis, drawing blood samples, urinalysis, and injections under the supervision of a physician.

Physician Extender – Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services.

Physician Services – The services provided by an individual licensed under state law to practice medicine or osteopathy. It does not include services that are offered by doctors while admitted in the hospital, and charges for which are included in the hospital bill.

Plan – An individual or group that provides, or pays the cost of, medical care.

Plan of Care – Strategies designed to guide health care 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 MCO by DHH for the provision of medical services to MCO members.

Policies – The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and federal rules and regulations.

Post-Stabilization Care Services – Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain, improve or resolve the member's condition pursuant to 42 CFR §422.113(c) and §422.114(e).

Potential Enrollee – A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in an MCO, but is not yet an enrollee of a specific MCO.

Poverty Level – Poverty guidelines issued annually in late January or early February of each year by HHS for the purpose of determining financial eligibility for certain programs including Medicaid and CHIP and which are based on household size.

Pre-Admission Screening and Resident Review (PASRR) – Pre-Admission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.

Preauthorization - A decision by the MCO that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification.

Pre-Certification – Review conducted prior to a member's utilization of a I service or course of treatment in a hospital or other facility.

Preferred Drug List (PDL) – a list maintained by the MCO indicating which drugs providers are permitted to prescribe without seeking prior authorization.

Premium – An amount to be paid on for an insurance policy.

Prescription Drugs – A drug that can be obtained only by means of a physician's prescription.

Prescription Drug Coverage – Health insurance or plan that helps enrollees pay for prescription drugs and medications.

Preventive Care – Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred; requires a face-to-face visit within 4 weeks of member request.

Primary Care Case Manager (PCCM) – A physician, physician group practice, or entity that employs or arranges with physicians to furnish primary care case management services.

Primary Care Physician – A physician who provides both the first contact for an enrollee with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.

Primary Care Provider (PCP) – An individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of a member's health care. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.

Primary Care Services – Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either 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.

Prospective Review – Utilization review conducted prior to an admission or a course of treatment.

Protected Health Information (PHI) – Individually identifiable health that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164.

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

Provider Appeal – The formal mechanism which allows a provider the right to appeal an MCO final decision.

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

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

Provider Preventable Condition – Preventable healthcare-acquired or other provider-preventable conditions and events, also known as never events, identified by DHH for nonpayment, such as but not limited to, bed pressure ulcers or decubitus ulcers; or events such as surgical or invasive procedures performed on the wrong body part or wrong patient; wrong surgical procedure performed on a patient.

Provider Subcontract – An agreement between an MCO and a provider of services to furnish core 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 MCO specifically related to fulfilling the MCO's obligations under the terms of this RFP.

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

Quality – As it pertains to external quality review means the degree to which an MCO 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 all MCO entities, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve health care 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 – Refers to DHH's assessment of the MCO's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of MCO 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 can make an informed assessment of the MCO's ability and readiness to render services.

Re-admission – Subsequent admissions of a patient to a hospital or other health care institution for treatment.

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.

Recovery (In reference to behavioral health services) – A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Redacted Proposal – The removal of confidential and/or proprietary information from one copy of the proposal for public records purposes**.**

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

Registered Nurse (RN) – Person licensed as a Registered Nurse by the Louisiana State Board of Nursing.

Rehabilitation Services and Devices – Services ordered by the member's PCP to help the member recover from an illness or injury. These services are provided by nurses and physical, occupational, and speech therapists.

Reinsurance – Insurance an MCO 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.

Related Party – A party that has, or may have, the ability to control or significantly influence a contractor/subcontractor, or a party that is, or may be, controlled or significantly influenced by a contractor/subcontractor. "Related parties" include, but are not limited to, agents, management employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Relationship – Relationship is described as follows for the purposes of any business affiliations discussed in Section 5: A director, officer, or partner of the MCO; A person with beneficial ownership of five percent or more of the MCO's equity; or A person with an employment, consulting or other arrangement (e.g., providers) with the MCO 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 MCO, payments for maternity, and adjustments.

Reporting Year – With regard to healthcare quality measure reporting, reporting year refers to the time frame when healthcare data are reported. For example, for HEDIS® 1997, the reporting year is 1997.

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.

Residential Options Waiver (ROW) – Medicaid 1915(c) waiver designed to assist beneficiaries of this service in leading healthy, independent, productive lives to the fullest extent possible and to promote the full exercise of their rights as citizens of Louisiana.

Responsible Party – An individual, often the head of household, 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.

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

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. The MCO, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Risk Adjustment – A method for determining adjustments to the PMPM rate that accounts for variation in health risks among participating MCOs when determining capitation payments.

Routine Care – Treatment of a condition which would have no adverse effects if not treated within 24 hours or that could be treated in a less acute setting (e.g., physician's office) or by the patient.

Routine Primary Care – Routine primary care services include the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/reduce risk of development of chronic illness or the need from more complex treatment. Examples include psoriasis, chronic low back pain; requires a face-to-face visit within four (4) weeks of member request.

Rural Area – Refers to any parish in the state that meets the Office of Management and Budget definition of rural. (See Appendix LL 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 health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services. RHCs must be reimbursed by the MCO using prospective payment system (PPS) methodology.

Rural Hospital – hospital licensed by DHH which meets the definition in R.S. 40:1300.143.

School Based Health Center (SBHC) – A health care provider certified by the Office of Public Health that is physically located in a school or on or near school grounds that provide convenient access to comprehensive, primary and preventive physical and mental health services for public school students.

Scope of Services – See “Covered Services.”

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.

Secondary Care – Health care services provided by medical specialists who generally do not have first contact with patients, but instead are referred to them by primary care providers.

Section 1915(b)(3) – This section of the Social Security Act allows the State to share cost savings resulting from the use of more cost-effective medical care with members by providing them with additional services. The savings must be expended for the benefit of the Medicaid member enrolled in the waiver.

Section 1931 – Category of Medicaid eligibility for low-income parents who do not receive cash assistance but whose income is below Louisiana’s 1996 Aid to Families with Dependent Children income threshold. Louisiana’s name for this program is Low Income Families with Children (LIFC).

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

Service Area – The designated area in which the MCO is authorized to furnish core benefits and services to enrollees. The service area is the entire 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 MCO 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 MCO-eligible population in the base year of 2013.

Skilled Nursing Care – A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Social Security Act – The current version of the Social Security Act of 1935 (42 U.S.C. §301 et seq.), which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).

Solvency – The minimum standard of financial health for an MCO where assets exceed liabilities and timely payment requirements can be met.

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

Special Health Care Needs Population – An individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care requirements. Specialized Behavioral Health Services include, but are not limited to services specifically defined in the Medicaid State Plan. Specialized Behavioral Health Services also include any other behavioral health service subsequently amended into the Medicaid State Plan or waivers. Effective December 1, 2015, these services are covered by the MCO for all covered populations except for Specialized Behavioral Health Services covered by the Coordinated System of Care contractor.

Specialist/Specialty Services – A specialist/subspecialist is a health care professional who is not a primary care physician.

Specialized Behavioral Health Services (BHS) – Mental health services and substance abuse services that include, but are not limited to, services specifically defined in the state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider.

Stabilized – With respect to an emergency medical condition; that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the

transfer of the individual from a facility, or with respect to a woman in labor, the woman has delivered (including the placenta).

Start-Up Date – The date MCO providers begin providing medical care to their Medicaid members. Also referred to as operations start date and "go-live :date.

State – The state of Louisiana.

State Plan – Refers to the Louisiana Medicaid State Plan.

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

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

Subsidiary – Means an affiliate controlled by such person or entity directly or indirectly through one (1) or more intermediaries.

Subspecialist Services – **See Specialty Services**

Supplemental Security Income (SSI) – A federal program which provides a cash benefit to people who are aged, blind or disabled and who have little or no income or assets Louisiana is a "Section 1634" state and anyone determined eligibility for SSI is automatically eligible for Medicaid.

Supports Waiver (SW) – Medicaid 1915(c) waiver designed to enhance the home and community based supports and services available to beneficiaries with developmental disabilities who require the level of care of an ICF/DD through vocational and community inclusion.

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 MCO from the provider and/or switch vendor until the MCO hands-off a response to the provider and/or switch vendor.

System Unavailability – Measured within the MCO'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.

Targeted Case Management – Case management for a targeted population of persons with special needs described in the Louisiana Medicaid State Plan.

Tenancy Supports – Supports provided under CPST to that subset of recipients accepted for participation in Louisiana's Permanent Supportive Housing program. Tenancy and pre-tenancy supports are designed to help members access and maintain successful tenancy in the community-integrated, affordable housing provided through Louisiana's PSH program. Tenancy and pre-tenancy supports consist of activities such as helping members complete apartment applications, seek reasonable accommodation, negotiate and enter into leases, understand the role of tenant, understand tenant rights, develop budgets, make timely rent payments, comply with terms of lease, adjust to new home and neighborhood (including how to get to and access essential services), apply for income benefits such as SSI, comply with medication and other treatment regimes, and develop/implement crisis plans to avoid eviction.

Tertiary Care – Highly specialized medical care, usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Third Party Liability (TPL) – Refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan.

Tiered Contraceptive Counseling - An approach in which information on the most effective contraceptive methods appropriate for a client (based on assessment of their reproductive intentions and contraceptive preferences) is presented first, before presenting information on less effective methods.

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

Title IV-E – Section of the Social Security Act of 1935 that encompasses medical assistance for foster children and adoption assistance.

Title V – Section of the Social Security Act of 1935 that encompasses maternal child health services.

Title X – Section of the Social Security Act of 1935 that encompasses and governs family planning services.

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

Title XXI – Section of the Social Security Act of 1935 that encompasses and governs the Children's Health Insurance Program (CHIP).

Transition Phase – Includes all activities the MCO is required to perform between the Contract effective date and the implementation date for the MCO.

Treatment Planning – is an administrative treatment planning activity provided under Medicaid requirements at 42 CFR §438.208(c) for entities for developing and facilitating implementation of individualized Plans Of Care. Treatment planning is provided to address the unique needs of clients living in the community and does not duplicate any other Medicaid State Plan service or services otherwise available to the recipient at no cost.

Treatment Planner – The function of the Treatment Planner is to produce a community-based, individualized treatment plan. This includes working with the individual and/or family to identify

who should be involved in the treatment planning process. The Treatment Planner guides the treatment plan development process. The Treatment Planner also is responsible for subsequent treatment plan review and revision as needed, under established guidelines, to review the treatment plan and more frequently when changes in the member's circumstances warrant changes in the treatment plan. The Treatment Planner will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the child or adult and family/caregivers.

Turnover Phase – includes all activities the MCO is required to perform in conjunction with the end of the Contract.

Turnover Plan – means the written plan developed by the MCO, approved by DHH, to be employed during the turnover phase.

Universal Rate – The PMPM rate initially paid to MCOs prior to the first risk adjustment, calculated using fee-for-service (FFS) data for the entire MCO population.

Urban Area – Refers to a geographic area that meets the definition of urban area at §412.62(f)(1)(ii) which is a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget; A list of Louisiana parishes in Metropolitan Statistical Areas can be found at http://www.doa.louisiana.gov/census/metroareas.htm

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. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. 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) – Refers to t*he* process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care 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 health care benefits and services, procedures or settings, and ambulatory review, prospective review, concurrent 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.

Value-Added Benefit – The additional benefits outside of the core benefits and services included in this RFP that are delivered at the MCO's discretion and are not included in capitation rate calculations. Value-added benefits seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.

Voluntary Population – Refers to categories of individuals eligible for, and enrolled in Louisiana Medicaid who are not mandated to enroll in an MCO. By default they will be included in the MCO program, if they do not opt out during the 30 day choice period.

WIC – (Women, Infants and Children) Federal program administered by the Office of Public Health that provides nutritional counseling; nutritional education; breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women and infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income. An individual who is eligible for Medicaid is automatically income eligible for WIC benefits.

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 Health Care (ADHC), Elderly Disabled and Adult (EDA), Supports Waiver, Residential Options Waiver (ROW), and any other 1915(c) waiver that may be implemented. Participants in waivers are excluded from enrolling in an MCO.

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

Will – Denotes a mandatory requirement.

Willful – Refers to conscious or intentional but not necessarily malicious act.

Wraparound Agency (WAA) – WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination for children within the CSoC needing such supports, with the goal of "one family, one plan of care, and one wraparound facilitator."

ACRONYMS

ACE – Adverse Childhood Experience

ACT – Assertive Community Treatment

ADA – Americans with Disabilities Act

AFDC – Aid to Families with Dependent Children

APM – Alternative Payment Model

APRN - Advanced Practice Registered Nurse

ASAM – American Society of Addiction Medicine

ASM – Addiction Services Manager

BCC – Breast and/or Cervical Cancer

BHS – Behavioral Health Services

BHSF – Bureau of Health Services Financing

CAH – Critical Access Hospital

CAHPS – The Consumer Assessment of Health Providers and Systems

CANS – Child and Adolescent Needs and Strengths

CAP – Corrective Action Plan

CCMP – Chronic Care Management Program

CDC – Centers for Disease Control and Prevention

CFR – Code of Federal Regulations

CHAMP – Child Health and Maternal Program

CHCQM – Certified in Health Care Quality and Management

CHIP – Children's Health Insurance Program

CM - Care Manager

CMS – Centers for Medicare and Medicaid Services

CNM – Certified Nurse Midwife

CNS – Clinical Nurse specialist

COB – Coordination of Benefits

COLA – Cost of Living Adjustment

CPHQ – Certified Professional in Healthcare Quality

CPST – Community Psychiatric Support and Treatment

CPT – Current Procedural Terminology

CSoC – Coordinated System of Care

CY – Calendar Year

DCFS – Department of Children and Family Services

DD – Developmentally Disabled

DHH – Department of Health and Hospitals

DHHS – Department of Health and Humans Services (also HHS)

DM – Disease Management

DME – Durable Medical Equipment

DMEPOS – Durable Medical Equipment, Prosthetics Orthotics and certain Supplies

DOI – Louisiana Department of Insurance

DUR – Drug Utilization Review

EB – Enrollment Broker

EBP – Evidenced Based Practices

EHR – Electronic Health Records

ELE – Express Lane Eligibility

EOB – Explanation of Benefits

EPO – Exclusive Provider Organizations

EPSDT - Early and Periodic Screening, Diagnosis and Treatment

EQR – External Quality Review

EQRO - External Quality Review Organization

FDA – Food and Drug Administration

FFP – Federal Financial Participation

FFS –- Fee for Service

FFT – Functional Family Therapy

FI – Fiscal Intermediary

FITAP – Family Independence Temporary Assistance Program

FMP – Full Medicaid Payment

FQHC – Federally Qualified Health Center

FSO – Family Support Organization

FTE – Full-Time Equivalent

FY – Fiscal Year

HCBS – Home and Community Based Services Waiver

HCFA – Health Care Financing Administration

HCP-LAN – Health Care Payment Learning and Action Network

HEDIS – Healthcare Effectiveness Data and Information Set

HHS –United States Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HIPDB – Health Integrity Protection Data Bank

HITECH – Health Information Technology for Economic and Clinical Health Act

HMO – Health Management Organization

HPE – Hospital Presumptive Eligibility

HRSA – Health Resources and Services Administration

HSIC - Human Services Interagency Council

IBNR – Incurred But Not Reported

ICF/DD – Intermediate Care Facility for the Developmentally Disabled

I/DD – Intellectual/Developmental Disability

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Plan

IHCP – Indian Health Care provider

IHS – Indian Health Service

IPAT – Integrated Practice Assessment Tool

IS – Information Systems

LAC – Licensed Addiction Counselor

LaCHIP – Louisiana Children's Health Insurance Program

LDOE – Louisiana Department of Education

LaHIPP – Louisiana Health Insurance Premium Payment Program

LCSW – Licensed Clinical Social Worker

LEIE – List of Excluded Individuals/Entities

LGE – Local Governing Entity

LIFC – Low Income Families and Children

LMHP – Licensed Mental Health Professional

LOB – Lines of Business

LOCUS – Level of Care Utilization System

LTSS – Long-Term Supports and Services

MCH – Maternal Child Health

MCO – Managed Care Organization

MEF – Medicaid Exclusion File

MHPAEA – Mental Health Parity and Addiction Equity Act

MH/SA – Mental Health/Substance Abuse

MHBG – Mental Health Block Grant

MHR – Mental Health Rehabilitation

MMIS – Medicaid Management Information System

MLR – Medical Loss Ratio

MST – Multi-Systemic Therapy

MU – Meaningful Use

MVA – Medical Vendor Administration

NAIC – National Association of Insurance Commissioners

NCQA –National Committee for Quality Assurance

NDC – National Drug Code

NEAT – Non-Emergency Ambulance Transportation

NEMT – Non-Emergency Medical Transportation

NOMS – National Outcome Measures

NP – Nurse Practitioner

NPI – National Provider Identifier

OIG – Office of Inspector General

OJJ – Office of Juvenile Justice

OON – Out of Network Provider

P&T – Pharmaceutical and Therapeutics

PA – Physician's Assistant

PA – Prior Authorization

PASRR – Pre-Admission Screening and Resident Review

PBM – Pharmacy Benefit Manager

PCCM – Primary Care Case Manager

PCN – Processor Control Number

PCP – Primary Care Provider

PCS – Personal Care Services

PDL – Preferred Drug List

PHI – Personal Health Information

PHR – Personal Health Record

PIP – Performance Improvement Projects

PMP - Prescription Monitoring Program

PMPM – Per Member, Per Month

PPACA – Patient Protection and Affordable Care Act

PPC – Provider Preventable Condition

PPO – Preferred Provider Organizations

PPS – Prospective Payment System

PRTF - Psychiatric Residential Treatment Facilities

PSAO - Pharmacy Services Administrative Organization

PSH – Permanent Supportive Housing

PSR – Psychosocial Rehabilitation

QAPI – Quality Assessment and Performance Improvement Plan

QM – Quality Management

RFP – Request for Proposals

RHC – Rural Health Clinic

RN – Registered Nurse

RSDI – Retirement, Survivors, and Disability Insurance

SABG – Substance Abuse Block Grant

SAM – System of Award Management

SBHC – School Based Health Center

SBHS – Specialized Behavioral Health Services

SFTP – Secure File Transfer Protocol

SHCN – Special Health Care Needs

SMI – Serious Mental Illness

SSA – Social Security Act

SSI – Supplemental Security Income

STP – Significant Traditional Provider

SUD – Substance Use Disorder

TANF –Temporary Assistance for Needy Families

TEDS – Treatment Episode Data Sets

TGH – Therapeutic Group Home

TPL – Third Party Liability

TTY/TDD – Telephone Typewrite and Telecommunications Device for the Deaf

UM – Utilization Management

UR – Utilization Review

WAA – Wraparound Agency

WIC – Women, Infants and Children Program

LIST OF APPENDICES TO RFP

This RFP should be considered to be comprised of all appendices herein. The list includes mandatory requirements for proposals to be considered complete as described in Appendix KK.

Appendix A – Certification Statement

Appendix B – DHH Standard Contract Form (CF-1)

Appendix C – HIPAA Business Associate Agreement

Appendix D – Veterans Hudson Initiative

Appendix E – Reserved

Appendix F – Louisiana Standardized Credentialing Application Form

Appendix G – Rates with Actuarial Rate Certification Letter

Appendix H – MLR (Medical Loss Ratio) Calculation Methodology

Appendix I – Reserved

Appendix J – MCO Performance Measures

Appendix K – WIC Referral Form

Appendix L – Hysterectomy Consent Form

Appendix M – Sterilization Consent Form

Appendix N – Abortion Consent Form

Appendix O – MCO Subcontract Requirements

Appendix P – MCO Data Use Agreement

Appendix Q – Requirements for MCO Physician Incentive Plans

Appendix R – Provider's Bill of Rights

Appendix S – Request for Newborn ID Manual

Appendix T – MCO Request for Member Disenrollment

Appendix U – Guidelines for Member Disenrollment

Appendix W – Enrollment Broker Responsibilities

Appendix X – DHH Event Submission Form

Appendix Y – Reserved

Appendix Z – DHH Marketing Complaint Form

Appendix AA – Member's and Potential Member's Bill of Rights

Appendix BB – Marketing Plan Monthly Report

Appendix CC – Grievance and Appeal and Fair Hearing Log Report

Appendix DD – Performance Improvement Projects

Appendix EE – Reserved

Appendix FF – MCO Provider and Subcontractor Listing

Appendix GG – Reserved

Appendix HH – EPSDT Reporting

Appendix II – Model Attestation Letter for Reports

Appendix JJ – Transition Period Requirements

Appendix KK – MCO Proposal Submission and Evaluation Documents

Appendix LL – Louisiana Rural Parishes Map

Appendix MM – Attestation of Provider Network Submission

Appendix NN – Person First Policy

Appendix OO – Emergency Management Plan Template

Appendix PP – Provider Incentive Payments Template

Appendix QQ – Reference Questionnaire

Appendix RR – MCO-OPH MOU

Appendix SS – Provider Network - Appointment Availability Standards

Appendix TT – Network Providers by Specialty Type

Appendix UU – Provider Network - Geographic and Capacity Standards

Appendix VV – Medicaid Ownership and Disclosure Form

Appendix WW – HEDIS Reporting

LIST OF MCO COMPANION GUIDES

1. **Financial Reporting Companion Guide**
2. **MCO Systems Companion Guide**
3. **State Fair Hearing Companion Guide**
4. **MCO Quality Companion Guide**
5. **MCO Encounter Data Companion Guide**
6. **Behavioral Health Companion Guide**
7. **Reporting Companion Guide**
8. **Batch Pharmacy Encounter Companion Guide**