LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

REQUEST FOR PROPOSALS

STATEWIDE MANAGEMENT ORGANIZATION

LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP

OFFICE OF BEHAVIORAL HEALTH

RFP # 305PUR-DHHRFP-SMO-2014-OBH
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GLOSSARY

Adverse Action – Any decision by the SMO to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 CFR §438.210(c).

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

Age Discrimination Act of 1975 – Prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements. The Age Discrimination Act is enforced by the Civil Rights Center.

Age of Majority – Louisiana Civil Code, Article 29, provides that majority is attained upon reaching the age of eighteen years.

Agent – Any person or entity with delegated authority to obligate or act on behalf of another party.

Americans with Disabilities Act of 1990 (ADA) – The Americans with Disabilities Act prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. The ADA also establishes requirements for telecommunications relay services.

Appeal – A request for a review of an action pursuant to 42 CFR §438.400(b).

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

Basic Behavioral Health Services – services provided in the member's PCP or medical office by the member's (non-behavioral health specialist) physician (i.e., DO, MD, APRN) as part of routine physician evaluation and management activities (e.g., screening, prevention and referral).

Bayou Health – Bayou Health is the way most of Louisiana's Medicaid and LaCHIP recipients receive health care services. In Bayou Health, Medicaid recipients have a choice to enroll in one of several different health plans, each with different provider networks, referral policies, health management programs, and extra services and incentives offered. It is designed to improve performance and health outcomes through the creation of a cost-effective integrated healthcare delivery system, which provides a continuum of evidence-based, quality-driven healthcare services for Medicaid/CHIP eligibles.

Board Certified – An individual who has successfully completed all prerequisites of a medical specialty board and has successfully passed the required examination for certification.

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

Business Day – Traditional workdays include Monday, Tuesday, Wednesday, Thursday, and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m.

Calendar Days – All seven days of the week. Unless otherwise specified, the term "days" in this document refers to calendar days.

Call Abandonment - the number of calls abandoned by callers after being placed in the ACD call queue and before being answered by a live customer service representative.

Can - Denotes a preference but not a mandatory requirement.

Care Coordination – Deliberate organization of member care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in a member's care. This coordination may include care provided by network or non-network providers. Organizing care involves the marshaling of personnel and other resources needed to carry out all required member care activities; it is often facilitated by the exchange of information among participants responsible for different aspects of the member's care.

Care Management – Overall system of medical management encompassing utilization management, 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; these services may include medical, social, educational, and other support services. Case management services include an individual needs and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and outcomes monitoring.

Centers for Medicare & Medicaid Services (CMS) – The agency within the U.S. 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. This agency was formerly known as the Health Care Financing Administration (HCFA).

CHIP – The Children's Health Insurance Program was created in 1997 by Title XXI of the Social Security Act. This program is known in Louisiana as LaCHIP.

***Chisholm* Class Members** – All current and future recipients of Medicaid in the State of Louisiana, under age 21, who are now on, or will in the future be placed on, the Developmental Disabilities Request for Services Registry.

Claim – A request for payment for benefits received or services rendered.

Clean Claim – A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

CMS 1500 – A universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.

Co-Occurring Disorders (COD) – The presence of mental and substance use disorders. Clients said to have COD have one or more substance use disorders, as well as one or more mental disorders.

Contract - A written, signed and statutorily approved agreement related to this RFP.

Contract Dispute - A circumstance whereby the Department and the contractor are unable to arrive at a mutual interpretation of the requirements, limitations, provisions or compensation for the performance of services under the contract.

Convicted - A judgment of conviction entered by a federal, state or local court, including a conviction based on a plea of guilty or nolo contendere, regardless of whether an appeal from that judgment is pending.

Coordinated System of Care (CSoC) - A component of the Louisiana Behavioral Health Partnership that is focused on responding to the needs of young people who have significant behavioral health challenges who are in or at imminent risk of out-of-home placement, and their families; 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.

Coordination of Benefits (COB) – Refers to the activities involved in determining Medicaid benefits when a recipient has other coverage through an individual or group insurance plan or other program that is liable to pay for the member's healthcare services.

Corrective Action Plan (CAP) – A plan that is designed to ameliorate an identified deficiency and prevent recurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.

CPT® – **Current Procedural Terminology**, current version, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other healthcare professional services and procedures under HIPAA.

CSoC Eligible – Children and youth eligible for services under the CSoC.

Culture - Refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

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

Department of Health and Human Services (DHHS; also HHS) – The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. DHHS provides oversight for more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families.

Dispensing Fee – the fee paid by the Health Plan to reimburse the overhead and labor expense incurred by pharmacy providers and the professional services provided by a pharmacist when dispensing a prescription.

Duplicate Claim – A claim that is either a total or partial duplicate of services previously paid.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – A federally-required Medicaid benefit for individuals under age 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of: 1) screening and diagnostic services to determine physical or mental defects and 2) healthcare, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (42 CFR §440.40(b)). EPSDT requirements help to ensure access to all medically necessary healthcare services within the federal definition of "medical assistance."

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

Eligible – An individual qualified to receive services through the SMO, consistent with any applicable eligibility requirements of DHH, DCFS, OJJ, LDOE, and the local education agencies.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish these services under 42 CFR §438.114(a) and §1932(b)(2) of the Social Security Act and that are needed to screen, evaluate, and stabilize an emergency medical condition.

Emergent – Serious or extreme risk of harm, such as current suicidal ideation with expressed intentions; recent use of substances resulting in decreased inhibition of harmful behaviors; repeated episodes of violence toward self and others; or extreme compromise of ability to care for oneself leading to physical injury.

Encounter Data – Records or data of medically-related services rendered by a provider to a SMO member on a specified date of service. This data is inclusive of all services for which there is any financial liability to a provider (Medicaid or non-Medicaid).

Enrollee – A Louisiana Medicaid or CHIP eligible (recipient) who is currently enrolled in a SMO. This definition may also include a person who is qualified for Medicaid and whose application has been approved but who may or may not be receiving services.

Enrollment – The process conducted by DHH to enroll a Medicaid or CHIP eligible into a SMO.

Evidence-Based Practice – Clinical interventions that have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired goals of health and wellness.

External Quality Review – An analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to health care services that an MCO or PIHP, or their contractors, furnish to Medicaid beneficiaries.

External Quality Review Organization (EQRO) — An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs EQR and/or other related activities for states with Medicaid managed care programs.

Experimental Treatment/Service – A procedure or service that requires additional research to determine its safety, effectiveness, and benefit compared to standard practices. The available clinical scientific date may be relatively weak or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

Family – For the purpose of the CSoC, family is defined as the primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of the psycho-education service“, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual. Services may be provided individually or in a group setting.

Federal Financial Participation (FFP) – Also known as federal match or the percentage of federal matching dollars available to a state to provide Medicaid and CHIP services. The Federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.

Federal Poverty Level (FPL) – Poverty guidelines issued annually, typically in late January or early February, by DHHS for the purpose of determining financial eligibility for certain programs, including Medicaid and CHIP. The guidelines are based on household size, and are updated from the Census Bureau's latest published weighted average poverty thresholds.

Federally Qualified Health Center (FQHC) – An entity that receives a grant under Section 330 of the Public Health Service Act, as amended (Also see Section 1905(1)(2)(B) of the Social Security Act) to provide primary healthcare and related diagnostic services to individuals on a sliding fee schedule. The FQHC may also provide dental, optometric, podiatry, chiropractic, and behavioral health services.

Fee-for-Service (FFS) – A method of provider reimbursement based on payments for specific services rendered to an enrollee.

FFS Provider – An institution, facility, agency, person, corporation, partnership, or association approved by DHH that accepts payment in full for providing care to a Medicaid or CHIP eligible person. The amounts paid are specified in the state's approved Medicaid reimbursement provisions, regulations, and schedules.

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

Fiscal Year (FY) – Refers to budget year. The federal fiscal year (FFY) is October 1 through September 30, and the state fiscal year (SFY) is July 1 through June 30.

Fraud – As it relates to the Medicaid program, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to 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 individual full-time employee who works 40 hours per week. The definition can also include a full-time primary care physician who delivers outpatient preventive and primary (routine, urgent, and acute) care for 32 hours or more per week (exclusive of travel time), during a minimum of four days per week.

GEO Mapping – The process of finding associated geographic coordinates (often expressed as latitude and longitude) from other geographic data, such as street

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

Go-Live – The date the contract becomes operational, preceded by the Division of Administration/Office of Contractual Review approval of the contract signed between DHH-OBH and the SMO.

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 healthcare purchasers understand the value of healthcare purchases and measure plan (e.g., SMO) performance.

Healthcare Professional – A physician or other healthcare practitioner licensed, accredited, or certified to perform specified health services consistent with state law.

Healthcare Provider – A healthcare professional or entity that provides healthcare services or goods.

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

HIPAA Security Rule (45 CFR Parts 160 & 164) - Federal regulations requiring covered entities to maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their electronic protected health information against any reasonably anticipated risks.

Home and Community-Based Services Waiver (HCBS) – Under Section 1915 (c) of the Social Security Act, states may request waivers of statewideness, 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 Healthcare, Supports Waiver, Adult Residential Options, and the pending Coordinated System of Care (CSoC) Severely Emotionally Disturbed (SED) Children's Waiver.

ICD-9-CM codes (International Classification of Diseases, 9th Revision, Clinical Modification) – Codes currently used to identify diagnoses. No earlier than October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures and for billing purposes will be replaced by ICD-10 code sets.

ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) – No earlier than October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.

IEP Services – These are specialized educational and related services–included in a student's Individualized Education Program (IEP); included, but not limited to are physical therapy, occupational therapy, speech/language therapy, audiology, special transportation, nursing services and behavioral health services. The enrolled provider must be a public school system (LEA) and the provider certifies the state match via CPE. The LEA bills on a fee-for-service basis through the MMIS claims payment

system, which makes an interim payment. A cost settlement process occurs at the end of the year.

Incurred But Not Reported (IBNR) – Services rendered for which a claim/ encounter has not been received by the SMO.

Plan of Care (PoC) – The Plan of Care identifies the waiver services, as well as other services and supports that a person needs in order to live successfully in the community and, therefore, avoid institutionalization. It must reflect the full range of a participant's service needs and include both the Medicaid and non-Medicaid services, along with informal supports that are necessary to address those needs. When non-waiver services and supports are needed to meet the needs of the participant, their provision must be monitored. The IPoC must contain, at a minimum, the services that are furnished, the amount and frequency of each service, and the type of provider to furnish each service. The IPoC must be revised, as necessary, to add or delete services or modify the amount and frequency of services. The IPoC must be reviewed at least annually, or whenever necessary, due to a change in the participant's needs.

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 or facilitating a business process or related transaction.

Insolvency – A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets, or as determined by the Louisiana Department of Insurance, pursuant to Title 22 of the Louisiana Revised Statutes.

Louisiana Children's Health Insurance Program (LaCHIP) – Louisiana's name for the Children's Health Insurance Plan created by Title XXI of the Social Security Act in 1997. Provides healthcare coverage for uninsured children up to age 19 through a Medicaid expansion program up to and including 217% FPL and a separate state CHIP program for the unborn prenatal option for uninsured pregnant women up to and including 214% FPL and for children with income from 218% up to and including 255% FPL.

LaCHIP Phase IV (Prenatal Program) – Louisiana's separate CHIP (Title XXI) program, which provides prenatal coverage through the Medicaid delivery system for unborn children whose uninsured citizen/non-citizen pregnant mothers are ineligible for Medicaid and have net family income at or below 214% FPL.

LaCHIP Phase V (Affordable Plan) – Louisiana's separate CHIP (Title XXI) program that provides health coverage to uninsured children in families with income from 218% up to and including 255% FPL.

LMHP – A Licensed Mental Health Professional (LMHP) is an individual who is licensed in the state of Louisiana to diagnose and treat mental illness or substance disorder acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)

- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & 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)

LOCUS (Level of Care Utilization System) – This clinical tool evaluates and determines level of care placements for psychiatric services.

Louisiana Behavioral Health Partnership - The behavioral health program managed by DHH-OBH that includes behavioral health services for adults with serious mental illness (SMI); the child/adult population with specialized behavioral health needs; and a special target population of children eligible for the Coordinated System of Care (CSoC). The benefit package for this second population includes inpatient psychiatric care, emergency room care, substance use services and care by psychiatrists for all adults and children. It also includes all EPSDT behavioral healthcare services for all Medicaid children. This population could be referred to as a traditional behavioral health carve-out program. The Louisiana Behavioral Health Partnership is managed by DHH-OBH, which oversees the Statewide Management Organization (SMO), the prepaid inpatient health plan (PIHP) that implements (1) the 1915(b) waiver; (2) the 1915(i) Medicaid State Plan Amendment for adults with serious mental illness; and (3) the CSoC – 1915(c) SED children's waiver. Pending CMS approval, the SMO will be at risk for adult and children's services. Adults are eligible under the SMO for Medicaid State Plan services including care by psychiatrists, inpatient psychiatric care, emergency rooms, and substance use services. Children are eligible under the SMO for those Medicaid State Plan services as well as all medically necessary EPSDT services. The SMO will also manage prior authorization of behavioral health services for non-Medicaid eligible populations served by DHH-OBH, DCFS, and OJJ, and funded through state general funds and block grants, including services for individuals with co-occurring mental health and addictive disorders.

Louisiana Medicaid State Plan – This is the binding written agreement between DHH and CMS that describes how the Medicaid program is administered and determines the covered services for which DHH will receive federal financial participation. Also referred to as the Medicaid State Plan.

Major Mental Disorder (MMD) – A diagnosable mental disorder commonly associated with higher levels of impairment, per the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or subsequent revisions of these documents, including schizophrenia, delusional disorders, psychotic disorders, bipolar disorders, and major, single, or recurrent depression.

Managed Care Organization (MCO) - An entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR §438.2, and that is a Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR §439; or any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

- Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
- Meets the solvency standards of 42 CFR §438.116.

Mass Media – A method of public advertising used to create SMO name recognition among a large number of Medicaid/CHIP recipients and educate them about potential healthcare choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters, and videos in doctors' waiting rooms.

Material Change – Material changes are changes affecting the delivery of care or services provided under the Provider Agreement. Material changes include, but are not limited to, changes in composition of the provider or contractor network; healthcare delivery systems, services, or expanded services; benefits; enrollment of a new population; procedures for obtaining access to or approval for healthcare services; any and all policies and procedures that require DHH approval prior to implementation; and the SMO's capacity to meet minimum enrollment levels. DHH-OBH shall make the final determination as to whether a change is material.

May - Denotes a preference but not a mandatory requirement.

Medicaid – A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving eligible individuals.

Medicaid/CHIP Eligible – Refers to an individual determined eligible, pursuant to federal and state law, to receive medical care, goods and services for which DHH may make payments under the Medicaid or CHIP programs.

Medicaid/CHIP Recipient – An individual who has been determined eligible for the Medicaid or CHIP program that may or may not be currently enrolled in the Program**,** and on whose behalf payment is made.

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

Medicaid Eligibility Office – DHH offices located within select parishes of the state that are responsible for making initial and ongoing Medicaid financial eligibility determinations.

Medicaid Enrollee - Refers to an individual determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid program, who is enrolled in the Medicaid program, and on whose behalf payments may or may not have been made.

Medicaid Managed Care Plan - Denotes either a managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, or primary care case management as defined in this Glossary.

Medicaid Management Information System (MMIS) – Mechanized claims processing and information retrieval system, which all state Medicaid programs are required to have and must be approved by the Secretary of DHHS. This system pays claims for Medicaid services and includes information on all Medicaid providers and enrollees.

Medicaid State Plan – This is the binding written agreement between DHH and CMS that describes how the Medicaid program is administered and determines the covered services for which DHH will receive federal financial participation. Also, Louisiana Medicaid State Plan.

Medical Loss Ratio – The expense ratio of administrative costs to service costs as it relates to revenue received by the SMO for their capitated rate population.

Medical Record – A single complete record kept at the site of the member's treatment(s) or care management entity, which documents all treatment plans developed, including, but not limited to, outpatient and emergency medical healthcare services, provided by the SMO, its contractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR §456.111 and 42 CFR §456.211.

Medically Necessary Services – Healthcare services that are in accordance with generally accepted evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must: 1) be 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 be 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 DHH-OBH Assistant Secretary and/or Medical Director, in consultation with the Medicaid Director and/or 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 of U.S. citizens age 65 and older and some people with disabilities under age 65.

Member – Persons enrolled in the SMO.

Member Bill of Rights – 42 CFR §438.100.

Mercer (Mercer Government Human Services Consulting) - The consulting firm with which the state has contracted to provide expertise in specific aspects of

healthcare management such as actuarial rate development and analysis, encounter reporting and analysis, healthcare reform and risk adjustment.

Monetary Penalties – Monetary sanctions that may be assessed whenever the SMO, its providers, or its contractors fail to achieve certain performance measures and other requirements defined in the terms and conditions of the provider agreement.

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 other managed care plans.

Near Real Time – Denoting or relating to information systems that incur a slight delay between automated data processing and transmission, which shall be within minutes for the purposes of this RFP.

Network – As used in the Contract, "network" may be defined as a group of participating providers linked through contractual arrangements to the SMO to supply a range of behavioral healthcare services. The term "provider network" may also be used.

Network Adequacy – Refers to the network of behavioral healthcare providers for the SMO (whether in- or out-of-network) that is sufficient in numbers and types of providers/facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, provider/patient ratios, geographic accessibility and travel distance, waiting times for appointments, and hours of provider operations.

Notice of Action – The purpose of the Notice of Action is to advise the beneficiary of the action as defined in Section 16 of this RFP and to provide information on the beneficiary's right to appeal the decision.

Notice to Cure – Notice issued by DHH to inform the SMO of a deficiency or non-compliance with the RFP or contract requirements. The Notice to Cure specifies a period of time for the SMO to bring its performance back into compliance with the contract. If the SMO's compliance is not corrected within the Notice to Cure time period, the SMO may face further remediation.

OBH– Office of Behavioral Health, Department of Health and Hospitals; created as a result of the merger between the Offices of Mental Health and Addictive Disorders.

Original - Denotes must be signed in ink.

Out-of-Home Placements – Arrangements for children and youth that have significant behavioral health challenges or co-occurring disorders that are in, or at imminent risk of, placement in any of the following settings including, but not limited to: 1) detention, 2) secure care facilities, 3) psychiatric hospitals, 4) residential treatment facilities, 5) developmental disabilities facilities, 6) addiction facilities, 7) alternative schools, 8) homeless, as identified by LDOE, and 9) foster care.

Ownership Interest – The possession of stock, equity in the capital, or any interest in the profits of the SMO.

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

Per Member Per Month (PMPM) Rate – The PMPM rate paid to the SMO for the provision of behavioral health services to SMO members. PMPM refers to the amount of money paid or received on a monthly basis for each enrolled individual.

Performance Measure – Statement identifying an activity, input, output, outcome, achievement, ratio, efficiency, or quality to be measured relative to a particular goal or objective in order to assess performance.

Permanent Supportive Housing – Housing with continued occupancy for a qualified tenant as long as the tenant's household pays the rent and complies with the lease or applicable landlord/tenant laws. The housing is linked with supportive services that are: flexible and responsive to the needs of the individual; available when needed by tenants; and accessible where the tenant lives, if necessary. Housing is located primarily in multi-family rental housing that meets HUD Housing Quality Standards and is made available by the Louisiana Housing Authority under an approved Housing and Urban Development (HUD) Public Housing Authority Plan or directly with other qualified housing organizations. Housing is affordable to the eligible target population (monthly rent and utilities do not exceed 30% of monthly adjusted income).

Pharmacy Benefits – For the purposes of this RFP and exclusion from core benefits and services, pharmacy benefits are defined as prescription drugs that are dispensed by pharmacies.

Pharmacy Benefit Manager – Third party administrator of prescription drug programs.

Plan of Care – Strategies designed to guide the development of an individual-specific plan to address the behavioral health and natural support needs of the member. Care plans are intended to ensure optimal outcomes for individuals during the course of their care.

Policies – The general principles which guide decisions and outcomes; high-level overall plans embracing general goals and acceptable procedure. As used herein in reference to DHH, policies are the general principles by which DHH is guided in its management of the Medicaid program.

Post-stabilization services - Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition.

Prepaid – A method of paying the SMO in advance for the cost of predetermined benefits for a population group, through premiums, dues, or contributions.

Prepaid Ambulatory Health Plan (PAHP) – an entity contracting with the state that meets the requirements for a PAHP contained in 42 CFR §438.2.

Prepaid Inpatient Health Plan (PIHP) – an entity contracting with the state that meets the requirements for a PIHP contained in 42 CFR §438.2 and that: 1) provides medical services to enrollees under contract with the state agency, on the basis of prepaid capitation payments, or other payment arrangements that do not use Medicaid State Plan payment rates; 2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and 3) does not have a comprehensive risk contract.

Primary Care Case Management - A system under which a PCCM contracts with the state to furnish case management services to Medicaid beneficiaries as outlined in 42 CFR §438.2.

Primary Care Provider (PCP) – An individual physician or licensed nurse practitioner responsible for the management of a member's healthcare, who is licensed and certified in one of the following general specialties: family practice, general practice, pediatrics, internal medicine, internal medicine and pediatrics, or obstetrics/gynecology. The primary care provider is the patient's point of access for preventive care of 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 – Healthcare 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 by the PCP or through appropriate referral to specialists and/or ancillary providers.

Prior Authorization (PA) – The process of determining medical necessity for specific services before they are rendered.

Proposer – Entity or company seeking a contract to provide stated deliverables and services identified within a Request for Proposal document.

Prospective Review – Utilization review conducted prior to an admission or a course of treatment.

Protected Health Information (PHI) – Individually-identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR Parts 160 and 164.

Provider - Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Medicaid managed care plan, any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the state in which it delivers services.

Provider Preventable Condition – Preventable healthcare-acquired or other provider-preventable conditions and events, also known as never events, identified by DHH for nonpayment, including but not limited to, bed pressure ulcers or decubitus ulcers; or events such as surgical or invasive procedures performed on the wrong body part or wrong patient; wrong surgical procedure performed on a patient.

Qualified Service Provider – Any individual or entity that is engaged in the delivery of behavioral healthcare services that meets the credentialing standards of the SMO and

all state licensing and regulatory requirements. It also applies to the delivery of Medicaid services, if certified by the Medicaid agency to participate in the Medicaid program.

Quality – As it pertains to external quality review, the degree to which the SMO increases the likelihood of desired health outcomes of its members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assessment and Performance Improvement Program (QAPI Program) - Program that objectively and systematically defines, monitors and evaluates the quality and appropriateness of care and services and promotes improved patient outcomes through performance improvement projects, 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, medically necessary, in keeping with established guidelines and standards, and reflective of the current state of medical and behavioral health knowledge.

Readiness Review – Refers to the process where DHH, or its contractor, assesses the SMO's ability to fulfill the requirements of the provider agreement. Such review may include, but is not limited to, review of proper licensure, operational protocols, SMO standards, and systems. The review may be completed 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 SMO's ability and readiness to render services.

Recipient - An individual entitled to benefits under Medicaid 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.

Redacted Copy – The removal of confidential and/or proprietary information from one copy of a proposal for public records purposes.

Related Party – A party that has, or may have, the ability to control or significantly influence a contractor; or a party that is, or may be, controlled or significantly influenced by a contractor. Related parties include, but are not limited to, agents, management employees, persons with an ownership or controlling interest in the entity, and their immediate families, contractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Relationship – For the purposes of any business affiliations discussed in Section 18, a director, officer, or partner of the SMO; a person with beneficial ownership of 5% or more of the SMO's equity; or a person with an employment, consulting or other arrangement (e.g., providers) with the SMO obligations under its contract with the state.

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

Risk – The chance or possibility of loss. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Risk Adjustment – A method for determining adjustments of the PMPM rate that accounts for variation in health risks among participating SMOs when determining per capita prepaid payment.

Routine – With regard to urgency of need for services, minimal to low risk of harm, such as absence of current suicidal ideation; substance use without significant episodes of potentially harmful behavior.

Rural Area – Refers to any geographic service area defined by the Office of Management and Budget's definition of rural.

Rural Health Center (RHC) – A clinic located in an area with a healthcare provider shortage that provides primary healthcare and related diagnostic services. It may also provide optometric, podiatric, chiropractic, and behavioral health services. A RHC must be reimbursed on a prospective payment basis.

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

Section 1915(b)(3) – This section of the Social Security Act allows the State to share cost savings resulting from the use of more cost-effective medical care with members by providing them with additional services. The savings must be expended for the benefit of the Medicaid member enrolled in the waiver.

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

Serious Mental Illness (SMI) – As per SAMHSA definition (according to 1915(i) HCBS Medicaid State Plan Services), SMI is one that resulted in serious functional impairment, which substantially interfered with or limited one or more major life activities. It requires the person to have at least one 12-month disorder, other than a substance use disorder, that met DSM-IV criteria (APA, 1994) and to have serious impairment.

Shall - Denotes a mandatory requirement.

Should - Denote a preference but not a mandatory requirement.

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

Social Security Act – The Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended, which encompasses the Medicaid program (Title XIX) and CHIP Program (Title XXI).

Solvency – The minimum standard of financial health for a SMO, in which assets exceed liabilities, and timely payment requirements can be met.

Span of Control – Information systems and telecommunications capabilities that the SMO itself operates, or for which it is otherwise legally responsible, according to the

terms and conditions of the agreement with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the SMO.

Special Needs – An individual of any age with a mental disability, physical disability, or other circumstances that place his/her health and ability to fully function in society at risk, requiring individualized healthcare requirements.

Start Date – The date SMO providers begin providing medical care to their Medicaid members. Also referred to as "go-live date"

State, state – The State of Louisiana

State Fair Hearing – Requirements for State Fair Hearings. DHH and the SMO shall comply with the applicable requirements of 42 CFR §431.200(b), §431.220(5), §438.414 and §438.10(g)(1).

State General Fund (SGF) – Refers to funding appropriated by the state of Louisiana from non–federal sources.

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

Subcontractor - Means any person having a contract to perform work or render service to contractor as a part of the contractor's agreement arising from this solicitation.

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 eligible for SSI is automatically eligible for Medicaid.

System Availability – Measured within the SMO's information system span of control. A system is considered not available when a system user does not obtain the complete, correct full-screen response to an input command within three minutes after depressing the "Enter" or other function key.

Third Party Liability (TPL) – Refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under the Medicaid State Plan.

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

Title XIX – Section of the Social Security Act of 1935 that encompasses and governs the Medicaid program.

Title XXI – Section of the Social Security Act of 1935 that encompasses and governs the Children's Health Insurance Program (CHIP).

TTY/TTD – Telephone typewriter and telecommunication device for the deaf, which allows for interpreter capability for deaf callers.

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 Office of

Management and Budget. A list of Louisiana parishes in MSAs can be found at http://www.doa.louisiana.gov/census/metroareas.htm.

Urgent – Moderate risk of harm, such as suicidal ideation without intent; or binge use of substances, resulting in potentially harmful behaviors without current evidence of such behavior.

Utilization Management (UM) – Refers to the process of evaluation of medical necessity, appropriateness, and efficiency of healthcare services, procedures, and facilities. UM is inclusive of utilization review and service authorization.

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

Will - Denotes a mandatory requirement.

Wraparound Agency (WAA) – WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination for children within the CSoC needing such supports, with the goal of "one family, one plan of care, and one wraparound facilitator."

Glossary of Acronyms

AAHSD – Acadiana Area Human Services District
ACD – Automated Call Distribution
ACT – Assertive Community Treatment
BESE –Louisiana Board of Elementary and Secondary Education
BH – Behavioral Health
BHSF – Bureau of Health Services Financing, Department of Health and Hospitals
CAHSD – Capital Area Human Services District
CANS – Child and Adolescent Needs and Strengths assessment tool
CFR – Code of Federal Regulations
CFT– Child and Family Team
CLHSD – Central Louisiana Human Services District
CMS – Centers for Medicare & Medicaid Services
COB – Coordination of Benefits
COD – Co-occurring Disorders of Mental and Addictive Disorders
CSoC – Coordinated System of Care
DCFS – Department of Children and Family Services
DHH – Department of Health and Hospitals
DHH-OBH – Department of Health and Hospitals-Office of Behavioral Health
DHH-OPH – Department of Health and Hospitals-Office of Public Health
DOA/OCR – Division of Administration, Office of Contractual Review
EBP – Evidence-Based Practices
EPSDT– Early and Periodic Screening, Diagnosis, and Treatment
FFS – Fee-for-Service
FI – Fiscal Intermediary
FINS – Families in Need of Services
FPHSA – Florida Parishes Human Services Authority
FSO – Family Support Organization
HEDIS – Healthcare Effectiveness Data and Information Set
HIPAA – Health Insurance Portability and Accountability Act
ImCal – Imperial Calcasieu Human Services Authority
IT – Information Technology
JLCB – Joint Legislative Committee on the Budget
JPHSA – Jefferson Parish Human Services Authority
LAN – Local Area Network
LBHP – Louisiana Behavioral Health Partnership
LDOE – Louisiana Department of Education
LEA – Local Education Agency
LGE – Local Governing Entities
MMIS –Medicaid Management Information System
LOC – Level of Care
MHBG – Mental Health Block Grant
MHSD – Metropolitan Human Services District
MST – Multisystemic Therapy
NCQA – National Committee for Quality Assurance
NEDSHA – Northeast Delta Human Services Authority
NLHSD – Northwest Louisiana Human Services District
OBH– Office of Behavioral Health
OJJ – Office of Juvenile Justice
PHI – Protected Health Information

PIHP – Prepaid Inpatient Health Plan
PIP – Performance Improvement Plan
PRTF – Psychiatric Residential Treatment Facility
QA/QI – Quality Assurance/Quality Improvement
QM – Quality Management
RFP – Request for Proposals
RHC/FQHC – Rural Health Clinic/Federally Qualified Health Center
SAMHSA – Substance Abuse and Mental Health Services Administration
SAPT Block Grant – Substance Abuse Prevention and Treatment Block Grant
SCLHSA – South Central Louisiana Human Services Authority
SED – Serious Emotional Disturbance
SFTP – Secure File Transfer Protocol
SMI – Serious Mental Illness
SMO – Statewide Management Organization
SUD – Substance Use Disorder
TANF –Temporary Assistance for Needy Families
TFC – Therapeutic Foster Care
TGH – Therapeutic Group Home
WAA – Wraparound Agency
WF – Wraparound Facilitation

1.0 GENERAL INFORMATION

1.1. Background

1.1.1. This Request for Proposals (RFP) covers the management of behavioral health services known as the Louisiana Behavioral Health Partnership (LBHP) to serve: 1) adults with serious mental illness (SMI) and/or substance use disorders (SUD); 2) the child and adult population who have specialized behavioral health needs; 3) eligible youth that are involved with the Department of Health and Hospitals (DHH), the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), and/or the Louisiana Department of Education (LDOE); and 4) a special population of children eligible for the Coordinated System of Care (CSoC).

1.1.2. The LBHP aims to improve access to services, quality of care, and efficiency in the delivery system for all children, youth, and adults eligible for behavioral healthcare services.

1.1.3. Participating state agencies in the LBHP include:

1.1.3.1. The Department of Health and Hospitals. DHH's mission is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. DHH is dedicated to fulfilling its mission through direct provision of quality services, protecting and promoting health, the development and stimulation of services, and the utilization of available resources in the most effective manner. DHH's responsibilities include administering the state's Medicaid program; ensuring and promoting public health through monitoring, coordination and outreach; maintaining a system for those with behavioral health needs, including both mental health and substance use disorders; and providing services for aging populations and people with developmental disabilities.

1.1.3.1.1. 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.

1.1.3.1.2. DHH has designated the DHH-Office of Behavioral Health (DHH-OBH) as the issuing agency for this RFP. DHH has also designated DHH-OBH as the agency responsible for policy direction and oversight of the LBHP. The mission of DHH-OBH is to lead the effort to build and provide a comprehensive, integrated, person-centered system of prevention and treatment services that promote recovery and resiliency for all citizens of Louisiana. DHH-OBH assures public behavioral health services are accessible, have a positive impact, are culturally and clinically competent and are delivered in partnership with all stakeholders. DHH-OBH serves adults with a severe mental

illness, children and adolescents with serious emotional/behavioral disorders, and all people experiencing an acute mental illness, as well as individuals of all ages with substance use disorders (SUDs). DHH-OBH is responsible for planning, developing, operating, and evaluating public mental health (MH) and substance use disorder (SUD) services for the citizens of the state.

1.1.3.1.3. DHH-OBH works closely with a system of independent healthcare districts or authorities (also referred to as local governing entities or LGEs, which are listed in Table 1 below).

Table 1: LGE Districts/Authorities

Region 1	Metropolitan Human Services District (MHSD)
Region 2	Capital Area Human Services District (CAHSD)
Region 3	South Central Louisiana Human Services Authority (SCLHSA)
Region 4	Acadiana Area Human Services District (AAHSD)
Region 5	Imperial Calcasieu Human Services Authority (ImCal)
Region 6	Central Louisiana Human Services District (CLHSD)
Region 7	Northwest Louisiana Human Services District (NWLHSD)
Region 8	Northeast Delta Human Services Authority (NEDHSA)
Region 9	Florida Parish Human Services Authority (FPHSA)
Region 10	Jefferson Parish Human Services Authority (JPHSA)

1.1.3.1.4. 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.

1.1.3.1.5. DHH-OBH advocates that services be delivered in a manner that is person-centered and which incorporates the person's needs and individual goals. The instillation of hope and the belief that persons can recover from mental health and substance use disorders is critical in the service planning process for individuals with behavioral health needs. Behavioral health supports and services should be rendered in the least restrictive manner, allowing the person to work toward increasing levels of independence.

1.1.3.1.6. DHH-OBH is responsible for monitoring, establishing standards for the operation, contracting, establishing expectations for service utilization and outcomes, and measuring outcomes for the LBHP.

1.1.3.1.7. DHH-OBH operates two intermediate/long-term inpatient care psychiatric hospitals: Eastern Louisiana Mental Health System in Jackson, Louisiana and Central Louisiana State Hospital in Pineville, Louisiana. In addition, DHH-OBH has

Cooperative Endeavor Agreements with four private hospitals to provide 32 acute beds for adults, 30 acute beds for children and adolescents, and 20 beds for the adolescent Developmental Neuropsych Unit.

The Bureau of Health Services Financing (DHH-BHSF) has oversight responsibilities for all Medicaid programs. DHH-OBH, as the designated purchaser of managed behavioral health services for the Louisiana Behavioral Health Partnership, will work under the oversight of BHSF to assure compliance with federal rules and regulations.

1.1.3.2. The Department of Children and Family Services (DCFS) is one of the administrative departments within the Executive Branch of state government in Louisiana. The administrative head of the Department is the Secretary, who is appointed by the Governor. DCFS provides for the public child welfare functions of the state, delivering services through a state-administered system of nine regional offices and 64 parishes. The vision of DCFS is to work to keep children safe, help individuals and families become self-sufficient, and provide safe refuge during disasters. The DCFS population of focus for the LBHP includes children and youth in custody of the state due to abuse and neglect or at risk of removal from their families.

1.1.3.3. The Louisiana Department of Education (LDOE) operates under the administrative lead of the state Superintendent of Education, whose function is to execute and implement public educational policy in accordance with the Louisiana Constitution, legislation, and regulations under the control and supervision of the state Board of Elementary and Secondary Education (BESE). LDOE's mission is maintained through Louisiana Believes, which is the state's comprehensive plan to ensure every Louisiana student is on track to a college degree or a professional career. Students learn best when their academic, emotional, physical, and social needs are met. The LDOE population of focus for the LBHP includes children and youth who have been identified as having a disability according to the Individuals with Disabilities Education Act (IDEA) and have an Individual Education Plan (IEP) that requires behavioral health services, and children and youth with behavioral health challenges who are in, or at risk of, alternative school placement or homelessness, as defined by LDOE. A strong comprehensive system of learning supports that addresses barriers to learning and teaching must be at the center of the state's education strategy. The successful implementation of the LBHP will help to eliminate many barriers for these children and assist LDOE in providing an equal opportunity for success in local schools.

1.1.3.4. The Office of Juvenile Justice (OJJ) is a cabinet-level agency under the direction of the Deputy Secretary that reports to the Governor and has policy oversight and support responsibilities for state programs for youth who are adjudicated delinquent, as well

as any youth adjudicated of a status offense. OJJ is responsible for youth assigned to care by the court system, either for supervision in the community or custody in residential placement or secure care. OJJ also provides services to youth under local court supervision. The Community Services program provides probation and parole supervision, and coordinates both residential and non-residential treatment services for adjudicated youth. OJJ behavioral health services consist of residential services, including secure care, contracted residential services, community treatment, and prevention/diversion services. The OJJ population of focus for the LBHP is youth with serious behavioral health challenges and/or: 1) on probation or parole supervision; 2) with a status offense; or 3) at risk of residential placement or those leaving residential placements.

1.2. Purpose of RFP

1.2.1. The purpose of this RFP is to solicit proposals from qualified behavioral health managed care entities with a minimum of five years' experience and demonstrated success in the provision of statewide managed behavioral healthcare services with complex, publicly-funded behavioral health programs, to operate as a pre-paid inpatient health plan (PIHP) under a capitated payment rate that implements the Medicaid State Plan, its amendments, and the waivers as detailed in the Scope of Work in Section 3 of this RFP.

1.2.2. The entity that is awarded the contract under this RFP will be referred to as the Statewide Management Organization (SMO).

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

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 an opportunity to do business with the state as the SMO.

1.2.5. Federal authority for DHH to implement the SMO program is contained in Section 1932(a)(1)(A) of the Social Security Act and 42 CFR Part 438, as those requirements apply to Medicaid PIHPs.

1.2.6. According to the Centers for Medicare & Medicaid Services (CMS) approved 1915(b) and (c) waivers and the 1915(i) Medicaid State Plan Amendment (SPA) for Medicaid members, the SMO shall:

1.2.6.1. Mandatorily assign all eligible Medicaid enrollees as members of the SMO for services through the LBHP as per the 1915(b) waiver;

1.2.6.2. Manage care for eligible children/youth in need of mental health and substance use disorder services, including children/youth eligible for CSoC services under the 1915(c) waiver or functionally eligible through the 1915(b)3 waiver; and

1.2.6.3. Manage behavioral health services for Medicaid adults with substance use disorders as well as adults with functional behavioral health needs, including: persons with acute stabilization needs; persons with SMI (federal definition of Serious Mental Illness); persons with Major Mental Disorder (MMD); and adults who have previously met the above criteria and need subsequent medically necessary services for stabilization and maintenance on a risk basis through the 1915(i) SPA. Persons eligible for 1915(i) services may be eligible for other specialized programs (e.g., Permanent Supportive Housing, Assertive Community Treatment, etc.).

1.2.7. For non-Medicaid members, the SMO shall be responsible for making prior authorization determinations based on medical necessity.

1.2.8. This program will seek to continue the work already begun by DHH-OBH to increase accountability through expanded oversight and utilization management (UM) by the SMO. Statewide uniformity of services across programs will be achieved by use of standardized practice guidelines, including well-defined service definitions and staff qualifications, evidence-based and informed practices, treatment planning, and outcome measurement.

1.3. Invitation to Propose

1.3.1. DHH-OBH invites qualified entities to submit proposals to provide SMO services in accordance with the specifications and conditions set forth herein.

1.4. RFP Addenda

1.4.1. 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://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm
May also be posted at:
http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

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

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2.0 ADMINISTRATIVE INFORMATION

2.1. RFP Coordinator

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

Mary Fuentes
Title: Contracts/Grants Review Manager
Louisiana Department of Health and Hospitals
628 North 4th Street, Baton Rouge, LA 70802
Telephone Number: (225) 342-5266
Facsimile Number: (225) 342-9046
E-mail: Mary.Fuentes@la.gov

This RFP is available at the following web links:
http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm
http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

2.1.2. All communications relating to this RFP must be directed to the RFP Coordinator named above. All communications between proposers and other DHH, DCFS, LDOE, or OJJ staff members concerning this RFP shall be strictly prohibited. Failure to comply with these requirements shall result in proposal disqualification.

2.2. Proposer Inquiries

2.2.1. DHH will consider written inquiries regarding the requirements of the RFP or Scope of Services to be provided before the date specified in the Schedule of Events. To be considered, written inquiries and requests for clarification of the content of this RFP must be received at the above address or via email address by the date specified in the Schedule of Events. Any and all questions directed to the RFP coordinator will be deemed to require an official response and a copy of all questions and answers will be posted by the date specified in the Schedule of Events to the following web link:

http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm
May also be posted at:
http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

2.2.2. 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.

2.2.3. 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.

2.2.4. Each proposer should carefully review this RFP, including but not limited to the *pro forma* contract, all applicable waivers and State Plan Amendments, and all Department issued Companion Guides for

questions, defects, objections, or any other matter requiring clarification or correction.

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

2.2.5.1. Has waived any claim of error or ambiguity in the RFP or resulting contract;

2.2.5.2. Cannot contest DHH's interpretation of such provision(s); and

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

2.3. Pre-Proposal Conference

2.3.1. Not required for this RFP.

2.4. Schedule of Events

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

Table 2: RFP Schedule of Events

Schedule of Events	
Public Notice of RFP	8/15/2014
Deadline for Receipt of Written Questions	8/22/2014
Deadline for Receipt of Letter of Intent to Propose	8/25/2014
Deadline for DHH Responses to Written Questions	9/1/2014
Deadline for Receipt of follow-Up Written Questions	9/5/2014
Deadline for DHH Response to Follow-Up Written Questions	9/12/2014
Deadline for Receipt of Written Proposals	10/8/2014 4:00 p.m. CT
Initial Proposal Evaluation Begins	10/13/2014
On-Site Proposer Presentations	10/23/2014
Final Proposal Scoring	10/24/2014
Contract Award Announced	10/31/2014
Contract Negotiations Begin	10/31/2014

Contract Go-Live Date	3/1/2015

2.4.2. DHH will provide the SMO sixty (60) days advance notice of any change in date that may be required in the SMO readiness review.

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3.0 SCOPE OF WORK

3.1. SMO Project Overview

3.1.1. The SMO will operate as a Prepaid Inpatient Health Plan (PIHP) healthcare delivery system responsible for providing specified Medicaid behavioral health core benefits and services included in the Louisiana Medicaid State Plan and CMS approved waivers to Medicaid recipients. The intent of this RFP is for DHH-OBH to contract with an SMO to administer and support behavioral health managed care services for children and adults. Louisiana's system reform efforts in support of effective management of behavioral health services focus on the following strategies:

3.1.1.1. Improving access, quality, and efficiency of behavioral health services for children and youth with specialized behavioral health needs and adults with SMI and SUD, through management of these services by the SMO.

3.1.1.2. Seamlessly coordinating behavioral health services with the comprehensive healthcare system without losing attention to the special skills of behavioral health professionals.

3.1.1.3. Advancing a resiliency, recovery, and consumer-focused system of person-centered care.

3.1.1.4. Implementing best, evidence-based and informed practices that are effective and efficient as supported by the data from measuring outcomes, quality, and accountability.

3.1.1.5. Increasing patient quality of care;

3.1.1.6. Providing outreach and education to promote healthier behaviors;

3.1.1.7. Achieving better outcomes for behavioral and physical health and improving quality by measuring these outcomes;

3.1.1.8. Emphasizing prevention and management of behavioral health diagnoses;

3.1.1.9. Increasing patient personal responsibility and self-management;

3.1.1.10. Reducing the rate of avoidable hospital stays and readmissions;

3.1.1.11. Decreasing fraud, abuse, and wasteful spending;

3.1.1.12. Maintaining the CSoC for children/youth and their families/caregivers, utilizing a family and youth-driven practice model, providing wraparound facilitation by child and family teams, that also utilize family and youth supports, and overall management of these services by the SMO;

3.1.1.13. Leveraging State General Funds (SGF) to appropriately obtain Medicaid financing; and

3.1.1.14. Effectively using state, federal, and local resources thereby creating a more sustainable system with greater accountability for dollars spent.

3.1.2. Pending CMS approval, DHH shall establish a Per Member Per Month (PMPM) actuarially sound risk-adjusted rate to be paid to the SMO for all Medicaid populations. The rates shall not be subject to negotiation or dispute resolution. The rate is intended to cover all benefits and management services outlined in the contract.

3.1.3. The SMO assumes full risk for the cost of services for the capitated populations under the contract and incurs loss if the cost of furnishing these services exceeds the payment received for providing these services.

3.1.4. The SMO shall operate a prepaid inpatient health plan (PIHP), as defined in 42 CFR §438.2, to provide management of the following criteria and functions, including but not limited to:

3.1.4.1. 24 hour, 7 days a week toll-free telephone access line for providers and members;

3.1.4.2. Member services;

3.1.4.3. Care management (CM);

3.1.4.4. Utilization management (UM);

3.1.4.5. Quality management (QM);

3.1.4.6. Grievances and appeals;

3.1.4.7. Provider network management;

3.1.4.8. Member protections, rights and responsibilities;

3.1.4.9. Reporting and monitoring;

3.1.4.10. Implementation planning;

3.1.4.11. Administrative organization;

3.1.4.12. Primary care coordination;

3.1.4.13. Transition planning requirements;

3.1.4.14. Fraud and abuse monitoring and compliance;

3.1.4.15. Technical requirements; and

3.1.4.16. Pharmacy Benefit Management.

3.1.5. The SMO is responsible for coordination and cooperation with DHH-OBH in the implementation of any court-mandated initiatives.

3.1.6. It is the State's intent to enter a managed care contract which shall offer holistic healthcare to its members requiring long-term care, including

behavioral health services. The SMO shall be responsible for coordinating with the new contractor(s) for any records or service management data required for the transition of members and services to and from the new contractors' systems and care management. This will result in the loss of Per Member Per Month (PMPM) payments to the SMO for members whom DHH determines to be eligible that are transitioning out of the LBHP into the new long-term supports and services system of care and may result in adjustments to the monthly capitated rate in order to maintain an actuarially sound rate range. The SMO shall adhere to all transition requirements provided by DHH upon implementation of the new managed care contract.

3.1.7. Specific scope of work requirements are detailed in the following sections of this RFP:

3.1.7.1. Section 4 - Health Care Integration

3.1.7.2. Section 5 - Eligibility

3.1.7.3. Section 6 - Staff Requirements and Support Services

3.1.7.4. Section 7 - SMO Reimbursement (i.e., Payment Terms)

3.1.7.5. Section 8 - Covered Benefits and Services

3.1.7.6. Section 9 - Pharmacy Benefit Management

3.1.7.7. Section 10 - Provider Network Requirements

3.1.7.8. Section 11 - Care and Utilization Management

3.1.7.9. Section 12 - Provider Payments

3.1.7.10. Section 13 - Provider Services

3.1.7.11. Section 14 - Enrollment

3.1.7.12. Section 15 - Member Education and Communications

3.1.7.13. Section 16 - Grievance and Appeals Procedures

3.1.7.14. Section 17 - Quality Management

3.1.7.15. Section 18 - Program Integrity

3.1.7.16. Section 19 - Systems and Technical Requirements

3.1.7.17. Section 20 - Claims Management

3.1.7.18. Section 21 - Contract Compliance and Monitoring

3.1.7.19. Section 22 – Remediation

3.1.7.20. Section 25 – Transition Requirements

3.1.7.21. Section 26 – Terms and Conditions

3.2. General SMO Requirements

3.2.1. In order to participate as the SMO, an entity must:

3.2.1.1. Meet the federal definition of a Medicaid PIHP as defined in 42 CFR §438.2;

3.2.1.2. Possess an appropriate license or certificate of authority from the Louisiana Department of Insurance to conduct business in the state as an insurer, and shall submit this documentation to DHH-OBH by the date the contract is signed. The SMO shall also meet all requirements of RS 40:2242;

3.2.1.3. Meet solvency standards as specified in federal regulations and Title 22 of the Louisiana Revised Statutes. The SMO shall, at all times, maintain capitalization and surplus requirements set forth in La.R.S. 22:254. In addition, the SMO's financial solvency shall be evaluated by the Louisiana Department of Insurance. DHH-OBH shall review the SMO's solvency and financial condition during the SMO procurement process, quarterly (upon submission of quarterly financial reports), annually (upon submission of annual audited financial statements), and upon any suspicion or findings of possible financial inadequacy for performance of the contract. The SMO's ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under the contract shall be given special emphasis;

3.2.1.4. Meet National Committee for Quality Assurance (NCQA) Health Plan or Managed Behavioral Healthcare Organization accreditation requirements, or if not accredited agree to achieve full accreditation status within nine (9) months of the contract go-live date unless otherwise approved by DHH-OBH, and once achieved, maintain accreditation through the life of this contract;

3.2.1.5. Have a sufficient provider network to meet member needs (See Section 10 of the RFP for access requirements);

3.2.1.6. Not have an actual or perceived conflict of interest that would interfere or give the appearance of possibly interfering with its duties and obligations under this contract or any other contract with DHH;

3.2.1.7. Be a successful proposer, be awarded a contract with DHH, successfully complete the readiness review prior to the start date of operations; and

3.2.1.8. Demonstrate ability to provide core benefits and services to all assigned members upon completion of the SMO implementation plan.

3.2.2. The SMO shall be responsible for the administration and management of the 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 SMO.

3.2.3. The SMO's administrative office shall maintain normal business hours of 8:00 a.m. to 5:00 p.m. CT 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://doa.louisiana.gov/osp/aboutus/2014holidays.htm

3.2.4. The SMO shall maintain appropriate personnel as required in Section 6 of this RFP.

3.2.5. The SMO shall coordinate with any entity contracted by the state as directed by DHH-OBH relative to the scope of work of this contract.

3.2.6. The SMO 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 standards 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-OBH 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.

3.2.7. The SMO must maintain policy and procedures concerning advance directives with respect to all adult individuals receiving services by or through the SMO in accordance with 42 CFR Part 489 and 42 CFR §438.6(i)(1) and submit them to DHH-OBH thirty (30) days prior to the contract go-live date. The written information provided by the SMO 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.

3.2.8. The Louisiana Department of Insurance (DOI) regulates risk-bearing entities providing Louisiana Medicaid services as to their solvency. Therefore, the SMO must comply with all DOI applicable standards, including adherence to RS 22:842 relative to the state premium tax, adherence to R.S. 22:571 relative to filing a statement with DOI along with additional filings as prescribed by the commissioner for the preceding year, adherence to R.S. 22:572 relative to filing a written catastrophe plan, and adherence to R.S. 22:673 relative to filing an audited financial report each year with DOI. In addition, a prepaid entity that participates in Louisiana Medicaid is required to obtain an insurer license or certificate of authority from the Louisiana DOI and is regulated by DOI with respect to licensure and financial solvency. However, with respect to the prepaid entity's products and services offered pursuant to the Medicaid program, it is regulated by DHH, subject to 42 USCA §1396 et seq. and all applicable federal and state laws, rules, and regulations relating to the Louisiana Medicaid program.

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

3.2.10. The SMO 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.

3.2.11. The SMO is required to have the following experience:

3.2.11.1. Five (5) or more years of behavioral health managed care experience and demonstrated success in its contracts for the provision of managed behavioral healthcare services with complex, publicly-funded behavioral health programs, including the following experience:

3.2.11.1.1. Management of Medicaid and other funding sources not part of the Medicaid program such as State General Funds and grant funds; and

3.2.11.1.2. Management of statewide (or substantial portions of a state) Medicaid managed behavioral healthcare programs.

3.2.11.2. Proven track record in providing services to other governmental clients and populations similar to the members covered under this contract as demonstrated by:

3.2.11.2.1. Experience managing care for adults with SMI;

3.2.11.2.2. Experience managing care for adults with substance use disorders;

3.2.11.2.3. Experience managing care for children and youth with specialized behavioral health needs and severe behavioral health challenges involved with the child welfare and juvenile justice systems, particularly those at risk of, or already in, restrictive settings outside their home

3.2.11.2.4. Experience in managing care under CMS authorities;

3.2.11.2.5. Success in establishing partnerships with governmental clients representing multiple child-serving agencies, and engaging community leaders, stakeholders, advocacy organizations, and providers in the delivery of behavioral health services;

3.2.11.2.6. Success in implementing complex public sector managed care programs consistent with the time frames listed in the Schedule of Events of this RFP;

3.2.11.2.7. A cohesive, integrated management structure that allows for timely decision at the local level, within a corporate framework that provides access to industry-leading tools, technology, expertise, and oversight; and

3.2.11.2.8. A proven reputation for being responsible and reliable in executing decisions based on values consistent with the principles and goals defined in this RFP.

3.2.11.3. Experience successfully collaborating with providers inclusive of:

3.2.11.3.1. Wraparound Agencies (WAAs), or similar entities that provide an intensive, individualized care planning and management process for children and their families;

3.2.11.3.2. Consumer and/or family services, such as peer and Family Support Organizations (FSOs);

3.2.11.3.3. Community-integrated, preferably scattered-site, "housing with supports," supportive housing, and/or permanent supportive housing for individuals with behavioral health or other disabilities; and

3.2.11.3.4. Nursing facilities and providers of long-term supports and services.

3.2.11.4. Experience and demonstrated success in creative approaches to implementing a coordinated and comprehensive system of behavioral health services for children, youth, and adults that:

3.2.11.4.1. Identifies and implements the preferences of members and their families in the design of services and supports;

3.2.11.4.2. Facilitates the development of consumer and family-led services, use of peer support, child and family teams for children and youth, and emphasizes inclusion of natural supports for people of all ages;

3.2.11.4.3. Facilitates the use of self-management and relapse prevention skills;

3.2.11.4.4. Promotes communication and plan of care development between medical and behavioral health providers;

3.2.11.4.5. Addresses the development and maintenance of healthy social networks, skills, school attendance and performance, and employment; and

3.2.11.4.6. Assists the member with obtaining a stable, safe, and permanent home.

3.2.11.5. A flexible, responsible member services approach that is respectful and responsive to callers representing diverse cultures, and provides clear information on member eligibility and service access to:

3.2.11.5.1. Members with SMI and severe mental health challenges and/or substance use disorders;

3.2.11.5.2. Families that negotiate multiple systems to obtain appropriate services for their children;

3.2.11.5.3. Medicaid eligible youth under age 21 requiring applied behavior analysis services or with Intellectual or

Developmental Disabilities (including Chisholm Class Members); and

3.2.11.5.4. Providers, schools, community organizations, advocates, members of the general public and others that contact the SMO.

3.2.11.6. Experience and demonstrated success in operating a Care Management/Utilization Management (CM/UM) program that successfully reduces utilization of inappropriate inpatient psychiatric hospital care for adults and children and reduction in the unnecessary use of out-of-home placements for children and youth.

3.2.11.7. Experience and demonstrated success in implementing practice guidelines that promote an evidence-based and informed culture through provider training and fidelity monitoring.

3.2.11.8. Experience and demonstrated success in providing a trauma-informed delivery system through workforce development of staff and providers.

3.2.11.9. Experience and demonstrated success in operating a Quality Management program that focuses on continuous quality improvement with strategies that:

3.2.11.9.1. Drive accountability and performance;

3.2.11.9.2. Contain valid, reliable metrics for outcome measurement;

3.2.11.9.3. Monitor the impact of clinical and other service decisions on member and provider satisfaction and outcomes;

3.2.11.9.4. Utilize performance improvement plans and/or corrective action plans to improve performance; and

3.2.11.9.5. Provide adequate oversight of staff making clinical decisions through initial orientation, ongoing training, and formal clinical supervision to ensure that the skills of clinical staff are consistent with best practices while continuously improving.

3.2.11.10. Experience and demonstrated commitment to developing and managing qualified culturally-competent provider networks that emphasize expansion of evidence-informed, evidence-based, and best practices, including community and family-based services and natural supports, including strategies that:

3.2.11.10.1. Emphasize provider orientation and ongoing training;

3.2.11.10.2. Pay subcontracted providers including incentivizing specialist providers to join the network, and provide timely responses to provider questions and concerns; and

3.2.11.10.3. Ensure the qualifications of providers meet required credentialing and certification, including state and federal requirements.

3.2.11.11. Administrative efficiency through technology, including:

3.2.11.11.1. A Behavioral Health Management Information System (MIS) that will electronically and securely interface with the DHH Medicaid Management Information System (MMIS), the WAA, and the DHH-OBH data warehouse. The behavioral health MIS must be capable of interagency electronic transfer to and from the participating state agencies (DHH, DCFS, LDOE, and OJJ) as needed to support the operations as outlined in the RFP;

3.2.11.11.2. A supportive and responsive Behavioral Health Management MIS and staff;

3.2.11.11.3. Automated systems for detection of suspected fraud and abuse in keeping with state and federal standards and procedures;

3.2.11.11.4. Knowledge and operability of Electronic Health Records (EHR) systems;

3.2.11.11.5. Data-driven approaches to monitor contract requirements including individualized Plan of Care (POC), treatment plans, crisis plans, advance directives, network adequacy, UM and outcomes monitoring;

3.2.11.11.6. A Louisiana-based SMO Data Warehouse that supports querying and table-creation by DHH-OBH authorized users;

3.2.11.11.7. 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;

3.2.11.11.8. Experience and demonstrated success in automated linkages to online information for transmission of large data files, such as timely, accurate transmission of encounter files. The behavioral health MIS will regularly (e.g., bi-weekly) electronically transfer client/episode-level recipient, assessment, service, and provider data to the DHH-OBH data warehouse / business intelligence system operated by the state 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;

3.2.11.11.9. Safeguards to protect the confidentiality of protected health information in keeping with contemporary HIPAA standards for privacy, security, and data integrity;

3.2.11.11.10. Experience and demonstrated success in integrating, analyzing/ reporting, transferring, and managing large complex data sets;

3.2.11.11.11. Technology supports that drive accurate, timely claims management and administration operations; and

3.2.11.11.12. Industry-leading reporting capabilities as needed by the state for effective and efficient management and oversight of the SMO operations.

3.2.11.12. A proven track record of being accountable to performance requirements under large, complex contracts, including:

3.2.11.12.1. Examples of successful achievement of performance thresholds or guarantees that embody the children/youth and adults and addiction and mental health system principles outlined in this contract;

3.2.11.12.2. Acceptance of performance measures, thresholds, and other requirements described in this contract; and

3.2.11.12.3. Capability to update performance measures as industry standards and program requirements change.

3.3. CMS Waiver Authorities

3.3.1. DHH submitted concurrent Medicaid State Plan Amendments and waiver applications to CMS in March of 2011, and was approved for the administration of the LBHP. The SMO must manage the LBHP as per the Medicaid State Plan and amendments and CMS approved waivers. The currently approved CMS authorities include:

3.3.1.1. 1915(b) prepaid inpatient health plan (PIHP) with mandatory enrollment and selective services contracting.

3.3.1.2. 1915(c) children's CSoC Severely Emotionally Disturbed (SED) Home and Community-Based Waiver.

3.3.1.3. 1915(i) Medicaid State Plan Amendment (SPA) for Adult Mental Health Rehabilitation services for individuals with Serious Mental Illness (SMI).

3.3.1.4. CMS approved DHH amendments for various Medicaid State Plan service categories.

3.3.1.5. These concurrent authorities are administered through the 1915(b) authority. The CMS authorities are included in the Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877 and the services are detailed in Section 8 of this RFP.

3.3.2. It is the intent of DHH to submit to CMS additional State Plan Amendments and waiver amendments relative to transforming the children's service model no later than December 31, 2015. Pending CMS approval, the SMO shall be responsible for implementing the enhanced children's service array as outlined in Section 8.6 of this RFP. If approval by CMS is not granted, the SMO shall operate under the current CMS approved authorities.

3.3.3. The SMO must comply with any changes/amendments to current SPAs or waivers and shall conform to any new services adopted by an approved SPA or waiver.

3.3.4. The currently approved 1915(b) waiver had the following number of eligible children and adults as of February 28, 2014, and includes all inpatient and outpatient behavioral healthcare for Medicaid eligibles except for limited basic behavioral healthcare for Bayou Health members:

Table 3: 1915(b) Eligible Children and Adults (Actuals)

	Year 1	**Year 2**
Population	**3/1/12-2/28/13**	**3/1/13-2/28/14**
Non-Disabled – Child*	679,328	680,578
Non-Disabled – Adult*	144,335	140,537
Foster Care & Disabled Child	57,137	56,723
Disabled Adult	127,295	129,035
CSoC SED 1915(c) Waiver	469	928
Total Annualized Enrollment	1,008,564	1,007,801
*Non-disabled indicates person is not receiving Social Security Income (SSI)		

3.4. Management of Services for Medicaid Members

3.4.1. The RFP seeks an SMO to manage Medicaid behavioral health services for children with specialized behavioral health needs, and for adults with SMI and/or substance use disorders, to promote utilization of best, evidence-based and informed practices and to improve access and deliver efficient, high quality services.

3.4.2. The SMO shall be responsible for contracting with providers for the provision of behavioral health services for this population. In the first two years of the LBHP, there is a reported caseload of over 85,000 children served and 106,000 adults.

3.4.3. DHH-OBH recognizes the continued need for development of crisis intervention and stabilization services through the potential development of Medicaid State Plan amendments and local collaborations to expand

and better manage behavioral health issues in the community. The SMO 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 SMO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.

3.4.4. DHH-OBH continues to move toward decreased reliance on institutional and inpatient level of care for children. The overall goal continues to be focused on the development of an effective service array for children in the community and avoiding out-of-home placement whenever possible. LBHP children/youth with specialized behavioral health needs must be able to access effective and coordinated services.

3.4.5. The SMO will be responsible for managing Medicaid State Plan services to the child and adult population for specialized behavioral health needs. For example, the SMO will implement evidence-based practices for children including, but not limited to, Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT), Homebuilders, Trauma Focused Cognitive Behavioral Therapy (TF-CBA), and other critical evidence-based and informed services available for children and their families as provided in the Service Definitions Manual (see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877).

3.4.6. The SMO shall manage treatment for substance use disorders for Medicaid members. Substance use services include the American Society of Addiction Medicine (ASAM) levels of care.

3.4.7. The SMO 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 SMO shall authorize Medicaid State Plan and waiver services as appropriate.

3.4.8. The SMO shall finalize a sustainable treatment plan that is consistent with the needs of the adult or child and medical necessity guidelines.

3.4.9. The SMO shall contract with providers (including the LGEs), and partner with OJJ, DCFS, LDOE, and other local stakeholder agencies for intake of eligible adults and youth.

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

3.4.11. The SMO shall provide quality assurance (QA) at the local level to monitor and support development of local provider capacity for the purpose of filling gaps in service availability.

3.4.12. Management of Services for Children Eligible for the Coordinated System of Care

3.4.12.1. DHH-OBH intends to contract for management of children's behavioral health services for children/youth in or at risk of out-of-home placement and involved with the state's child-serving agencies (DCFS, LDOE, DHH-OBH, and OJJ) through a Coordinated System of Care (CSoC).

3.4.12.2. The goals of CSoC include:

3.4.12.2.1. Reduction in the number of children and youth in detention and residential settings;

3.4.12.2.2. Reduction of the state's cost of providing services by leveraging Medicaid and other funding sources for previously unallowable services; and

3.4.12.2.3. Improving the overall outcomes of these children and their caregivers.

3.4.12.3. The CSoC is a research-based model that is part of a national movement to develop family and youth-driven care and keep children with severe behavioral health needs at home, in school, and out of the child welfare and juvenile justice system. The CSoC also creates partnerships with public and private providers to form a multi-agency, multi-disciplinary system of care. The system of care model involves collaboration among agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services for CSoC youth and families.

3.4.12.4. CSoC is currently organized by the following regions with the intent to implement the program statewide, pending CMS approval:

3.4.12.4.1. Region 1 (Orleans Area) including: Jefferson, Orleans, Plaquemines and St. Bernard parishes.

3.4.12.4.2. Region 2 (Capital area) including: Ascension, East Baton Rouge (includes Zachary, City of Baker and Central Community school systems), West Baton Rouge, East Feliciana, West Feliciana, Iberville, and Pointe Coupee parishes.

3.4.12.4.3. Region 7 (Alexandria area) including: Avoyelles, Grant, LaSalle, Vernon, Rapides, Catahoula, Concordia, and Winn parishes.

3.4.12.4.4. Region 8 (Shreveport area) including: Caddo, DeSoto, Natchitoches, Red River, Sabine, Bienville, Bossier, Claiborne, Jackson, and Webster parishes.

3.4.12.4.5. Region 9 (Monroe area) including: Morehouse, Ouachita (includes the City of Monroe School System), East Carroll,

Franklin, Jackson, Lincoln, Madison, Richland, Tensas, Union and West Carroll parishes.

3.4.12.5. During the first two years of implementation of the LBHP, approximately 2,250 children and youth were served through CSoC in the five implemented regions utilizing 1,200 available slots.

3.4.12.6. Wraparound facilitation is an intensive, individualized care planning and management process that addresses the needs of the youth within the context of the broader family unit. The organizations providing wraparound facilitation in Louisiana's CSoC are WAAs. WAAs are responsible for developing a single plan of care and providing intensive care coordination for children within CSoC.

3.4.12.7. There is capacity through the 1915(c) waiver to cover up to 2,400 children and youth through CSoC statewide at any given point in time. The SMO shall reallocate CSoC capacity based on demand/need.

3.4.12.7.1. The SMO shall be responsible for contracting with WAAs to provide Wraparound Facilitation (WF) for CSoC eligible children/youth and their families. WAAs will provide intensive, individualized care planning and management through Child and Family Teams (CFT). The SMO shall be responsible for monitoring and ensuring that the WAAs adhere to the responsibilities and requirements outlined in the 1915(c) waiver.

3.4.12.7.2. The SMO will be responsible for training wraparound facilitators and coaches within the WAAs. The SMO shall submit its WAA training plan, which shall be consistent with National Wraparound Initiative (NWI) training standards, to DHH-OBH for approval within 30 days of the Division of Administration/Office of Contractual Review (DOA/OCR) approval of the signed contract.

3.4.12.8. Families enrolled in CSoC will have access to family and youth support in accordance with the approved waivers.

3.5. Management of Services for Uninsured/Non-Medicaid Members

3.5.1. This RFP identifies different requirements for management of Medicaid and uninsured or non-Medicaid populations (hereinafter referred to as "non-Medicaid"), including payment methods depending on the state departments providing funding for non-Medicaid members. Payment terms for services provided to non-Medicaid members is outlined in Section 7.8 of this RFP.

3.5.2. Non-Medicaid behavioral health services shall be managed for adults with SMI and/or AD and children not eligible for the CSoC. The SMO shall promote utilization of evidence-based and best practices and improve access and deliver efficient, high quality services.

3.5.3. Monitoring mechanisms relative to this population shall be in a format and frequency to be determined by DHH-OBH.

3.5.4. The SMO shall contract with providers (including the LGEs), and partner with OJJ, DCFS, LDOE, and other local stakeholder agencies for intake of non-Medicaid adults and youth.

3.5.5. The SMO will be responsible for the application of service authorization criteria based on medical necessity for all behavioral health services provided to non-Medicaid members, including the state's contracted inpatient psychiatric beds.

3.5.6. The SMO shall track and monitor services provided to individual non-Medicaid members including, but not limited to, the type and duration of services provided, outcomes, and costs of services.

3.5.7. The SMO shall provide quality assurance (QA) at the local level to monitor and support development of local provider capacity for the purpose of filling gaps in service availability for this population.

3.5.8. The SMO shall work with DHH-OBH to establish the framework for managing care and provider enrollment necessary for the delivery of prior authorization, screening, assessment, treatment plan development, concurrent review and referral for non-Medicaid eligible members and non-Medicaid services.

3.5.9. The SMO will provide the following administrative services to qualified and enrolled non-Medicaid eligible members, including but not limited to:

3.5.9.1. 24/7 telephonic availability for screening and referral to emergency services and service providers.

3.5.9.2. Referral to a provider (within the non-Medicaid provider network) for a comprehensive assessment for clients who are eligible for further assessment of need for services utilizing approved OBH instruments, such as the Addiction Severity Index (ASI), the Level of Care Utilization System (LOCUS) or other DHH-OBH approved methods (based on DHH-OBH set criteria) as indicated and track treatment effectiveness before the reauthorization of additional services.

3.5.9.3. Based on assessment recommendations, authorize the development of a treatment plan and prior authorize the appropriate services (service package) available within the LBHP.

3.5.9.4. Provide client level data on services provided and service providers including, but not limited to, summary reporting and trend analysis of services and outcomes.

3.5.9.5. Provide concurrent review and level of care decisions based on assessments and treatment planning.

3.5.9.6. Enroll into the SMO network existing LGE providers and clinics.

3.5.10. The SMO shall work with the state to accomplish the comprehensive management of services to the non-Medicaid SMI and AD populations throughout the duration of the contract by:

3.5.10.1. Establishing with DHH-OBH the procedures for enrollment of existing and future qualified (non-Medicaid eligible), persons as members. This procedure and qualification/eligibility standards should parallel enrollment procedures/processes for the LBHP Medicaid program.

3.5.10.2. Design credentialing standards for the non-Medicaid providers that adhere to criteria established by DHH-OBH.

3.5.11. The SMO shall further develop, implement and maintain policies and procedures and obtain appropriate staffing and resources to ensure the following requirements are met relative to the non-Medicaid population as members of the LBHP:

3.5.11.1. Provider network development as outlined in Section 10 of this RFP, including but not limited to:

3.5.11.1.1. Education and training to non-Medicaid providers relative to managed care (e.g., billing and payment practices and required reporting).

3.5.11.1.2. Incorporation of non-Medicaid providers and services into the Network Development and Management Plan.

3.5.11.2. Care and utilization management including, but not limited to, service authorization, care coordination and transition, and provider utilization as outlined in Section 11 of this RFP for LBHP members.

3.5.11.3. Member Services as outlined in Section 15 of the RFP including, but not limited to required member education and materials, provision of a member call center and interpretive services, maintaining and supplying a provider registry for both Medicaid and non-Medicaid providers on its website, and notice of provider termination.

3.5.11.4. Development of a grievance process for members and providers similar to the required grievance process outlined in Section 16 of this RFP. The non-Medicaid grievance process shall be submitted to DHH-OBH for approval within thirty (30) days of DOA/OCR approval of the signed contract.

3.5.11.5. Quality management as detailed in Section 17 of this RFP relative to LBHP members and providers.

3.5.11.6. Maintain system functionality for tracking non-Medicaid members and services including, but not limited to encounter data (referrals and denials) and other data as requested by DHH-OBH for monitoring and auditing. Technical requirements for this population are detailed in Section 19 of this RFP.

3.6. Permanent Supportive Housing (PSH)

3.6.1. DHH partners with the Louisiana Housing Authority to co-manage the Permanent Supportive Housing (PSH), a cross-disability program that provides access to approximately 3,300 affordable housing units and subsidies statewide, depending upon new programs/voucher availability. The SMO will be responsible for outreach to potential and current PSH recipients with behavioral health needs, managing the prior authorization and referral process for adults and children who qualify for this service as defined in PSH program policy, assuring service delivery in accordance with the member's care plan, services authorization as applicable, specialized care management including responding to tenant-property manager issues as identified by the PSH program policy, reporting services utilization data, assuring an adequate network of qualified service providers are certified to deliver services. The SMO shall:

3.6.1.1. Assist with targeted outreach for the PSH program statewide to LBHP members, as well as to entities who provide services or outreach to individuals and households who could benefit from PSH. This may include, but is not limited to, the nine Continua of Care throughout the state and their member agencies serving individuals with SMI, inpatient and residential treatment providers, discharge planners, the SMO provider network, legal services organizations, district offices, behavioral health advocacy organizations, and the criminal justice community.

3.6.1.2. Provide specialized care management to assure certified PSH providers are assisting members in need of PSH to meet PSH eligibility requirements, apply for PSH, take the necessary steps to enter into a lease agreement, move into housing, and assuring providers deliver post tenancy supports in accordance with the member's plan of care including assisting members to meet their obligations as a tenant.

3.6.2. Maintain regular contact with the PSH program as required by DHH and the Louisiana Housing Authority (LHA) to meet the terms of the Cooperative Endeavor Agreement (CEA) (see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877) and the Interagency Partnership Agreement between DHH and LHA. SMO duties include targeted outreach, member referrals, assistance to members in completing an application for PSH, processing PSH applications, service authorization and payment, network management, PSH provider credentialing, eligibility, tracking, reporting, quality management and, if needed, responding to requests from tenant services management. The SMO will assign a lead staff member to have overall responsibility for assuring performance of these tasks, including monitoring to assure the SMO meets expectations as set forth in the CEA and Interagency Partnership Agreement, providing feedback to and participating with the PSH Program in program coordination and the dissemination of information.

3.7. Deliverables

3.7.1. General Requirements

3.7.1.1. The SMO shall comply with all the reporting requirements established by this contract. As per 42 CFR §438.242(a)(b)(1)(2) and (3), the SMO shall maintain an information system that collects, analyzes, integrates and reports data that complies with DHH-OBH, federal reporting requirements, and the requirements of this RFP.

3.7.1.2. As specified in Section 19, the SMO shall maintain a SMO Data Warehouse for reporting purposes which will be accessible by DHH-OBH approved users for analytics purposes. In addition, the SMO shall provide the necessary data extracts to the DHH-OBH Data Warehouse and MMIS as required by this RFP and outlined in Section 19.

3.7.1.3. The SMO shall create reports or files (known as Deliverables) using the electronic formats, instructions, and timeframes as specified by DHH-OBH and at no cost to DHH-OBH. Any changes to the formats must be approved by DHH-OBH.

3.7.1.4. All deliverables should be accompanied with a standard title page which shall include only the SMO name, name of deliverable as listed in the RFP, date, date of any subsequent revision, indicate draft or final version, and the SMO owner/contact person.

3.7.1.5. In the event that there are no data to report, the SMO shall submit the standard report title page and a report so stating.

3.7.1.6. Data submitted by the SMO including, but not limited to, all documents specified by DHH-OBH, encounter and claims data and other information required as a deliverable in the contract, shall be certified. The certification shall attest, based on best knowledge, information, and belief as to the accuracy, completeness, and truthfulness of the documents and data. The SMO shall submit the certification concurrently with the certified data and documents. This certification shall be in a format approved by DHH-OBH.

3.7.1.7. All data and documents requiring certification the SMO submits to DHH-OBH shall be certified by one of the following: SMO's Chief Executive Officer; SMO's Chief Financial Officer; or an individual who has delegated authority to sign for, and who reports directly to, the SMO's Chief Executive Officer or Chief Financial Officer.

3.7.1.8. The SMO shall prepare and submit any other reports as required and requested by DHH-OBH, LBHP partners, and/or CMS that is related to the SMO's duties and obligations under this contract. Information considered to be of a proprietary nature shall be clearly identified as such by the SMO at the time of submission.

3.7.1.9. The SMO shall provide DHH-OBH with a sample of all reports upon request of DHH-OBH prior to submission of the deliverable.

3.7.1.10. DHH-OBH reserves the right to request ad hoc reports and/or deliverables. Due dates will be determined by DHH-OBH in consultation with the SMO and consideration for the need or urgency of the ad hoc report/deliverable.

3.7.1.11. DHH-OBH reserves the right to require additional regularly scheduled (annually, monthly, weekly, etc.) deliverables beyond the deliverables outlined in this contract.

3.7.1.12. Failure to submit deliverables (including ad hoc reports) on or before the due date and in the correct format may result in remediation as per Section 22 of this RFP.

3.7.1.13. The SMO shall submit deliverables as specified in this RFP. DHH-OBH shall have the right to approve, disapprove or require modification of these documents.

3.7.1.14. DHH-OBH reserves the right to request follow-up to any deliverable. Follow-up may include, but not be limited to, providing additional information, DHH-OBH on-site monitoring, tracking of issues identified in the deliverable, request for corrective action plan and DHH-OBH monitoring of corrective action plan, and/or requiring changes to the deliverable.

3.7.1.15. DHH-OBH reserves the right, at its discretion, to discontinue any report or deliverable outlined in this RFP.

3.7.2. Errors

3.7.2.1. The SMO agrees to prepare complete and accurate reports for submission to DHH-OBH. If after preparation and submission, an SMO error is discovered either by the SMO or DHH-OBH; the SMO shall correct the error(s) and submit accurate reports for encounters and all other reports (including ad hoc) within fifteen (15) calendar days from the date of discovery by the SMO or date of written notification by DHH-OBH (whichever is earlier).

3.7.2.2. DHH-OBH may, at its discretion, extend the due date of the correction if an acceptable corrective action plan has been submitted and the SMO can demonstrate to DHH-OBH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.

3.7.2.3. Failure of the SMO to respond within the above specified timeframes for correction may result in remediation as per Section 22 of this RFP.

3.7.3. Software Reporting Requirement

3.7.3.1. All reports submitted to DHH by the SMO 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.

3.7.3.2. The system shall make reports available in Microsoft Excel 2007 or later as requested by DHH-OBH when appropriate to report in Excel format.

3.7.4. Report Submission Timeframes

3.7.4.1. Appropriate reporting timeframes for quarterly reports will be established by DHH-OBH or in accordance with the federal authorities associated with this contract.

3.7.4.2. The SMO shall ensure that all required reports or files, as stated in this RFP, are submitted to DHH-OBH according to the time frames as set forth in this RFP or the associated federal authorities for review and approval unless changed by mutual agreement of the parties. The SMO's failure to submit the deliverables, reports, or files as specified may result in remediation as per Section 22 of this RFP.

3.7.4.3. Ad hoc reports shall be submitted upon the agreed date of delivery.

3.7.5. Deliverable Submissions Table

3.7.5.1. The *Deliverable Submissions Table* in Appendix C (see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877) contains a summarized list of deliverables, reports, and/or files to be submitted by the SMO.

3.7.5.2. In the event that a deliverable is not listed in Appendix C but is included in this RFP or the federal authorities associated with this contract, the required deliverables in the RFP and federal authorities override the appendix, and the SMO is not exempt from the deliverable requirement.

3.8. Term of Contract

3.8.1. The term of the contract is anticipated to be March 1, 2015, through December 31, 2016. 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 SMO sixty (60) days prior notice of such change to provide the SMO the opportunity to prepare for the on-site Readiness Review. The term of this contract is anticipated for a period of twenty-two (22) months. With all proper approvals and concurrence with the successful proposer, DHH-OBH may also exercise an option to extend for up to twelve (12) additional months at the same terms and conditions of the initial contract term. Adjustments to rates shall be actuarially sound.

3.8.2. Beyond a thirty-six (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 a thirty-six (36) month term.

3.8.3. No contract/amendment shall be valid, nor shall the state be bound by the contract/amendment, until it has first been executed by the head of DHH, or his designee, and the SMO and has been approved in writing by the director of the Office of Contractual Review. Total contract term, with extensions, shall not exceed five (5) years. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

3.9. Subcontracting Information

3.9.1. The state shall have a single prime contractor, the SMO, as the result of any contract negotiation, and the SMO shall be responsible for all deliverables specified in the RFP and proposal. This general requirement notwithstanding, proposers may enter into subcontractor arrangements; however, it should be acknowledged in their proposals that total responsibility for the entire contract lies with the proposer.

3.9.2. If the SMO intends to subcontract for portions of the work, the SMO should identify any subcontractor relationships and include specific designations of the tasks to be performed by the subcontractor. Information required of the SMO under the terms of this RFP shall also be required for each subcontractor. The SMO shall be the single point of contact for all subcontract work.

3.9.3. Unless provided for in the contract with the state, the SMO shall not contract with any other party for any of the services herein contracted without the express prior written approval of the state.

3.9.4. For subcontractor(s), before commencing work, the SMO will provide letters of agreement, contracts or other forms of commitment which demonstrate that all requirements pertaining to the SMO will be satisfied by all subcontractors through the following:

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

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

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4.0 HEALTHCARE INTEGRATION

4.1. Background and Purpose

4.1.1. The SMO shall support the integration of both physical and behavioral health services through screening and strengthening prevention/early intervention at the Primary Care Practitioner (PCP) level of care. It is anticipated that the SMO will work in conjunction with Bayou Health. The SMO shall develop methods to incentivize PCPs to collaborate with behavioral health specialists (public or private) to ensure the provision of services to members as specified in the Medicaid State Plan and applicable waivers.

4.1.2. Core Concepts of Care Integration

4.1.2.1. Enhanced detection and treatment of behavioral health disorders in primary care settings;

4.1.2.2. 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;

4.1.2.3. Assist members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder, and

4.1.2.4. Approved communication and consultation by behavioral health providers with primary care practitioners (PCPs) of co-enrolled members with co-existing medical and behavioral health disorders requiring co-management.

4.1.3. Principles that guide operations are as follows:

4.1.3.1. Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings;

4.1.3.2. Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions;

4.1.3.3. 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;

4.1.3.4. 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.

4.2. Scope of Work

4.2.1. The SMO shall strongly support the integration of both physical and behavioral health services through:

4.2.1.1. Encouraging screening and strengthening prevention/early intervention at the PCP level of care;

4.2.1.2. Educating LBHP members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, when available and appropriate;

4.2.1.3. Identifying shared members (i.e., those members receiving both Bayou Health managed primary medical care and SMO-managed specialty behavioral healthcare) who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate SMO-contracted behavioral health specialists;

4.2.1.4. Tracking names of shared members who visit ED/ER, generate and distribute monthly reports to Bayou Health that include names of members and dates of service;

4.2.1.5. Ensuring referral, continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring medical services. An approved “SMO and Bayou Healthcare Plan Coordination of Care” referral form should be used;

4.2.1.6. Utilization of a Pharmacy Benefit Management program by the SMO for members of the LBHP when ordered by a covered prescriber including psychiatrists, medical psychologists and Advanced Practice Registered Nurses (APRNs) with a psychiatric specialty as defined under LMHP;

4.2.1.7. SMO Care Managers utilization of secure email to provide notice to referring Bayou Health Plan Care Manager that a Coordination of Care Referral Form was received, and will contact Bayou Health Plan Care Manager within 3 business days of receipt of referral for routine referrals and within one business day, if referral is marked “urgent;”

4.2.1.8. Documenting authorized referrals in the SMO’s clinical management system;

4.2.1.9. Developing capacity for enhanced rates or incentives for integrated care by providers;

4.2.1.10. Documenting the member’s PCP in the Care Management record or, if none, follow up on the PCP referral as part of the ongoing care management process, thus ensuring that each member has

an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the member;

4.2.1.11. Providing or arranging for training of SMO providers and Care Managers on identification and screening of medical/physical health conditions and referral procedures;

4.2.1.12. Distributing Release of Information forms as per 42 CFR §431.306, and provide training to SMO providers on its use;

4.2.1.13. Dedicating two (2) full time SMO Care Coordinators to Bayou Health matters;

4.2.1.14. Implementing rounds with behavioral health-pregnancy specialist at least twice monthly;

4.2.1.15. Conducting Case Management rounds at least monthly with each Bayou Health plan;

4.2.1.16. Developing and implementing a case management program through a process which provides that appropriate and cost-effective medical services, social services, and behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs; and

4.2.1.17. Participating in regular collaborative meetings yearly, which include Bayou Health, DHH-OBH, and other DHH representatives for the purpose of coordination and communication.

4.2.1.18. Behavioral health consultation services:

4.2.1.18.1. The SMO shall use dedicated Masters level clinicians as integrated care managers. The role of the care manager will be to provide concise clinical summaries to consulting behavioral health physicians, provide oversight to ensure consultation activities are recorded in the medical record, provide information to patients, and provide support to primary care staff.

4.2.1.18.2. Using a team approach, the SMO shall deploy "navigators," such as certified peer specialists, to help members navigate the healthcare system. Navigators could be clinical social workers, nurses or paraprofessionals. A navigator's functionality can range from simply helping individuals to seek care, to interacting with their healthcare providers on their behalf, and/or to improving home and community-based support for their clients. Navigators also foster patient engagement.

4.3. Federal Authorities

4.3.1. In developing an integrated care model, DHH may amend or apply for any federal authority in order to implement integration efforts, including but not limited to waivers and/or Medicaid State Plan amendments.

4.3.2. The SMO shall comply with all applicable federal, state and local laws, rules and regulations, which are incorporated, as amended or revised from time to time, in connection with the performance of its obligations under the contract.

4.4. Contract Amendments

4.4.1. DHH-OBH reserves the right to amend this contract at any time for the purpose of further enhancing primary and behavioral healthcare integration within the intent of this section.

4.4.2. Upon CMS approval of new Medicaid authorities, or changes to the waivers or Medicaid State Plan for the purpose of integrating physical and behavioral healthcare, the contract shall be amended in order for the State to come into compliance with federal requirements.

4.4.3. Payment for integrated healthcare services shall be in accordance with appropriate CMS approved authorities.

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5.0 ELIGIBILITY

5.1. Eligibility Determinations

5.1.1. DHH determines eligibility for Medicaid and CHIP for all coverage groups. DHH does not determine eligibility needed for 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.

5.1.2. 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.

5.1.3. 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).

5.1.4. DHH may add, delete, or otherwise change mandatory, voluntary opt-out, voluntary opt-in, and excluded populations. If changed, the contract shall be amended and the SMO given sixty (60) days advance notice when possible. The SMO shall adhere to all transition requirements provided by DHH upon implementation of such changes, including coordination of any data or records exchanges.

5.2. Duration of Medicaid Eligibility

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

5.2.2. Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through two months post-partum or post-loss of pregnancy.

5.2.3. 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.

5.3. Eligibility Criteria

5.3.1. Eligibility criteria for enrollment in the Louisiana Behavioral Health Program are the same as the eligibility criteria for the Louisiana Medicaid and Louisiana CHIP Programs.

5.4. Included LBHP Populations

5.4.1. Medicaid groups participating in the LBHP include the following children who are:

5.4.1.1. Non-Disabled ages 0-20;

5.4.1.2. Disabled or in foster care ages 0-20;

5.4.1.3. Persons dually enrolled in Medicare and full Medicaid;

Note: Medicaid-unique behavioral health services shall be paid by the SMO for dually eligible child populations with full Medicaid benefits. For dually eligible individuals, Medicare "crossover" claims (claims that include primary payment from Medicare) for Inpatient, Outpatient, Emergency Room and Professional services are excluded from coverage under the capitation rates. These services will be administered separately by the Medicaid Fiscal Intermediary from the services covered under the capitation rates effective under this contract.

5.4.1.4. In LaCHIP Phases I-III – Title XIX Medicaid Expansion CHIP Program covering children under age 19;

5.4.1.5. In LaCHIP Phase IV - Separate Title XXI CHIP program covering pregnant women under age 21;

5.4.1.6. In the LaCHIP Phase V – Separate Title XXI CHIP program covering children under age 19; and

5.4.1.7. Age 0-20 and meet a hospital or nursing facility level of care but are receiving home and community-based services through the 1915(c) waiver and are not otherwise eligible for Medicaid.

5.4.2. Medicaid groups participating in the LBHP include the following adults who are:

5.4.2.1. Non-disabled ages 21-64;

5.4.2.2. Over age 65;

5.4.2.3. Disabled ages 21-64; and

5.4.2.4. Age 19 or older, not otherwise eligible for Medicaid, who meet 1915(i) level of need and Medically Needy financial criteria.

5.4.2.5. Persons dually enrolled in Medicare and full Medicaid;

Note: Medicaid-unique behavioral health services shall be paid by the SMO for dually eligible child populations with full Medicaid benefits. For dually eligible individuals, Medicare "crossover" claims (claims that include primary payment from Medicare) for Inpatient, Outpatient, Emergency Room and Professional services are excluded from coverage under the capitation rates. These services will be administered separately by the Medicaid Fiscal Intermediary from the services covered under the capitation rates effective under this contract.

5.4.3. Permanent Supportive Housing eligibility within the LBHP is based on the following criteria:

5.4.3.1. Member is in need of PSH as defined in PSH program policy.

5.4.3.2. Medicaid adult and child members are eligible for 1915(i) SPA services or other behavioral health service managed by the SMO

that includes long term supportive services necessary for successful tenancy.

5.4.4. Non-Medicaid child and adult populations are eligible for services through the LBHP, but shall be excluded from Medicaid payment. Additional details and revisions regarding this population shall be provided by DHH-OBH, OJJ, DCFS, and LDOE as needed.

5.5. Excluded LBHP Populations

5.5.1. Medicaid groups excluded from participating in the LBHP include the following child/youth populations:

5.5.1.1. Eligible under the Refugee Cash/Medical Assistance program;

5.5.1.2. Eligible for Tuberculosis-related services only program;

5.5.1.3. Eligible under the Medicare Savings Program (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualified Individuals, and Qualified Disabled Working Individuals);

5.5.1.4. Eligible under the Emergency Services Only program (aliens who do not meet Medicaid citizenship/ 5-year residency requirements);

5.5.1.5. Eligible under the Long-Term Care Medicare Co-insurance program;

5.5.1.6. Eligible under the Section 1115 Greater New Orleans Community Health Connection Waiver;

5.5.1.7. Medically Needy Spend-down individuals;

5.5.1.8. Eligible under the Family Planning Eligibility Option (FPEO) that provides family-planning-services; and

5.5.1.9. Any Medicaid eligible person during a period of incarceration.

5.5.2. Medicaid groups excluded from participating in the LBHP include the following adult populations:

5.5.2.1. Eligible under the Refugee Cash/Medical Assistance program;

5.5.2.2. Eligible for Tuberculosis-related services only program;

5.5.2.3. Eligible under the Medicare Savings Program (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualified Individuals, and Qualified Disabled Working Individuals);

5.5.2.4. Eligible under the Emergency Services Only program (aliens who do not meet Medicaid citizenship/5-year residency requirements);

5.5.2.5. Eligible under the Long-Term Care Medicare Co-insurance program;

5.5.2.6. Eligible under 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;

5.5.2.7. Eligible under the Section 1115 Greater New Orleans Community Health Connection Waiver;

5.5.2.8. Medically Needy Spend-down individuals;

5.5.2.9. Eligible under the Family Planning Eligibility Option (FPEO) that provides family-planning-services;

5.5.2.10. Adults residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD);

5.5.2.11. Non-Medicaid adult on the eligibility file who is eligible for a Low-Income Subsidy program administered by the Social Security Administration; and

5.5.2.12. Any Medicaid eligible person during a period of incarceration.

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6.0 STAFF REQUIREMENTS AND SUPPORT SERVICES

6.1. General Requirements

6.1.1. Sixty (60) days prior to contract go-live, the SMO shall have in place the organizational, operational, managerial, and administrative systems capable of fulfilling all contract requirements. The SMO shall be staffed by qualified persons in numbers appropriate to the SMO's size of enrollment.

6.1.2. The SMO shall provide a listing of LBHP dedicated corporate resources to DHH-OBH upon request.

6.1.3. The SMO shall require and provide documentation that all staff have the training, education, experience, orientation, and credentialing, as applicable, to perform assigned job duties. The SMO shall maintain current organization charts, resumes, and written job descriptions for both key staff and consultants. All information shall be made available to DHH-OBH upon request.

6.1.4. The SMO shall operate the program through an entity authorized to do business in Louisiana. DHH believes maintaining a presence in Louisiana is vital to the successful fulfillment of the terms of the contract and essential that the proposer have offices within close proximity to DHH's headquarters in order to facilitate oversight of the SMO with face to face meetings, on site record and system reviews, audits, SMO staff trainings and monitoring of operations such as the Louisiana-based call center. DHH-OBH shall approve the location of the SMO headquarters based on travel time and distance from the DHH headquarters. This site shall be a smoke-free environment. The SMO shall employ and contract with individuals in accordance with requirements outlined in Section 18: Program Integrity of this RFP, including employee screens for exclusion and criminal background checks.

6.1.5. The SMO must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The SMO'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 SMO does not achieve the desired outcomes or maintain compliance with contractual obligations and DHH-OBH determines this is due to lack of resources, additional monitoring of resource allocation may be employed by DHH-OBH, including but not limited to requiring the SMO to hire additional staff.

6.1.6. The SMO shall be responsible for any additional costs associated with on-site audits or other oversight activities as determined by DHH that result when required systems are located outside of the state of Louisiana.

6.1.7. The SMO shall remove or reassign, upon written request from DHH, any SMO employee or subcontractor employee that DHH deems to be unacceptable.

6.1.8. The SMO may terminate any of its employees designated to perform work or services under this contract, as permitted by applicable law.

6.1.9. The SMO shall attest that they shall not employ or contract with or have a financial relationship with any employee or former employee of the state who participated in discussions regarding or assisted in the drafting of this RFP within the prior two (2) years from the date the signed contract is approved by DOA/OCR.

6.1.10. The SMO shall provide details on support functions domiciled and managed outside of Louisiana, including corporate functions as applicable. Details shall include the percentage of support services allocated outside of Louisiana compared to services provided in state, and staff time allocated with the associated out-of-state tasks.

6.2. Key Staff Positions

6.2.1. The SMO shall employ key staff to work full-time (full-time equivalent per position) at a location approved by DHH-OBH.

6.2.2. An individual staff member is limited to occupying a maximum of two of the key staff positions listed below for a period up to six (6) months unless prior approval is obtained by DHH-OBH or otherwise stated below.

6.2.3. The SMO shall provide DHH-OBH, upon request, with the opportunity to pre-approve key staff prior to hire.

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

6.2.5. Replacement of key staff positions shall require prior written approval from DHH-OBH which will not be unreasonably withheld provided a suitable candidate is proposed. The SMO shall replace any of the key staff with a person of equivalent experience, knowledge, and talent.

6.2.6. If key staff are not available for work under this contract for a continuous period exceeding thirty (30) days, or are no longer working full-time in the key position, the SMO shall notify DHH-OBH within five (5) days after the date of notification by the key staff of the change in availability or change in full-time employment status to the SMO.

6.2.7. The SMO shall fill the vacant positions within ninety (90) days of the notification or shall be penalized as per the provisions of Section 22 of this RFP.

6.2.8. Thirty (30) days prior to contract go-live, the SMO must provide the organization chart of key staff and consultants, including the name of the staff members performing the duties of the key staff. The organizational chart shall be updated upon employment of new key staff and supplied to DHH-OBH upon request and at least annually.

6.2.9. Key staff positions are as follows:

6.2.9.1. The **Chief Executive Officer (CEO)** must serve in a full time (40 hours weekly) position available during DHH working hours to fulfill the responsibilities of the position and to oversee the entire operation of the SMO. The CEO shall devote sufficient time to the SMO's operations to ensure adherence to program requirements and timely responses to DHH. The Chief Executive Officer shall have at least ten (10) years' experience with management of behavioral health services of organizations similar in size and scope to the requirements of this RFP.

6.2.9.2. The **Chief Medical Officer (CMO)** must be 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 Chief Medical Officer shall devote full time (minimum 32 hours weekly) to the SMO's operations to ensure timely medical decisions, including after-hours consultation as needed. During periods when the CMO is not available, the SMO shall have physician staff to provide competent medical direction. When the CMO is board certified in general psychiatry, the Medical Administrator (see below) shall be board certified in child and adolescent psychiatry, or vice versa. Similarly, either the CMO or the Medical Administrator must be board certified in Addiction Psychiatry or the SMO must contract with an Addictionologist for at least ten (10) hours per week. These positions shall have the responsibility for effective implementation of the Quality Management (QM) program and the Utilization Management (UM) of services and associated appeals as these functions relate to children and youth, and adults with SMI and/or substance use disorders. The CMO will share responsibility to manage the SMO's behavioral health services delivery system with the Chief Operations Officer, and shall be actively involved in all major clinical and quality management components of the SMO. The CMO shall be responsible for:

6.2.9.2.1. 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 SMO Grievance System;

6.2.9.2.2. Physician recruitment and supervision;

6.2.9.2.3. The decision making process for approval and denial of provider credentialing;

6.2.9.2.4. Administration of all medical management activities of the SMO;

6.2.9.2.5. Provider profile design and interpretation;

6.2.9.2.6. Provider education, in-service training and orientation;

6.2.9.2.7. Attendance at regular (at least quarterly) DHH-OBH designated medical director meetings, including linkage with the Bayou Health CMOs/Medical Directors for primary care;

6.2.9.2.8. Administration of all medical management activities of the SMO;

6.2.9.2.9. Serve as director of the UM committee and chairman or co-chairman of the Quality Assessment and Performance Improvement (QAPI) committee;

6.2.9.2.10. Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;

6.2.9.2.11. Ensuring appropriate concurrent review and discharge planning of inpatient stays is conducted; and,

6.2.9.2.12. Development, implementation, and monitoring the provision of care coordination, disease management, and case management functions.

6.2.9.3. The **Medical Administrator** must have a Louisiana license as a physician, board-certified in either general psychiatry or child psychiatry, in complement to the Chief Medical Officer's board certification in either general or child psychiatry, and shall have the responsibility for the design of clinical-medical programs in compliance with federal and state laws and the requirements set forth in this contract, including all documents incorporated by reference. A board certified child and adolescent psychiatrist may be substituted with a board certified psychiatrist in general psychiatry having at least seven (7) years' experience providing services to children and youth. The Medical Administrator may be board certified in Addiction Psychiatry in place of the CMO (or, as stated 5.2.8.2, the SMO must contract with an Addictionologist for at least ten (10) hours per week).

6.2.9.4. The **Chief Financial Officer (CFO)** shall be a certified public accountant with experience and demonstrated success in managed behavioral healthcare responsible for effective implementation and oversight of the budget, accounting systems, and all financial and financial reporting operations of the SMO in compliance with federal and state laws and the requirements set forth in this contract, including all documents incorporated by reference.

6.2.9.5. The **Chief Operations Officer (COO)** shall meet the requirements for a LMHP and have at least seven (7) years' experience in managing behavioral healthcare operations. The COO 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 COO will share responsibility to manage the SMO's behavioral health services delivery system with the CMO.

6.2.9.6. The **Corporate Compliance Administrator** must be qualified by training and experience in healthcare or risk management to oversee a fraud and abuse program to prevent and detect potential fraud and abuse activities pursuant to state and federal rules and regulations. The Corporate Compliance Administrator will carry out the provisions of the SMO's compliance plan, including fraud and abuse policies and procedures, investigating unusual incidents and implementing any corrective action plans. The Corporate Compliance Administrator shall have access to all persons employed within the behavioral health delivery system managed under this contract and shall have designated and recognized authority to access provider records and make independent referrals to the DHH Program Integrity Unit (DHH-PIU) or other duly authorized enforcement agencies. The Compliance Administrator shall have significant experience and expertise in operating compliance programs and shall report directly to the CEO. The Corporate Compliance Administrator shall have on staff at least one investigator, located in Louisiana, dedicated to program integrity fraud, waste, and abuse, investigations. The Corporate Compliance Administrator is responsible for the following:

6.2.9.6.1. Oversight, administration, and implementation of the SMO's Compliance Program;

6.2.9.6.2. Overseeing all audits related to the contract;

6.2.9.6.3. Ensuring SMO compliance with policy and procedure; and,

6.2.9.6.4. Collaborating with the DHH Fraud and Abuse program, Medicaid Fraud Control Units (MFCU), and the Louisiana Attorney General's Office.

6.2.9.7. The **Contract Compliance Officer** will serve as the primary point-of-contact for all SMO operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinating the tracking and submission of all contract deliverables; fielding and coordinating responses to DHH/DCFS/OJJ/LDOE inquiries, coordinating the preparation and execution of contract requirements, random and periodic audits and *ad hoc* visits and deliverables.

6.2.9.8. The **Grievance and Appeals Administrator** will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals, and requests for hearings and provider claim disputes in compliance with federal and state laws and the requirements in the contract, including all documents incorporated by reference. The

Grievances and Appeals Administrator advocates for member rights within the organization, assuring grievance and appeal trends are reported to and addressed within the QAPI committee. The SMO shall not permit its in-house legal counsel, corporate attorney or risk management attorney to act as or supervise its Grievances and Appeals Administrator.

6.2.9.9. The **Business Continuity Planning and Emergency Coordinator** will manage and oversee the SMO'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. Upon prior approval of DHH-OBH, this position's responsibilities may be performed through a consultation contract, be part-time (minimum hours per week to be approved by DHH-OBH) or be combined with another key staff position.

6.2.9.10. The **Quality Management Coordinator (QMC)** must be an LMHP. This position is responsible for the development of the SMO's QA/PI and UM Plan and its effective implementation in collaboration with the Chief Medical Officer, the Medical Administrator, and the Utilization Review Administrator, and compliance with federal and state laws and the requirements in this contract, including all documents incorporated by reference. As specified in 42 CFR §438.200 – §438.242, the QMC shall have significant experience and expertise in the oversight of effective quality improvement public sector programs and managed behavioral healthcare delivery systems. The QMC shall be responsible for the following:

6.2.9.10.1. Ensuring individual and systemic quality of care;

6.2.9.10.2. Integrating quality throughout the organization;

6.2.9.10.3. Implementing process improvement;

6.2.9.10.4. Resolving, tracking and trending quality of care grievances;

6.2.9.10.5. Ensuring a credentialed provider network;

6.2.9.10.6. Developing and implementing a QAPI plan in collaboration with the Chief Medical Officer;

6.2.9.10.7. Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services;

6.2.9.10.8. Focusing organizational efforts on improving clinical quality performance measures;

6.2.9.10.9. Developing and implementing performance improvement projects and corrective action plans;

6.2.9.10.10. Utilizing data to develop intervention strategies to improve outcomes; and,

6.2.9.10.11. Reporting quality improvement/performance outcomes.

6.2.9.11. The **Care Management/Utilization Review Administrator** is a LMHP with significant experience in the implementation of a UM program that assures members receive effective medically necessary services, with strong emphasis on community and family-based services, in compliance with federal and state laws and the requirements in this contract, including all documents incorporated by reference. In addition, the Care Management/Utilization Review Administrator will be responsible for the following:

6.2.9.11.1. Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards; and,

6.2.9.11.2. Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services.

6.2.9.12. The **Network Management Administrator** will coordinate communications between the SMO and its subcontracted providers. The Network Management Administrator must have expertise in network development and recruitment as it is responsible for assuring network adequacy and appointment access, development of network resources in response to unmet needs, and adequacy of the provider network to provide member choice of providers, and contracting with qualified service providers in compliance with federal and state laws and the requirements in this contract, including all documents incorporated by reference. The Network Management Administrator shall have experience and expertise in the development of provider behavioral health services for: 1) children and youth involved in multiple services systems (child welfare, juvenile justice and behavioral health and in or at risk of out-of-home placement), and 2) adults with SMI and/or substance use disorders.

6.2.9.13. The **Provider Services Manager** is responsible for assuring timely inter-provider referrals and associated appointment access, and assisting in resolving provider grievances, disputes between providers and the investigation of member grievances regarding providers; coordinates provider site visits; implements and monitors corrective action plans after grievances are resolved, as needed; and assures accuracy of provider service delivery reports (e.g., encounter information verification). The Provider Services Manager shall have significant experience and expertise in quality management and provider behavioral health services for: 1) children and youth involved in multiple services systems (child welfare, juvenile justice and behavioral health); and 2) adults with SMI and/or substance use disorders and the EBP practices recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) for these populations

and high risk groups such as individuals with co-occurring major mental disorders and substance use disorders.

6.2.9.14. The **Member Services Administrator** will coordinate communications between the SMO 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 SMO program. The Member Services Administrator shall have significant experience and expertise in the management of a member services department and grievance resolution, in compliance with federal and state laws and the requirements in this contract, including all documents incorporated by reference.

6.2.9.15. The **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 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, DHH-OBH, and the WAAs to ensure a statewide program that meets the goals and values of the CSoC in compliance with federal and state laws and the requirements set forth in this contract, including all documents incorporated by reference.

6.2.9.16. The **Adult Systems Administrator (ASA)** must meet the requirements of an LMHP and have at least seven (7) years of experience and expertise in special behavioral health needs of adults with SMI and/or substance use disorders. The ideal candidate will have at least three (3) years' experience in the application of EBPs related to these populations. The ASA will work closely with the COO and Addiction Services Manager.

6.2.9.17. The **Addiction Services Manager (ASM)** will must meet the requirements of an 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 Quality Management Coordinator, and the Chief Medical Officer in assuring quality, appropriate utilization management, and adequacy of the addiction provider network.

6.2.9.18. The **Claims/Encounters Administrator** will develop, implement and administer a comprehensive claims processing system capable of paying claims in accordance with state and federal

requirements and the terms of the contract, including all documents incorporated for reference. The Claims/Encounters Administrator shall have significant experience and expertise in processing behavioral health claims and encounters, especially related to Medicaid and Medicare requirements, and coordination of benefits, including preparation of claims and encounter data for multiple state agencies (i.e., child welfare, juvenile justice, education). The primary functions of the Claims Administrator are:

6.2.9.18.1. Developing processes for cost avoidance;

6.2.9.18.2. Ensuring minimization of claims recoupments;

6.2.9.18.3. Meeting claims processing timelines;

6.2.9.18.4. Meeting DHH encounter reporting requirements; and,

6.2.9.18.5. Ensuring accuracy of claims and encounters.

6.2.9.19. The **Eligibility Administrator** serves as the primary interface on day-to-day issues regarding eligibility between Louisiana Medicaid and the SMO. The primary functions of the Eligibility Administrator are:

6.2.9.19.1. Participating in all activities related to Louisiana Medicaid eligibility in relation to the SMO;

6.2.9.19.2. Possessing a thorough understanding of Louisiana Medicaid Eligibility policies (including dual eligible) and how to apply these policies to the SMO's electronic system;

6.2.9.19.3. Holding responsibility for delivering any routine and ad hoc reports from the SMOs electronic system regarding Louisiana Medicaid eligibility;

6.2.9.19.4. Acting as the lead in performing ongoing changes to the SMO's electronic system as Medicaid eligibility programs are implemented and/or modified;

6.2.9.19.5. Holding responsibility for having a team who can research all Louisiana Medicaid issues that arise on the SMO's electronic system and provide details to support findings;

6.2.9.19.6. Having familiarity with electronic data interfaces between multiple systems; and

6.2.9.19.7. Fully reconciling eligibility data between the SMO and DHH at the direction of Louisiana DHH.

6.2.9.20. The **Information Management Systems Director** must be trained and experienced in information systems, data processing, and data reporting to oversee all SMO information systems functions including, but not limited to, establishing and

maintaining connectivity with DHH information systems, sending and receiving encounters to and from the state's Medicaid Fiscal Intermediary (FI), systems coordination with the LBHP partner agencies as needed (i.e., DCFS, OJJ and LDOE), and providing necessary and timely reports to DHH. The Information Management Systems Director shall have significant experience and expertise in behavioral health data systems.

6.2.10. Additional Required Staff

6.2.10.1. In addition to the key staff, the SMO shall have sufficient number of qualified staff to meet the responsibilities of this contract, including sufficient experience and expertise in working with the eligible members served under this contract: 1) children and youth with behavioral health needs; 2) children and youth served by multiple child-serving agencies (child-welfare, juvenile justice, schools, behavioral health) in, or at risk of out-of-home placements; 3) adults with SMI, substance use disorders and co-occurring disorders of SMI and addictions with complex physical health needs. The SMO shall have a sufficient number of the staff at a minimum in the following categories:

6.2.10.1.1. **Prior Authorization Staff** to authorize healthcare 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 or other LMHP, physician, or physician's assistant.

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

6.2.10.1.3. **Quality Management Staff** to oversee the implementation of the SMO's QAPI and UM Plan and to track, review, and investigate critical incidents and other quality of care issues (e.g., seclusion/restraint, accidents, etc.), including reviewing performance measures, measuring treatment outcomes, assuring timely access to care, and implementing, measuring, and reporting on performance and reporting requirements.

6.2.10.1.4. **Behavioral Health Advisors**, who meet the criteria for one of the following categories, to provide utilization review and consultation on member treatment plans/plans of care:

6.2.10.1.4.1. Psychiatrists who are board certified in child and adolescent psychiatry and addiction psychiatry.

6.2.10.1.4.2. Primary care physicians who are board certified in addiction medicine.

6.2.10.1.4.3. Clinical and medical psychologists.

6.2.10.1.5. **Clerical and Support Staff** to ensure proper functioning of the SMO's operation.

6.2.10.1.6. **Provider Services Staff** to enable providers to receive prompt responses and assistance and handle provider inquiries, 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 SMO program.

6.2.10.1.7. **Provider Network Staff** to train providers on: 1) compliance with billing and documentation requirements; 2) evidence-based and best practices; 3) LBHP (CSoC, 1915(i), etc.) mission, goals and care coordination strategies; and 4) other areas identified in the SMO's Quality Management and provider profiling program.

6.2.10.1.8. **Member Services Staff** to enable members to receive prompt telephonic 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.

6.2.10.1.9. **Program Integrity Investigator** shall be located in Louisiana and shall be dedicated to investigating program integrity fraud, waste, and abuse cases. This position shall be located in Louisiana and report to the Corporate Compliance Administrator.

6.2.10.1.10. **Grievance and Appeals Staff** to timely and accurately process grievances by members, appeals, and provider claims disputes in a timely manner and to be available to testify or present evidence at administrative hearings and other court proceedings.

6.2.10.1.11. **Claims Processing Staff** to ensure the timely and accurate processing of original claims, resubmissions, and overall adjudication of claims. The location of claims processing staff shall be indicated and shall be at minimum located in the continental United States. Staff shall be medically trained and appropriately licensed consistent with National Committee for Quality Assurance (NCQA) accreditation standards, whose primary duties are to assist in evaluating claims for service authorization criteria based on medical necessity.

6.2.10.1.12. **Encounter Processing Staff** to ensure the timely, accurate and complete submission of encounter data to DHH and to correct and resubmit encounter data.

6.2.10.1.13. **Care Management Staff** to assess, plan, facilitate and advocate options and services to meet the members' health needs through communication and available

resources to promote quality cost-effective outcomes. At least 50% of the Care Management Staff shall be LMHPs, and the remaining 50% shall have obtained, at minimum, a Masters level degree in Human Services or Behavioral Health sciences.

6.2.10.1.14. **Data Analysts** to collect and analyze and assure the accuracy of encounter data from sub-contracted providers and other information regarding the SMO's performance.

6.2.10.1.15. **Systems Helpdesk Staff** to assist in triaging all SMO system issues, provide user support, track and document resolution times, and answer questions regarding system functionality, claims processing/encounter submission procedures and process changes, and the SMO data warehouse. The Systems Helpdesk will work with the Medicaid FI systems as well as provide user support to both SMO employees and providers/DHH staff utilizing the SMO systems.

6.2.10.1.16. **Human Resources Staff**, to ensure ongoing hiring and recruitment of staff, keep pace with staff needs and to assure staff disputes are handled fairly and quickly to avoid an unnecessary, negative impact on morale.

6.2.10.1.17. At the minimum, but not limited to, staff to provide the following liaison activities:

6.2.10.1.17.1. Medicaid eligibility;

6.2.10.1.17.2. DCFS, LDOE, OJJ and DHH-OBH eligibility and coordination;

6.2.10.1.17.3. Fiscal/claims management coordination;

6.2.10.1.17.4. Health plan liaison;

6.2.10.1.17.5. Emergency Response/Business Continuity and Recovery that is the single point of contact regarding behavioral health disaster response needs, recovery, and business functions in the event of a disaster or power outage;

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

6.2.10.1.17.7. Consumer and family organizations for children, youth and adults.

6.3. In-State Positions

6.3.1. The SMO is responsible for maintaining a significant local presence within Louisiana, at a location approved by the OBH. All key staff positions previously listed should be located at this site.

6.4. Written Policies, Procedures, and Job Descriptions

6.4.1. The SMO shall develop and maintain written policies, procedures and job descriptions for each functional area, consistent in format and style. The SMO 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 by the SMO to ensure that the SMO's written policies reflect current practices. Reviewed policies shall be dated and signed by the SMO'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 SMO's Medical Director.

6.4.2. If DHH-OBH deems a SMO policy or process to be inefficient and/or places an unnecessary burden on members or providers, the SMO will be required to work with DHH-OBH to change the policy or procedure within a time period specified by DHH-OBH.

6.5. Staff Training and Meeting Attendance

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

6.5.2. The SMO must provide initial and ongoing staff training that includes, but is not limited to, an overview of DHH, DHH policy and procedure manuals, contract requirements (including the 1915(c) and 1915(b) waivers and 1915(i) SPA), currently approved CMS authorities (waivers and Medicaid State Plan), current and applicable EBP, Medicaid State Plan, CSoC services, Medicaid eligibility, and any state and federal requirements specific to individual job functions. The SMO 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. All staff working directly with members shall have crisis intervention training. Additionally, staff should be trained on other Medicaid services as determined by DHH-OBH, including Medicaid transportation.

6.5.3. The SMO shall provide all training materials and documentation thereof to DHH-OBH upon request.

6.5.4. Prior authorization and member services representatives must have access to mapping search engines (e.g., MapQuest, Yahoo Maps, Google Maps, etc.) for the purposes of authorizing services in and recommending providers in the most geographically appropriate location.

6.5.5. The SMO 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. Attendance shall be in person unless otherwise allowed by DHH.

6.5.6. DHH reserves the right to attend any and all training programs or meetings and seminars conducted by the SMO. The SMO shall provide DHH a list of all training dates (See Section 15, "Member Education and Communication"), time and location, at least fourteen (14) calendar days prior to the actual date of training.

6.5.7. The SMO shall provide documentation of meetings and training upon request. Meeting minutes, agendas, and sign-in sheets along with action items must be provided to all meeting attendees by the SMO within 72 hours of the meeting.

6.6. Annual Reporting to DHH

6.6.1. The SMO must submit to DHH the following items annually by contract year:

6.6.1.1. 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 SMO contract, other contracts, and other lines of business.

6.6.1.2. A functional organization chart of the key program areas, responsibilities and the areas that report to that position.

6.6.1.3. A listing of all functions and their locations; and a list of any functions that have moved outside of the state in the past contract year.

6.6.1.4. The SMO shall provide within 30 days of DOA/OCR approval of the signed contract a Human Resources and Staffing Plan that describes how the SMO will maintain the staffing level to ensure the successful accomplishment of all duties outlined in the contract. The key staff and required staff listed in the RFP are required. The SMO may propose to DHH-OBH a staffing plan that combines positions and functions outlined in the RFP for other positions as long as the SMO describes how the Table of Organization and staff roles delineated in the RFP will be addressed.

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7.0 SMO REIMBURSEMENT

7.1. Background and Purpose

7.1.1. In its first three years of operation, the LBHP operated under a capitated payment model for adults and a fee-for-service (FFS) payment model for children/youth services.

7.1.2. Pending CMS approval, DHH intends that the LBHP shall transition to a fully capitated payment structure for both children and adults eligible for Medicaid.

7.1.3. If the waiver changes and SPAs for the new, capitated children's service model are not approved by CMS, payment for children's services will revert to the Medicaid non-risk model for such services. Under this model, the SMO shall serve as the Administrative Service Organization (ASO) for this population and receive an administrative fee for the purpose of providing actual utilization consistent with required state encounter data and administrative costs incurred in that month by using the Financial Reporting Template schedules. No payment will be provided to the SMO for services without complete encounter data submittals or in absence of this report.

7.2. Payment Terms

7.2.1. Services provided by a provider or subcontractor of the SMO under the LBHP shall be billed to the SMO. Through a contract, the SMO will make payment to subcontractors for the provision of services under the LBHP as stipulated in the contract under Section 12 of this RFP.

7.2.2. The SMO shall not assign its right to receive payment to any other entity.

7.2.3. The SMO is not responsible for reimbursement of disproportionate share hospital (DSH) payments.

7.2.4. 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 United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

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

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

7.2.7. The SMO shall ensure that payment is not made for excluded populations. The SMO may be subject to remediation for payment made for excluded populations as outline in Section 22 of this RFP.

7.2.8. The SMO shall submit weekly encounter data on all services provided to covered populations. Submissions must meet client level detail sufficient for required financial reporting via the Financial Reporting Template (see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877), for which instructions will be prescribed by DHH-OBH after the contract award. Encounter data should not include payments, services, or populations that are not covered under this contract.

7.2.9. The SMO shall submit deliverables in accordance with Section 3.7 (*Deliverables*).

7.2.10. In the event that SMO does not provide the services listed under this contract, or only provides a portion of the services, DHH reserves the right to withhold payments until such time as SMO demonstrates that the services have been provided.

7.2.11. Changes to covered services mandated by federal or state law subsequent to the signing of this contract will not affect the contract services for the term of this contract, unless (a) agreed to by mutual consent, (b) unless the change is necessary to continue to receive federal funds or is necessary due to action of a court of law, or (c) for the purpose of healthcare integration as outlined in Section 4 or any other change in the applicable LBHP federal authorities detailed in this RFP. The SMO shall receive thirty calendar days' notice prior to such changes and the rates shall be adjusted accordingly. The method of retrospective reconciliation will not be altered by any changes in the payments.

7.2.12. DHH-OBH reserves the right to determine timing of payments and can change with thirty (30) calendar days written notice to the SMO.

7.3. SMO Payment Schedule

7.3.1. The risk-adjusted monthly capitated payment shall be based on member enrollment for the previous month and retrospectively paid in the weekly payment cycle nearest the first (1^{st}) day of the following month.

7.3.2. Member enrollment for the month is determined by the total Medicaid eligibles assigned to the SMO 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.

7.4. Determination of SMO Rates

7.4.1. 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 SMO capitation for adults or children. DHH will develop monthly capitation rates that will be offered to the SMO on a "take it or leave it" basis.

7.4.2. Pending CMS approval of the submitted waiver and Medicaid State Plan amendments, DHH intends to develop monthly capitation rates for children's services eligible for Medicaid under the LBHP. If the waiver and Medicaid State Plan Amendments for the new, capitated children's service model are not approved by CMS, payment for children's services will revert to the Medicaid fee-for-service model for such services.

7.4.3. The SMO shall be paid in accordance with the monthly capitated rates specified in the *Mercer Behavioral Health Data Book* (Appendix F found at http://new.dhh.louisiana.gov/index.cfm/page/1877) for children and adults.

7.4.4. 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).

7.4.5. DHH-OBH reserves the right to adjust the rate for instances including, but not limited to:

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

7.4.5.2. Changes to Medicaid population groups eligible to enroll in the SMO;

7.4.5.3. Legislative appropriations and budgetary constraints;

7.4.5.4. Changes in the LBHP federal authorities outlined in this RFP; or

7.4.5.5. Changes in federal requirements.

7.4.6. As the program matures and FFS data is no longer available, there will be increasing reliance on encounter data and/or financial data to set future rates, subject to comparable adjustments.

7.5. Annual Actuarial Study

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

7.5.2. The capitation rate may be adjusted based on applicable program changes, trend or other actuarial factors that impact rates as deemed appropriate by the state. The SMO will be given a capitation rate at least thirty calendar days in advance of expiration of the current year's contract. Nothing in this RFP shall be construed to mean that the capitation rate will be increased, only that it will be evaluated by an outside actuarial consulting firm.

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

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

7.5.4. Actuarially sound capitation rate ranges for the Medicaid members shall be set by DHH-OBH's actuary, using the methodology described in the *Mercer LBHP Capitation Rate Development Assumptions* (Appendix D found at http://new.dhh.louisiana.gov/index.cfm/page/1877). The historical data used to set rates can be found in the Mercer Behavioral Health Data Book for the capitated adult and children behavioral health programs.

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

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

7.6. Payment for Medicaid Eligible Children

7.6.1. Pending CMS approval and in full consideration of the contract services rendered by the SMO, DHH-OBH agrees to pay the SMO monthly payments based on the number of enrolled child/youth members and their eligibility category.

7.6.2. If the waiver and Medicaid State Plan Amendments for the new, capitated children's service model are not approved by CMS, payment for children's services will revert to the Medicaid fee-for-service model for such services.

7.6.3. Payment to the SMO shall be based on Medicaid enrollment data each month during the term of the contract. Payment for Medicaid members assigned by a month-end (six business days prior to the last day of the month) will be made according to a pre-determined schedule during the first full week of each service month.

7.6.4. For age group assignment purposes, age will be defined as of the beginning of the month for which the payment is intended.

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

7.6.6. The SMO will receive a roster listing Medicaid eligible children and youth at the beginning of each month for which payment shall be made. The SMO shall also receive a weekly eligibility reconciliation file and daily updates of any eligibility modifications/updates.

7.6.7. With the exception of payments for CSoC enrolled children/youth and the WAAs, all payments to the SMO for Medicaid eligible children will be made for a full month and no pro-rations shall be used. Payment for CSoC youth and WAA invoices shall be at a frequency to be determined by DHH-OBH.

7.6.8. Medicaid-unique behavioral health services shall be paid by the SMO for dually eligible child/youth populations with full Medicaid benefits. These services are included under the capitated rates for children and youth. For dually eligible individuals, Medicare "crossover" claims (claims that include primary payment from Medicare) for Inpatient, Outpatient, Emergency Room and Professional services are excluded from coverage under the capitation rates. These services will be administered separately by the Medicaid Fiscal Intermediary from the services covered under the capitation rates effective under this contract. Specific payment mechanisms surrounding these populations shall be determined by DHH in the SMO Systems Companion Guide.

7.6.9. In the event of a continuation of FFS payment methodology for children's services if CMS does not approve the children's model service changes, special administrative payments will be made accordingly:

7.6.9.1. An administrative service organization fee will be paid to the SMO for administering Medicaid payments for all child/youth members based on the number of members reported through the Medicaid eligibility system.

7.6.9.2. A separate pass-through payment will be made to the SMO to pay the Wraparound Agencies (WAAs) to cover treatment planning and wraparound facilitation functions.

7.7. Payment for Medicaid Eligible Adults

7.7.1. In full consideration of the contract services rendered by the SMO, DHH-OBH agrees to pay the SMO monthly payments based on the number of enrolled adult members and their eligibility category.

7.7.2. Payment to the SMO shall be based on Medicaid enrollment data each month during the term of the contract. Payment for Medicaid members assigned by a month-end (six business days prior to the last day of the month) will be made according to a pre-determined schedule during the first full week of each service month.

7.7.3. For age group assignment purposes, age will be defined as of the beginning of the month for which the payment is intended.

7.7.4. Individuals who lose eligibility for Medicaid due to failure to provide eligibility reports on a timely basis, but whose eligibility is consequently re-established prior to the end of the month, will receive a full month of

eligibility, and will be reported on the daily eligibility files sent to the SMO. Payment for these members will be made with the capitation payments for the next benefit month. SMO will be given notice if this payment schedule changes.

7.7.5. The SMO will receive a roster listing Medicaid eligible adult at the beginning of each month for which payment shall be made. The SMO shall also receive a weekly eligibility reconciliation file and daily updates of any eligibility modifications/updates.

7.7.6. All payments to the SMO for Medicaid eligible adults will be made for a full month and no pro-rations shall be used.

7.7.7. Medicaid is secondary to all other third parties with the exception of Special Health Services, Vocational Rehabilitation, Indian Health Services, Crime Victim's Compensation Funds and the SAPT Block Grant. As capitated payments made to the SMO are from Medicaid funds, the SMO's Medicaid capitation payments would be secondary to all other third parties not listed above.

7.7.8. Medicaid-unique behavioral health services shall be paid by the SMO for dually eligible adult populations with full Medicaid benefits. These services are included under the capitated rates for adults. For dually eligible individuals, Medicare "crossover" claims (claims that include primary payment from Medicare) for Inpatient, Outpatient, Emergency Room and Professional services are excluded from coverage under the capitation rates. These services will be administered separately by the Medicaid Fiscal Intermediary from the services covered under the capitation rates effective under this contract. Specific payment mechanisms surrounding these populations shall be determined by DHH in the SMO Systems Companion Guide.

7.8. Payment for Non-Medicaid Adults and Children

7.8.1. Non-Medicaid Children and Youth Service Claims

7.8.1.1. The SMO is required to pay for all services according to the fee schedule established by the responsible funding agency (OJJ, DCFS, and DHH) for non-Medicaid children and youth.

7.8.1.2. The SMO is responsible for rendering payment for services to the non–Medicaid population with each of the agencies in accordance with a Memorandum of Understanding or contract as determined by each of the LBHP partner agencies (i.e., OJJ, DCFS, and DHH-OBH).

7.8.1.3. The fees and costs associated with the non-Medicaid payments for the DCFS and OJJ agency populations are the responsibility of each of the respective agencies. DHH-OBH assumes no fiscal responsibility or liability associated with these non-OBH populations.

7.8.1.4. On a schedule determined by DCFS and OJJ, the SMO shall submit client level data and an invoice to DCFS, OJJ, and DHH-

OBH for the services provided to individuals eligible for DCFS and OJJ, who are not eligible for Medicaid. The client level data will comply with DCFS and OJJ reporting requirements and be detailed enough for DCFS and OJJ to verify the units rendered. DCFS and OJJ are responsible for payment to the SMO for services rendered to individuals eligible and approved for DCFS/OJJ services as documented in both the client level data and invoice.

7.8.1.5. OJJ and DCFS reserve the right to recover inappropriate monthly administrative payments and inappropriate payments to the SMO for services rendered.

7.8.1.6. LDOE Exemption: If a non-Medicaid child is referred to the SMO by any source, including LDOE, and the child is not eligible through OJJ, DCFS, or DHH-OBH non-Medicaid funding, and the child does not have a third party payment option or self-pay capacity, then the child is not eligible for services under the LBHP through the SMO. There is no assumption that LDOE or school districts shall pay for non-Medicaid services unless they are required under IDEA.

7.8.1.7. The SMO will utilize an electronic process to include prior authorization, electronic delivery of information provided by the provider that verifies services provided, all necessary/required data elements are included to support payment for services, post authorization of payment and services provided, and specific guidelines on how the payment is made.

7.8.2. Non-Medicaid Adult Service Claims

7.8.2.1. For the term of this contract and until otherwise determined by DHH-OBH in collaboration with the SMO, the SMO will submit client level data electronically to DHH-OBH to verify administrative services rendered by the SMO at the end of each month for non-Medicaid eligible members.

7.8.2.2. This electronic delivery of information shall include, but not be limited to, client level data and summary reporting regarding telephone calls received and any resultant screenings, assessments, treatment planning, level of care decisions, concurrent reviews, and appeals and their results, as applicable.

7.8.2.3. Client level information provided by the SMO shall also include access to non-Medicaid benefit services data in order to access the effectiveness/outcomes associated with services authorized for this population.

7.8.3. Administrative Fee for Non-Medicaid Population

7.8.3.1. For the administrative oversight of the DHH-OBH non-Medicaid population, the payment will be a fixed payment amount based upon annual appropriations in the state budget. Payment of this fee will be made on a monthly basis.

7.8.3.2. In the event of a reduction in the appropriation from the state budget, DHH-OBH may recalculate the administrative fee based upon this adjustment with thirty (30) calendar day's written notice.

7.8.3.3. The SMO shall not be paid a rate that exceeds 7.5% of service costs for the administrative costs associated with the DCFS and OJJ non-Medicaid populations.

7.9. Payment Adjustments

7.9.1. In the event that an erroneous payment is made to the SMO, DHH shall reconcile the error by adjusting the appropriate SMO payment.

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

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

7.9.4. In cases of a retroactive effective date for Medicare enrollment of a member, the SMO will recoup payments made to the providers. The SMO shall instruct the provider to resubmit the claim(s) to Medicare.

7.9.5. The SMO will refund payments received from DHH for months of service that is paid after the month of death or after a member has been incarcerated. Members involuntarily incarcerated by the Louisiana Department of Public Safety and Corrections will be suspended from Medicaid and the SMO effective the month following the incarceration. The adjustment is made by DHH or its designee to the SMO's monthly capitation payment as part of the eligibility reconciliation process.

7.9.6. The entire monthly capitation payment will be paid during the month of birth and month of death.

7.9.7. DHH-OBH reserves the right to recover inappropriate payments, including PMPM and invoiced service payments when the SMO actually authorized a service, if the member is subsequently determined to be ineligible for the month in question.

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

7.9.9. Adjustment to PMPM Rates for Medicaid Populations and Administrative Payments for Non-Medicaid Populations:

7.9.9.1. 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).

7.9.9.2. The state reserves the right to alter benefits and/or services under this contract through a contract amendment and thirty (30) calendar days written notice to the SMO. Capitation rates will be adjusted accordingly and in conformity with actuarially sound rate ranges.

7.9.9.3. Nothing in this contract shall be construed to mean that the administrative per member per month rate will be increased.

7.9.9.4. In the event of a reduction in the appropriation from the state budget for any allocation, including but not limited to, the required Maintenance of Effort (MOE) in the support of the Block Grant, DHH-OBH may either renegotiate this contract, including PMPM capitation rates, or terminate with thirty (30) calendar days written notice.

7.9.9.5. The SMO shall have the right to not continue the contract if the new or confirmed rates established by the actuary after each rate assessment are deemed to be insufficient notwithstanding any other provision of this contract. The SMO shall notify DHH-OBH regarding its desire to continue the contract within five (5) calendar days of receipt of the new rates.

7.10. Risk Sharing

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

7.11. Medical Loss Ratio

7.11.1. The SMO shall provide an annual Medical Loss Ratio (MLR) report by June 1 following the end of the MLR reporting year. If the MLR (cost for Medicaid at-risk capitated services and specified quality expenditures) is less than the threshold established by DHH-OBH, the SMO shall refund DHH the difference by August 1 following the end of the reporting year. Any unpaid balances after August 1 shall be subject to interest of 10% per annum. The formula will be provided as part of the Financial Reporting Template (see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877) and instructions prescribed by DHH-OBH.

7.12. Cost Sharing/Co-payments

7.12.1. Any cost sharing imposed on Medicaid members must be in accordance with 42 CFR §447.50 through §447.58 and cannot exceed cost sharing amounts in the Medicaid State Plan. Louisiana currently has no cost

sharing requirements for any of the SMO core benefits and services. DHH reserves the right to amend cost sharing requirements.

7.12.2. The SMO and its subcontractors are not required to impose any copay or cost sharing requirements on their members. The SMO and its subcontractors, however, are not permitted to charge their members fees of any kind or any copay or cost-sharing amount above what exists in the Medicaid State Plan.

7.12.3. The SMO or its subcontractors may not:

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

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

7.12.3.3. Impose copayments for the following:

7.12.3.3.1. Family planning services and supplies;

7.12.3.3.2. Emergency services;

7.12.3.3.3. Services provided to:

7.12.3.3.3.1. Individuals younger than 21 years old;

7.12.3.3.3.2. Pregnant women;

7.12.3.3.3.3. Individuals who are inpatients in long-term care facilities or other institutions;

7.12.3.3.3.4. Native Americans; and

7.12.3.3.3.5. Alaskan Eskimos.

7.13. Return of Funds

7.13.1. All amounts owed by the SMO 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 30 calendar days following notification to the SMO by DHH unless otherwise authorized in writing by DHH. DHH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to DHH to future payments. DHH reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR §30.18. This rate may be revised quarterly by the Secretary of the Treasury and is published by the United States Department of Health and Human Services (HHS) in the Federal Register.

7.13.2. The SMO shall reimburse all payments as a result of any federal disallowances, penalties, or sanctions imposed on DHH as a result of the SMO's failure to abide by the terms of the contract. The SMO 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.

7.14. Third Party Liability (TPL)

7.14.1. General TPL Information

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

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

7.14.1.3. SMO shall ensure submission of TPL information to the FI on a weekly basis as per an agreed upon layout by the FI, Medicaid, DHH-OBH and the SMO. A process regarding testing, submission, errors, edits, etc. shall be developed by the SMO and submitted to DHH-OBH within thirty (30) days of DOA/OCR approval of the signed contract.

7.14.1.4. The SMO shall coordinate benefits in accordance with 42 CFR §433.135 et seq. and Louisiana Revised Statutes, Title 46, so that costs for services otherwise payable by the SMO are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery. The SMO shall use these methods as described in federal and state law.

7.14.1.5. Establishing Third Party Liability takes place when data matches are conducted with insurance carriers that confirm insurance coverage exists for the recipient outside of Medicaid.

7.14.1.6. If the probable existence of Third Party Liability cannot be established, the SMO must adjudicate the claim. The SMO must then utilize post-payment recovery which is described in further detail below.

7.14.1.7. The term “state” shall be interpreted to mean “SMO” for purposes of complying with the federal regulations referenced above. The SMO may require subcontractors to be responsible for

coordination of benefits for services provided pursuant to this contract.

7.14.2. Cost Avoidance

7.14.2.1. The SMO shall cost-avoid a claim if it establishes the probable existence of Third Party Liability at the time the claim is filed.

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

7.14.3. Post-payment Recoveries

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

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

7.14.3.1.2. The SMO must have established procedures for recouping post-payments for DHH's review during the readiness review process. The SMO must void encounter totals for claims that are recouped in full. For recoupments that are not recouped in full, the SMO must submit adjusted encounter totals for the claims.

7.14.3.1.3. The SMO will take responsibility for identifying and pursuing third party liability for Medicaid enrollees that are enrolled in their network with casualty insurance, tort claims and settlements or personal injury. The SMO shall be required to seek amounts greater than five hundred dollars ($500) as required by Medicaid State Plan and federal Medicaid guidelines. The amount of any subrogation recoveries collected by the SMO shall be reported through adjusted invoice and/or encounter data.

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

7.14.3.1.5. Prior to accepting a Third Party Liability settlement on claims equal to or greater than $25,000, the SMO shall obtain approval from DHH-OBH.

7.14.4. Distribution of TPL Recoveries

7.14.4.1. The SMO may retain up to 100% of its Third Party Liability collections if all of the following conditions exist:

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

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

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

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

7.14.5. TPL Reporting Requirements

7.14.5.1. The SMO shall provide DHH Third Party Liability information in a format and medium described by DHH and shall cooperate in any manner necessary, as requested by DHH, with DHH and/or a cost recovery vendor of DHH.

7.14.5.2. The SMO shall track its TPL recovery for members and report this recovery amount to DHH-OBH according to the format and schedule specified by DHH-OBH. Data transfer of TPL information on any member shall occur according to the format and schedule specified by DHH-OBH.

7.14.5.3. The SMO must report the existence of Third Party Liability, to DHH on a weekly basis by 4:00pm every Thursday through the established SFTP site. The SMO shall transfer to DHH-OBH any new TPL information on any member that comes to their attention. DHH or its designee shall also transfer to the SMO any new TPL information for any member weekly by 4:00pm every Thursday through the established SFTP site.

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

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

7.14.5.6. Upon the request of DHH, the SMO shall demonstrate that reasonable effort has been made to seek, collect and/or report Third Party Liability and recoveries. DHH shall have the sole responsibility for determining whether or not reasonable efforts

have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

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

7.14.5.8. In accordance with 42 CFR §433.138(e), the SMO shall be responsible for identifying any accident or injury utilizing diagnosis and trauma related codes 800 through 999, excluding 994.6.

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

7.14.6. DHH Right to Conduct Identification and Pursuit of TPL

7.14.6.1. When the SMO fails to collect payment from the Third Party Liability within three hundred (365) days from date of service, DHH may invoke its right to pursue recovery.

7.14.6.2. If DHH determines that the SMO is not actively engaged in cost avoidance activities the SMO shall be subject to remediation.

7.14.6.3. DHH-OBH will retain responsibility for collecting medical subrogation. DHH-OBH will coordinate these activities with the SMO. The SMO is required to comply with any information requests regarding medical subrogation.

7.15. Financial Disclosures for Pharmacy Services

7.15.1. The SMO must disclose all financial terms and arrangements for remuneration of any kind that apply between the SMO and any prescription drug manufacturer or labeler, including, without limitation, formulary management, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees. DHH or state auditors may audit such information at any time. DHH agrees to maintain the confidentiality of information disclosed by the SMO pursuant to the contract, to the extent that such information is confidential under Louisiana or federal law.

7.16. Financial Reporting

7.16.1. The SMO shall report all financial reporting requirements as outlined in the Financial Reporting Template (see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877).

7.16.2. The SMO shall develop and submit to DHH-OBH for approval within thirty (30) days of DOA/OCR approval of the signed contract a procedure

relative to recovery of overpayments to providers upon reaching a certain threshold. The procedure shall require that the SMO immediately report to DHH-OBH on all overpayments upon reaching the approved threshold and provisions for notifying the affected provider(s). The SMO shall track all provider notifications resulting from overpayment, amounts of overpayment, and any other related data.

7.16.3. The SMO shall comply with federal and state laws and DHH Policy requiring an audit of the SMO's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, one (1) copy of the audit shall be sent to the Department of Health and Hospitals, Attention: Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-9117 and one (1) copy of the audit shall be sent to the contract monitor. DHH-OBH may at its discretion develop other financial reporting requirements (FRRs) that are designed to evaluate the specific operations of the SMO related to this contract.

7.16.4. Audit Requirement: Circular A-133 is issued under the authority of sections 503, 1111, and 7501 et seq. of title 31, United States Codes, and Executive Orders 8248 and 11541 Non-federal entities that expend $300,000 ($500,000 for fiscal years ending after December 31, 2003) or more in a year in federal awards shall have a single or program-specific audit conducted for that year in accordance with the provisions of this part.

7.16.5. Non-federal entities that expend $300,000 ($500,000 for fiscal years ending after December 31, 2003) or more in a year in federal awards shall have a single audit conducted in accordance with §500 except when they select to have a program-specific audit conducted in accordance with paragraph (c) of this section.

7.16.6. The SMO shall provide near real-time, read-only access to its financial reporting systems.

7.16.7. The SMO shall implement processes for verifying the accuracy and timeliness of reported data, screen the data for completeness, logic, and consistency, and collect service information in standardized industry formats. The SMO shall submit timely, accurate, and complete data or shall be subject to remediation under Section 22 of this RFP.

7.16.8. The SMO shall develop an accounting and financial reporting system that tracks revenue and expenses associated with various funding streams/sources separately and that will have capability and capacity to integrate with DHH and state systems.

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

7.16.10. In addition to the annual audit requirements discussed within this section, the SMO shall submit quarterly unaudited financial statements no later than 60 days after each calendar quarter and shall use generally

accepted accounting principles in preparing the unaudited quarterly financial statements which shall include, but not limited to, the following:

7.16.10.1. Balance Sheet

7.16.10.2. Income Statement

7.16.10.3. Statement of retained earnings

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

7.16.10.5. Annual disclosure and additional financial information requests that will be developed in a format prescribed by DHH-OBH.

7.16.11. The SMO shall report the managed care days and payments to hospitals in order to comply with Section 1932(g) of the Social Security Act, "Identification of Patients for Purposes of Making DSH Payments", and 42 CFR §447.299 reporting requirements. This SMO shall ensure this reporting meets the needs of the State (all inpatient and outpatient encounters must include ancillary charges and the appropriate revenue codes).

7.16.12. Budget Tracking System (Early Warning System)

7.16.12.1. The SMO in conjunction with DHH-OBH shall develop a system to track revenue, expenditures, utilization, cost per service and recipients in service by funding source and eligibility group. The purpose of the system will be to track actual to budget expenditures and assist in the budget process and identify potential budget surpluses or overages. Client/service specific data shall be reported to ensure proper accounting for budget expenditures at each of the participating state agencies (DHH-OBH, DCFS, LDOE and OJJ).

7.16.12.2. The SMO shall provide, in a format prescribed by DHH-OBH, annual projections with monthly reporting to gauge expenditure patterns.

7.16.12.3. The SMO shall adhere to the state budget timeline in order to assure DHH-OBH can submit timely and accurate budget information.

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8.0 COVERED BENEFITS AND SERVICES

8.1. General Provisions

8.1.1. The Statewide Management Organization (SMO) shall have available for members, at a minimum, those core behavioral health benefits and services specified in the contract and, for Medicaid members, as defined in the Medicaid State Plan and its amendments, administrative rules, DHH policy and procedure manuals, and any other services as provided through the 1915(i) SPA, and 1915(c), and 1915(b) waivers, or additional waivers adopted during the course of the contract. The SMO shall possess the expertise and resources to ensure the delivery of quality behavioral healthcare services to LBHP members in accordance with Louisiana Medicaid program standards and the prevailing industry standards.

8.1.2. The SMO shall provide a mechanism to reduce inappropriate and duplicative use of behavioral healthcare services. Services shall be furnished in an amount, duration, and scope that is not less than the amount, duration, and scope for the same services furnished to eligibles under fee-for-service Medicaid, as specified in 42 CFR §438.210(a)(1) and (2). Upward variances of amount, duration and scope of these services are allowed.

8.1.3. The SMO may exceed the service limits as specified in the Medicaid State Plan to the extent that those service limits can be exceeded with authorization. No service limitation can be more restrictive than those that currently exist under the LBHP or legacy Medicaid fee-for-service.

8.1.4. Although the SMO shall provide the full range of required core benefits and services listed in this contract, it may choose to provide services over and above those specified when it is cost effective to do so under the capitated rate. Additionally, the SMO 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, and the potential for improved health status of the member. However, this does not necessarily qualify the service for Medicaid reimbursement.

8.1.5. The SMO will track the benefit package and funding source of each eligible member and ensure that the member is offered all eligible benefits and that the appropriate funding source reimburses for the covered benefits.

8.1.6. The SMO 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.

8.1.7. The SMO 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.

8.1.8. The SMO shall not portray core benefits or services as an expanded health benefit.

8.1.9. Covered services shall be available statewide (unless service is not approved for statewide availability) and provided by the SMO through its subcontracts.

8.1.10. The SMO may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Medically necessary services are defined as those healthcare services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. DHH shall make the final interpretation of any disputes about the medical necessity and continuation of core benefits and services under this RFP.

8.1.11. The SMO shall use the state Medicaid definition of "medically necessary services" in a manner that is no more permissive or restrictive than the state Medicaid program. All services for which a member is eligible shall at a minimum cover:

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

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

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

8.1.12. Only Medicaid members can receive Medicaid funded services. Medicaid services shall be provided by SMO contracted providers that have been credentialed by the SMO and certified by DHH-OBH.

8.1.13. If specific access problems are reported by the SMO, DHH-OBH, DCFS, OJJ, LDOE, or other stakeholders and are verified by DHH-OBH, the SMO shall actively recruit, train, and subcontract with additional providers, including independent practitioners, to meet the needs of members. Recruitment and training of additional providers to meet access standard requirement shall be in a timeframe approved by DHH-OBH.

8.1.14. Subject to the terms, conditions, and definitions of this contract, the SMO shall be responsible for the provision of all administrative services and all covered services to adults and children enrolled in the SMO.

8.2. Medicaid State Plan Services

8.2.1. The SMO shall provide the following services to all Medicaid members if medically necessary. The core benefits and services that shall be provided to members according to the Medicaid State Plan are:

8.2.1.1. Inpatient Hospital Services

8.2.1.2. Outpatient Hospital Services

8.2.1.3. Lab Services

8.2.1.4. Diagnostic Services

8.2.1.5. Physician Services (including Psychiatrist)

8.2.1.6. Federally Qualified Health Center (FQHC) with specialized behavioral health services provided by a psychiatrist or Licensed Mental Health Professional (LMHP)

8.2.1.7. Psychiatric Residential Treatment Facility (PRTF)

8.2.1.8. Therapeutic Group Home (TGH)

Note: TGH has a non-Medicaid funding component for room and board.

8.2.1.9. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services including services provided by a Licensed Mental Health Professional (LMHP) including:

8.2.1.9.1. Medical Psychologists

8.2.1.9.2. Licensed Psychologists

8.2.1.9.3. Licensed Clinical Social Workers (LCSWs)

8.2.1.9.4. Licensed Professional Counselors (LPCs)

8.2.1.9.5. Licensed Marriage and Family Therapists (LMFTs)

8.2.1.9.6. Licensed Addiction Counselors (LACs)

8.2.1.9.7. 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 and Mental Health, Child-Adolescent Mental Health)

8.2.1.10. Mental health rehabilitation services:

8.2.1.10.1. Community Psychiatric Support and Treatment

8.2.1.10.2. Psychosocial Rehabilitation

8.2.1.10.3. Crisis Intervention

8.2.1.11. Addiction services:

8.2.1.11.1. Outpatient

8.2.1.11.2. Intensive Outpatient

8.2.1.11.3. Residential

8.2.1.12. The SMO shall provide behavioral health services that are incidental to a pregnancy in accordance with 42 CFR Part 440 Subpart B, which provides that pregnancy-related services are those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of

the woman having been pregnant. This includes services for other conditions that might complicate the pregnancy including those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus, such as a behavioral health complication.

8.2.1.13. Other services determined to be medically necessary (related to single case agreements), and any other behavioral health service subsequently amended into the Medicaid State Plan for coverage under the LBHP.

8.2.2. 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 age 21 (42 CFR Part 441, Subpart B – EPSDT of Individuals under age 21). The SMO is responsible to provide all medically necessary core benefits and services in the Medicaid State Plan identified in the contract and Service Definitions Manual.

8.3. 1915(i) Medicaid State Plan Amendment (SPA) for Adults with Serious Mental Illness

8.3.1. The SMO will be responsible for the administration of 1915(i) Medicaid State Plan Services. These services are for those members who are:

8.3.1.1. Medicaid eligible and aged 21 and older, or

8.3.1.2. Who are 19 and older and Medicaid eligible using institutional financial eligibility criteria (i.e., 1915(i)-only population).

8.3.2. Clinical eligibility requires that these adults must meet the following clinical criteria to be eligible for 1915(i) services:

8.3.2.1. Has acute stabilization needs

8.3.2.2. Suffers from Serious Mental Illness

8.3.2.3. Has a Major Mental Disorder

8.3.2.4. Persons diagnosed with a substance use disorder with an additional co-occurring Axis I disorder as defined in the current 1915(i) SPA.

8.3.2.5. Has previously met the above criteria and now needs subsequent medically necessary services for stabilization and maintenance

8.3.3. Any adult as defined in Section 8.3.1.2 above that meets Medicaid community financial criteria is eligible for medically necessary services under the 1915(i) Medicaid State Plan Amendment (i.e., 1915(i)-only population).

8.3.4. The services available for this population includes treatment by a LMHP, Community Psychiatric Support and Treatment, Psychosocial

Rehabilitation, Crisis Intervention, Case Conference, and Treatment Planning.

8.3.5. The SMO shall be responsible for conducting or contracting for providers to conduct independent assessments as per the requirements of the 1915(i) SPA.

8.4. 1915(c) Children's CSoC Serious Emotional Disturbance (SED) Home and Community-Based Waiver

8.4.1. The SMO will be responsible for administration of this HCBS waiver in order to provide home and community-based waiver services to Medicaid eligible individuals with serious emotional disturbance who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan and who have a hospital or nursing home Level of Care. Hospital levels of care include psychiatric care within a general hospital and inpatient psychiatric hospital for individuals under age 22 as provided in 42 CFR 440.160., and skilled nursing facilities. The SMO shall assist recipients with the Medicaid application process who meet the LOC but otherwise would not be eligible for Medicaid.

8.4.2. The SMO shall be responsible for ensuring that wraparound facilitation using the National Wraparound and Initiative's Child and Family Team approach is provided to all members in the 1915(c) waiver.

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

8.4.4. It is the intent of DHH to modify its current 1915(c) waiver by shifting certain services to the Medicaid State Plan and adding new and enhanced waiver services. The SMO shall adapt its policies and procedures to comply with waiver modifications as outlined in Section 8.6 below.

8.5. 1915(b)(3) services for Children and Youth who are Functionally Eligible for CSoC

8.5.1. The SMO will be responsible for administration of 1915(b)(3) services which will serve individuals from age 0 to under 22, who do not meet the Level Of Care to qualify for the 1915(c) waiver, yet meet the functional requirements for CSoC services.

8.5.2. Because these individuals meet CSoC functional eligibility, they receive Medicaid State Plan services and the same services as are in the 1915(c) waiver, which are Youth Support and Training, Parent Support and Training, Crisis Stabilization, Short-term Respite, and Independent Living/Skills Building.

8.5.3. The SMO shall be responsible for ensuring that wraparound facilitation using the National Wraparound and Initiative's Child and Family Team approach is provided to all members in the 1915(b)(3) waiver.

8.6. Anticipated Changes to Children/Youth Services to be Submitted for CMS Approval

8.6.1. It is the intent of DHH to submit to CMS additional State Plan Amendments and waiver amendments relative to transforming the children's service model. Pending CMS approval, the SMO shall be responsible for implementing the enhanced children's service array as outlined below. If approval by CMS is not granted, the SMO shall operate under the current CMS approved authorities outlined in Sections §8.2 through §8.5 above.

8.6.2. Proposed Medicaid State Plan amendments relative to children/youth services include:

8.6.2.1. DHH proposes to transition the following services from the 1915(c) waiver to the Medicaid State Plan:

8.6.2.1.1. Parent Support and Training (name will change to Parent Peer Support);

8.6.2.1.2. Youth Support and Training (name will change to Youth Peer Support); and

8.6.2.1.3. Crisis Stabilization.

8.6.2.2. Additionally, DHH proposes to add Therapeutic Foster Care (TFC) as a Medicaid reimbursable service under the Medicaid State Plan. See Service Definitions Manual in the procurement library for additional information regarding TFC.

Note: TFC has a non-Medicaid funding component for room and board.

8.6.3. Proposed 1915(c) Waiver Amendments include:

8.6.3.1. Transitioning Parent Support and Training, Youth Support and Training, and Crisis Stabilization from the 1915(c) waiver to the Medicaid State Plan.

8.6.3.2. Adding the following new 1915(c) waiver services:

8.6.3.2.1. Consultation to Family and Community Supports (CFCS) – This service will be used to assist caregivers, natural supports, and/or paid support staff (Skills Builders and others) in carrying out individual treatment/support plans. Home or community-based consultation activities are provided by professionals in psychology, social work, counseling and behavior management. This service includes assessment, development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the participant and other providers in the implementation of the plan. Family counseling may be provided.

8.6.3.2.2. Customized Goods and Services – This service will allow for individualized supports that youth who have severe emotional disturbances or mental illness may need to fully benefit from mental health services. Examples of Customized Goods and Services include, but are not limited to: tutoring, parenting skills, homemaker services, structured mainstream recreation, therapeutic or day support activities, mentor or behavioral aid, a utility deposit to help stabilize a child's behavioral health crisis, environmental modification to the participant's residence to enhance safety and ability to continue the living arrangement, or other customized goods and services to provide flexible community services and to maintain stability in the child's residence. The use of Customized Goods and Services is tied directly to a specified need documented on the Plan of Care with clear rationale.

8.6.3.3. Providing Parent/Youth Partners for CSoC members through a Family Support Program embedded within each Region's WAA and as part of the administrative per member per month rate.

8.6.3.4. Changing the requirement for provision of at least one waiver service per month to monthly monitoring of the individual when services are furnished on a less than monthly basis.

8.6.3.5. Allowing enrollment in CSoC for at least thirty (30) days prior to residential discharge to prevent disruption and improve stabilization upon reentry into home and community environment.

8.6.4. The delivery of new Medicaid State Plan, 1915(c) and 1915(b) waiver, and 1915(i) SPA services shall appear seamless to all members, but retain separate fund accountability for audit and encounter data purposes. The SMO may only use Medicaid funds to purchase Medicaid services for Medicaid enrollees. The SMO is encouraged to propose additional services to Medicaid beneficiaries, and may propose additional services to be added to the non-Medicaid service array after consultation with DHH-OBH.

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

8.7. Non-State Plan Services

8.7.1. Covered Services include:

8.7.1.1. Behavioral health services, including substance use disorder and mental health treatment for adults and children who are not eligible for Medicaid and paid with state funding.

8.7.1.2. All medically necessary behavioral health services, as well as 1915(b)(3) services to non-Medicaid children functionally and financially eligible for the CSoC program in accordance with the approved Plans of Care that have an available state funding source through DHH-OBH, DCFS, or OJJ.

8.7.1.3. Behavioral health services for children involved with and approved by OJJ and DCFS, who are not eligible for Medicaid. Additionally, LDOE provides behavioral health services to all students with an IEP who are enrolled in a public school system, regardless of Medicaid eligibility.

8.7.2. During the term of the contract, the SMO may provide cost-effective services that are not covered in the Medicaid State Plan and in addition to those covered under this contract as alternative treatment services and programs for enrolled members under 42 CFR §438.6(e) for adults and children under the capitation. These services may also include behavioral healthcare services which are in excess of the amount, duration, and scope in the Medicaid State Plan.

8.7.3. These services/benefits shall be specifically defined by the SMO in regard to amount, duration and scope in a quarterly report submitted to DHH-OBH called the Quarterly Report on Non-State Plan Services.

8.7.3.1. The SMO shall provide DHH-OBH a description of all non-State Plan services/benefits offered by the SMO, including the type of service, estimated number of recipients and providers, and improved outcomes for each type of service in the quarterly report.

8.7.3.2. As directed by the state, the SMO shall perform a cost-benefit analysis for any new services it proposes to provide under the capitated rate as cost-effective services per 42 CFR §438.6(e), including whether the proposed service would have an impact on the Medicaid capitation rates or on the non-Medicaid payments once implemented, and how the proposed service would be cost-effective compared to the Medicaid State Plan services. The SMO shall continue to monitor cost effectiveness and report its findings to DHH-OBH in the quarterly report.

8.7.4. DHH will not provide any additional reimbursement for these services/benefits.

8.7.5. If gaps remain in service availability after implementing traditional methods for network sufficiency and service array, the SMO shall find alternate ways to ensure sufficiency, either by incentivizing providers or implementing expanded non-State Plan services.

8.7.6. Examples of identified service gaps in the LBHP include, but are not limited to:

8.7.6.1. 1915(i) services to individuals aged 21 to under 22 years of age enrolled in the 1915(c) waiver who are aging out of EPSDT services;

8.7.6.2. Licensed nurses to provide injection services embedded in cost of evaluation and utilization management visits through a physician code extender;

8.7.6.3. LMHP services in lieu of psychiatric services for outpatient therapy for non-1915(i) Medicaid eligible adults aged 21 and over;

8.7.6.4. Free standing psych hospital use in lieu of general hospital psychiatric units; and

8.7.6.5. Crisis intervention services for all Medicaid eligible adults rather than limiting to 1915(i) adults only.

8.8. Services for Priority Populations

8.8.1. Priority Populations are defined as:

8.8.1.1. Pregnant females;

8.8.1.2. Substance using women with young children;

8.8.1.3. Women with co-occurring disorders and young children;

8.8.1.4. Persons with HIV;

8.8.1.5. Persons who are Intravenous (IV) drug users;

8.8.1.6. Children with behavioral health needs in contact with other child-serving systems but not functionally eligible for CSoC; and

8.8.1.7. The Permanent Supportive Housing population.

8.8.2. Services for Priority Populations not otherwise included in the 1915(c) and 1915(b)(3) waivers or the 1915(i) SPA include treatment planning, and Medicaid services, if medically eligible.

8.8.3. Different members are eligible for different packages of services that will need to be tracked and provided by the SMO. However, all Medicaid behavioral health services for members, including inpatient and outpatient hospital services and community-based services are included under this contract for enrolled beneficiaries.

8.9. Mixed Service Protocol

8.9.1. Certain circumstances are identified as being covered by either the Bayou Health plan or the SMO. These circumstances are not exclusive. Coordination of benefits between a member's physical health plan (Bayou Health) and behavioral health plan (SMO) is complex and requires cooperation and collaboration between the two plans. Services in which patient coverage may be shared between the member's physical health plan and behavioral health plan are defined as Mixed Services.

8.9.2. Medicaid managed care enrollees in Bayou Health plans will be enrolled under this contract to receive specialized (non-basic) behavioral health services. Specialized behavioral health services are defined as those

services provided by a psychiatrist or a LMHP. Basic behavioral health services are defined as those provided in the member's PCP or medical office by the member's (non-behavioral health specialist) physician (i.e., DO, MD, APRN) as part of routine physician evaluation and management activities (i.e., screening, prevention and referral).

8.9.3. As circumstances of mixed service protocol are identified, those circumstances will be articulated in "informational bulletins" and incorporated as coverage/billing protocol with the SMO.

8.9.4. The state shall be the final arbiter of mixed service protocol questions relative to payment source.

8.9.5. The following services shall be included under the SMO when a Medicaid member is enrolled in a Bayou Health plan and the service is medically necessary:

8.9.5.1. Lab and radiology services performed in the facility as part of an inpatient psychiatric hospital stay, emergency department visit, FQHC visit or residential treatment facility stay when ordered by a contracted psychiatrist or Licensed Mental Health Practitioner (LMHP). The SMO shall only be responsible for payment if the psychiatrist or LMHP is an SMO contracted network provider, unless the service is ordered in the emergency room setting.

8.9.5.2. Any lab and radiology services that are prior authorized and provided as outpatient services performed by a free-standing psychiatric hospital or distinct part psychiatric unit and ordered by a contracted psychiatrist or LMHP.

8.9.5.3. Inpatient and outpatient services (other than acute detox in a general hospital inpatient setting) provided by a psychiatrist or LMHP. When provided in a general hospital, the SMO shall pay professional claims of psychiatrists or LMHPs only. The SMO shall pay both facility and professional claims when the service is performed in a psychiatric hospital or distinct part psychiatric unit. Providers must be contracted with the SMO or be operating under a single case/ad hoc agreement with the SMO. Prior authorization is required.

8.9.5.4. Behavioral health services provided in a Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) only when a service by a psychiatrist or an LMHP is claimed in the encounter submission. Pending any rulemaking changes in the Medicaid State Plan relative to reimbursement for FQHC encounters, the SMO will continue to reimburse only for psychiatrist and/or LMHP encounter claims.

8.9.5.5. Emergency room services provided by a psychiatrist or LMHP only. When provided in a general hospital emergency room, SMO shall pay professional claims of psychiatrist or LMHP only. SMO shall pay all claims when service performed in a psychiatric or acute emergency room.

8.9.5.6. CPT codes for neuropsychological testing and behavioral assessment and intervention are covered even though there is no behavioral health diagnosis present. These services must be rendered by a contracted psychiatrist or LMHP in order to be covered under the LBHP by the SMO.

8.9.5.7. Claims submitted for acute detoxification in a psychiatric hospital or distinct part psych unit regardless of provider type.

8.9.6. The following services are covered by Bayou Health and are not covered under the SMO contract:

8.9.6.1. All inpatient hospital and outpatient services when provided by a provider who is not a psychiatrist or LMHP, with the exception of claims submitted for acute detoxification in a psychiatric hospital or distinct part psychiatric unit only.

8.9.6.2. All general hospital emergency room facility claims.

8.9.6.3. All behavioral health emergency room facility and professional claims when not provided by a psychiatrist or LMHP.

8.9.6.4. All lab and radiology claims when not ordered by a psychiatrist or LMHP.

8.9.6.5. Medical services covered by Bayou Health include, but are not limited to:

8.9.6.5.1. Inpatient hospital services for acute detox for members in a general hospital setting,

8.9.6.5.2. Behavioral health services in an FQHC or RHC for members when not provided by a psychiatrist or LMHP.

8.9.6.5.3. Basic behavioral health services when not provided by a psychiatrist or LMHP.

8.9.6.6. Upon referral by a contracted SMO provider and with prior authorization by the SMO, all non-emergency medical transportation (NEMT) for members to and from a contracted SMO provider (or providers operating under approved single/ad hoc case agreements) shall be reimbursed through Bayou Health. All Medicaid eligible NEMT shall be coordinated in conjunction with State Medicaid (i.e., single state broker, state contractor, or Bayou Health as applicable).

8.10. Coverage for Permanent Supportive Housing (PSH)

8.10.1. The Louisiana Permanent Supportive Housing (PSH) model combines affordable rental housing with voluntary, flexible and individualized community-based services to assist people with the most severe and complex disabilities to live successfully in the community.

8.10.2. The SMO's role with PSH is to ensure outreach to potential PSH recipients, verifying PSH service eligibility consistent with PSH program

requirements, assist members in the application process for PSH, provide specialized care management, and ensure that tenancy supports associated with PSH are provided through CPST, PSR, ACT and other LBHP services to 1915(i) eligible recipients.

8.10.3. The SMO shall be responsible for authorizing payment for PSH tenancy support services for the 1915(i) eligible population in PSH.

8.11. Coverage and Payment for Emergency Services for Medicaid Members

8.11.1. The SMO shall be responsible for coverage, payment, and provision of outpatient emergency behavioral health services and covered post-stabilization services performed by LMHP in an emergency room setting. The SMO shall provide that emergency behavioral health services for LBHP members be rendered without the requirement of prior authorization. The SMO must cover and pay for emergency behavioral health services regardless of whether the provider that furnishes the emergency behavioral health services has a contract with the SMO. If an emergency behavioral health condition exists, the SMO is obligated to pay for the emergency behavioral health service. The coverage will be provided consistent with 42 CFR §438.114.

8.11.2. This responsibility shall not replace hospitals' responsibilities under the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.

8.11.3. A member who has an emergency behavioral health condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilization.

8.11.4. The attending emergency physician and LMHP, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized from an emergency medical and/or behavioral health condition for transfer or discharge from an emergency room, and that determination is binding on the SMO for payment of behavioral health emergency services rendered by the psychiatrist or LMHP only. Any services, including behavioral health, rendered by an emergency room non-LMHP physician shall be paid by Bayou Health for its members.

8.11.5. The SMO shall not deny payment for any service or treatment obtained from a psychiatrist or LMHP when a member has an emergency behavioral health condition, including cases in which the absence of immediate care would result in the outcomes specified in 42 CFR §438.114(a) of the definition of emergency medical condition.

8.11.6. The SMO shall not limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.

8.11.7. For emergency behavioral health services provided to a member by a contracted or non-contracted provider, the SMO shall not refuse to cover the emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the SMO of the member's screening and treatment with as required by 42 CFR §438.114.

8.11.8. For emergency services provided for behavioral health reasons, the SMO shall reimburse for the following:

8.11.8.1. Institutional fees: The SMO shall be responsible for the facility/hospital for emergency services when provided only at a psychiatric emergency room, contingent upon the facility's compliance with notification policies required by 42 CFR §438.114. All general hospital emergency department facility/institutional fees shall be reimbursed by Bayou Health.

8.11.8.2. Professional fees: The SMO shall reimburse professional emergency room claims for all emergency services provided by a contracted psychiatrist or LMHP, including ancillary costs.

8.11.8.3. Non-contracted psychiatrists and LMHPs shall be paid an emergency room fee, which is no less than the state's Medicaid rate for such services listed here:

http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm.

8.11.9. The SMO shall be responsible for educating members (within the guidelines outlined in the member services) and providers regarding appropriate utilization of emergency room services for behavioral health emergencies.

8.11.10. The SMO shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate 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.

8.12. Coverage and Payment for Post-Stabilization Services.

8.12.1. The SMO shall be responsible for post-stabilization services in accordance with provisions set forth at 42 CFR §422.113(c) and which are listed below:

8.12.1.1. The SMO shall be financially responsible for pre-authorized medically necessary post-stabilization covered services that are delivered by a network provider or other representative.

8.12.1.2. The SMO shall be financially responsible for medically necessary post-stabilization covered services obtained within or outside the network that are not pre-approved, but administered to maintain the member's stabilized condition within one hour of a request to the SMO for pre-approval of further post-stabilization covered services.

8.12.1.3. The SMO shall be financially responsible for medically necessary post-stabilization covered services obtained within or outside the network that are not pre-approved, but administered to maintain, improve, or resolve the member's stabilized condition if:

8.12.1.3.1. The SMO does not respond to a request for pre-authorization within one hour.

8.12.1.3.2. The SMO cannot be contacted.

8.12.1.3.3. The SMO and the treating provider cannot reach an agreement concerning the member's care, and the SMO's care manager is not available for consultation. In this situation, the SMO shall give the treating provider the opportunity to consult with the SMO's care manager, and the treating provider may continue with care of the member until the SMO's care manager is reached.

8.12.1.3.4. The SMO shall limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the SMO.

8.12.1.3.5. The SMO's financial responsibility for medically necessary post-stabilization covered services not pre-authorized ends when:

8.12.1.3.5.1. A network provider with privileges at the treating hospital assumes responsibility for the member care.

8.12.1.3.5.2. A network provider assumes responsibility for the member's care through transfer.

8.12.1.3.5.3. The SMO's representative and the treating provider reach an agreement concerning the member's care.

8.12.1.3.5.4. The member is discharged.

8.13. Prior authorization and concurrent utilization review for inpatient psychiatric hospitalization for adults and children/youth.

8.13.1. The SMO will 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 health hospitals. Medicaid will pay for only those inpatient concurrent utilization reviews that are covered under Medicaid.

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

8.13.2.1. The patient shall meet one or more of three categories for severity:

8.13.2.1.1. Patient presents a danger to self.

8.13.2.1.2. Patient presents as a danger to others due to a DSM-5 or ICD-9/ICD-10 diagnosis.

8.13.2.1.3. Patient is gravely disabled and unable to care for self as evidenced by a DSM-5 or ICD-9/ICD-10 diagnosis.

8.13.2.2. The patient shall meet all intensity of service criteria:

8.13.2.2.1. Ambulatory resources will not meet needs.

8.13.2.2.2. Services in hospital are expected to improve condition or prevent further regression.

8.13.2.2.3. Treatment of the condition requires inpatient services.

8.13.2.3. The patient does not have an exclusionary criteria:

8.13.2.3.1. Not medically stable.

8.13.2.3.2. Patient with criminal charges with no DSM-5 or ICD-9/ICD-10.

8.13.2.3.3. Person with anti-social behavior that is characterological.

8.13.2.3.4. Persons with a diagnosis of an intellectual disability (ID) without a DSM-5 or ICD-9/ICD-10.

8.13.3. 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, the state does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.

8.13.4. Concurrent utilization review includes:

8.13.4.1. 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 consumer 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 SMO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour when requested 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.

8.13.4.2. 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 in Section 8.13.4.1 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 SMO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours. The screen to determine appropriate treatment shall be completed within 24 hours of the SMO's referral. 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.

8.13.5. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the SMO shall notify the provider and individual requesting the screen of the results in writing within 48 hours. If denied, the SMO shall notify the individual requesting the screen immediately, and within 48 hours 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.

8.13.6. Certification of Need for PRTFs

8.13.6.1. The team responsible for the certification and recertification of PRTF services in Louisiana shall include an LMHP, in conjunction with a qualified team. 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 youth, in addition to the recommendations of a team that includes a physician, which determines that ambulatory resources will not meet the needs of the individual requesting PRTF services.

8.13.6.2. The SMO shall ensure that the qualified team completing the certification is independent of the facility, in addition to the recommendations of team that includes a physician, which determines that ambulatory resources will not meet the needs of the individual requesting PRTF services.

8.13.6.3. The SMO may use an LMHP/team composed of the SMO's staff or the SMO 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 SMO shall ensure that the team is assembled by a subcontract in the youth's county of residence (if not in state custody) or the youth's county of responsibility (if in state custody).

8.13.6.4. Recertification shall occur every sixty (60) 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.

8.13.6.5. Through the certification of need for services, the SMO shall ensure that:

8.13.6.5.1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient.

8.13.6.5.2. Proper treatment of the recipient's psychiatric condition requires services on a residential basis under the direction of a physician.

8.13.6.5.3. The services can reasonably be expected to improve the recipient's condition or prevent further regression, so that the services will no longer be needed.

8.13.6.6. The certification of need for services shall be completed by a team, independent of the facility and at the time of admission (unless the member applies for Medicaid while in the PRTF), that:

8.13.6.6.1. Includes a physician.

8.13.6.6.2. Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry.

8.13.6.6.3. Has knowledge of the individual's situation.

8.13.6.7. For an individual who applies for Medicaid while in the PRTF, the certification must be made by the team responsible for the plan of care as specified in 42 CFR 441.156, and cover any period before application for which claims are made.

8.13.6.8. The physician must certify for each member that inpatient services are or were needed. The certification must be made at the time of admission or if an individual applies for assistance while in the facility before the Medicaid agency authorizes payment.

8.13.6.9. The SMO team responsible for recertification of inpatient psychiatric/PRTF services in Louisiana shall be a physician, a physician assistant, or a nurse practitioner in accordance with 42 CFR §456.160. Recertification shall occur within sixty (60) days of certification.

8.13.6.10. In addition to certifying need, the SMO shall:

8.13.6.10.1. Be responsible for tracking the member’s authorization period for PRTF stays and providing notification to the responsible party when a re-certification is due.

8.13.6.10.2. Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility:

8.13.6.10.2.1. Upon completion of the certification of need, if the inpatient admission is approved, within 48 hours the SMO shall notify in writing, the provider requesting the certification of the results. If denied, the SMO 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 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.

8.13.6.10.2.2. Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen.

8.13.6.10.2.3. Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions.

8.13.6.10.2.4. Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable.

8.13.6.10.2.5. Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.

8.13.7. The SMO will work with DHH-OBH, DCFS, and OJJ to develop prior authorization and concurrent utilization review of therapeutic group homes and other residential levels of care, including group homes, and Therapeutic Foster Care.

8.14. Authorization and Integration of Medicaid-funded LEA Behavioral Health Services.

8.14.1. The SMO is responsible for receiving information from the Louisiana Department of Education (LDOE) regarding services available through schools and the assessed needs of children in schools.

8.14.2. The Individualized Education Program (IEP) for students with disabilities is the prior authorization for services; no additional authorization is needed for current level of service provided by the Local Education Agency (LEA).

8.14.3. The SMO will receive all required data elements from the LDOE for all eligible students. The data will include all behavioral health services provided, units, procedure codes, etc. for which LEAs will seek reimbursement.

8.14.4. The information from the IEP, including needs and school services provided, will be integrated into the SMO's care management and prior authorization systems and if appropriate, made available in order to facilitate understanding of the totality of the child's needs and services being received.

8.14.5. Upon request of a LEA, the SMO will provide consultation and education regarding effective treatments for the school age eligible child with behavioral health needs.

8.14.6. The SMO will work with the LEA to identify additional resources in the community for the school age eligible child.

8.14.7. All service data for LEAs will be submitted by the LDOE to the SMO for claim development, adjudication and payment. The SMO will develop the claim and authorize payment for LEA provided services, but will not pay those claims. Instead, the SMO will forward approved claims to the state for payment through a mutually agreed upon payment mechanism and file format. The SMO will pay behavioral health providers who are not LEA employees but provide services on the school campus.

8.14.8. To assist in this process, LDOE will systematically share with the SMO the data needed to develop a claim including the dates, service provided, type of service (individual or group), procedure and diagnostic codes, frequency, and provider name.

8.14.9. The SMO will systematically share with LDOE the monthly claims denied, reason for SMO denial, and reimbursement reports per LEA district.

8.15. Procedure for non-covered EPSDT service identified as medically necessary by a Child and Family Team:

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

8.15.1.1. As much information regarding the recipient is gathered by the SMO including, but not limited to age, diagnosis, condition, medical records relative to the service being requested.

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

8.15.1.3. Information regarding the requested service is gathered. This information would include, but not be limited to, reasons/policy for non-coverage, alternative services, etc. All supporting information for coverage and medical necessity in individual case is gathered.

8.15.1.4. This information is presented by the SMO to the Medicaid and DHH-OBH Medical Directors or other designee.

8.15.1.5. The designated Medical Director(s) within DHH review as much information on the recipient as possible, the prospective provider and the requested service to determine if the service being requested is medically necessary, if other possible treatment options exists and/or if there are rules, SPA or federal regulations impacting coverage decision.

8.15.1.6. A determination of availability of federal financial participation (FFP) will be made by DHH-BHSF. If FFP is not available, due to federal regulations, then a recommendation for coverage and a request to pay out of all state funds is forwarded for approval to the Medicaid Director. If the service is determined medically necessary, but is investigational or experimental, then

recommendation is sent to Medical Director for consideration of final approval and appropriate match rate.

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

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9.0 PHARMACY BENEFIT MANAGEMENT (PBM)

9.1. PBM Purpose

9.1.1. The SMO shall have the flexibility to effectively manage the pharmacy benefit, including appropriate care, network and formulary management.

9.1.2. Access to in-person pharmacy services is essential to patient care management, particularly with specialized behavioral healthcare.

9.1.3. The primary purpose of behavioral health pharmacy benefit management includes, but is not limited to, the following objectives:

9.1.3.1. to manage prescription drug cost and utilization in a clinically sound, evidence-based manner;

9.1.3.2. to educate both member and prescriber as to cost-effective drug utilization;

9.1.3.3. to reduce program administrative costs and improve service and access to those who need it;

9.1.3.4. to obtain full disclosure and clarification from the SMO of their sources of profit;

9.1.3.5. to maintain positive relationships with the provider community;

9.1.3.6. to achieve greater efficiency in behavioral health pharmacy prior authorization processing;

9.1.3.7. to improve patient health outcomes via appropriate and safe drug therapies; and

9.1.3.8. to prevent and reduce fraud, waste, and abuse.

9.1.4. The SMO shall have capabilities and experience in managing, monitoring, and adjudicating behavioral health pharmacy claims that are administered in a prescriber's office, hospital, or other professional care setting.

9.1.5. The SMO shall have capabilities and experience in using 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.

9.1.5.1. Physicians that deviate from the guidelines and/or standard practice (e.g., exceeding maximum dosage levels, rapid switching from drug to drug, prescribing stimulants to youth 5 years of age or younger, etc.) shall be notified that their prescribing practice does not conform to the standard of practice, and sent appropriate educational materials.

9.1.5.2. If the suboptimal prescribing practice continues despite peer intervention and educational material interventions, the SMO

shall call the physician and offer to establish a call or in-person meeting with a board-certified psychiatrist to review the specific case.

9.2. PBM Scope of Work

9.2.1. The SMO shall provide behavioral health pharmacy benefit management (PBM) services to DHH-OBH for Medicaid-eligible adult and youth members who receive their behavioral health medication prescriptions from specialty behavioral health prescribers, including any contracted LMHP authorized by their scope of practice to legally prescribe medication (i.e., psychiatrists, medical psychologists, APRNs with a psychiatric specialty). Behavioral health pharmacy benefit management offerings must include appropriate therapeutic controls and careful monitoring of quality and prescriber performance.

9.2.2. The SMO shall develop and maintain a Pharmacy and Therapeutics Committee or similar entity for the development of the formulary and Preferred Drug List (PDL), which shall include members who are practicing behavioral health prescribers and pharmacists from the contracted network, as well as representatives from DHH-OBH.

9.2.2.1. The SMO must ensure that DHH-OBH and Louisiana network behavioral health prescribers, pharmacists, and specialists have the opportunity to participate in the development of the formulary, PDL, and clinical drug policies and, prior to any changes to the formulary or PDL, to review, consider, and comment on proposed changes.

9.2.2.2. The Pharmacy and Therapeutics committee must meet at least quarterly to consider products in categories recommended for consideration for inclusion/exclusion on the SMO's formulary or PDL.

9.2.2.3. In developing its recommendations for a formulary and PDL, the committee must consider the clinical efficacy, safety, cost-effectiveness, and any program benefit associated with each product included in a category of products.

9.2.3. Procedures for Formulary/PDL Development

9.2.3.1. The formulary and Preferred Drug List (PDL) shall be reviewed and approved by DHH-OBH prior to contract go-live.

9.2.3.2. The SMO shall notify DHH-OBH thirty (30) days prior to implementation of any new provisions and obtain written approval before making material changes to the PDL/formulary and the prior authorization process, including, but not limited to any/all prior authorization, fail first, step therapy requirements, or prescription quantity limits.

9.2.3.3. The formulary shall be reviewed in its entirety at least annually and submitted for approval to DHH-OBH.

9.2.4. Formulary requirements:

9.2.4.1. All therapeutic classes and agents specified in the formulary shall be prior approved by DHH-OBH.

9.2.4.2. The SMO 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.

9.2.4.3. The formulary shall include only FDA approved drug products. For each therapeutic class, the selection of drugs included for each drug class shall be sufficient to ensure enough provider choice and include FDA approved drugs to best serve the needs of members, especially those with special needs.

9.2.4.4. The formulary may only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the SMO shall include in its formulary any FDA-approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition for FDA approved indications.

9.2.4.5. The SMO shall expand its formulary, as needed, to include newly FDA approved drugs for FDA approved indications, which are deemed to be appropriate, safe, and efficacious in the medical management of members.

9.2.4.6. The SMO shall authorize the provision of a drug not on the formulary requested by a prescriber on behalf of the member, if the approved prescriber provides relevant clinical information to the SMO to support the prior authorization based on the medical necessity of the drug, and an explanation as to why a generic alternative or other preferred drug in the same therapeutic category cannot be used. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.

9.2.4.7. The SMO shall have in place a DHH-OBH approved prior approval process for authorizing the dispensing of non-formulary drugs.

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

9.2.4.9. The SMO shall limit negative changes to the formulary (e.g., remove a drug, impose step therapy, etc.) to four times annually, 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 formulary change.

9.2.5. Preferred Drug List (PDL) requirements:

9.2.5.1. The SMO may use a preferred drug list (PDL), which shall be approved by DHH-OBH.

9.2.5.2. The PDL must meet the following minimum requirements:

9.2.5.2.1. The PDL is a list of the preferred drug products available on the formulary and an up-to-date version shall be available to all providers and members through the SMO website and electronic prescribing tools.

9.2.5.2.2. The PDL shall be reviewed in its entirety and updated at least annually.

9.2.5.2.3. The selection of drugs included for each drug class shall be sufficient to ensure enough provider choice and include FDA approved drugs to best serve the needs of members.

9.2.5.2.4. The SMO shall authorize the provision of a drug not listed on the PDL requested by a prescriber on behalf of the member, if the approved prescriber provides relevant clinical information to the SMO to support the prior authorization based on the medical necessity of the drug. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.

9.2.5.2.5. The SMO shall have in place a DHH-approved prior approval process for authorizing the dispensing of non-PDL drugs.

9.2.5.2.6. The SMO shall not replace an approved preferred drug on the PDL with an add-on without prior approval of DHH-OBH and a six (6) month transition period where the preferred drug being removed continues to be approved.

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

9.2.5.2.8. The SMO shall limit negative changes to the PDL (e.g., remove a drug, impose step therapy, etc.) to four times annually, unless urgent circumstances require more timely action, such as drug manufacturer’s removal of a drug from the market due to patient safety concerns.

9.2.6. Submission and Publication of the Formulary and PDL

9.2.6.1. The SMO shall submit an electronic version of its formulary and PDL to DHH-OBH at least quarterly. The formulary and PDL must be provided in a format and program approved by DHH-OBH, which may include formulary management software commonly used by prescribers.

9.2.6.2. The most recently approved version of the PDL/formulary shall be made available to all prescribers in a readily-accessible manner, including but not limited to the SMO's provider website.

9.2.7. The SMO shall develop DHH-OBH approved policy and procedures related to the behavioral health pharmacology prior authorization process. All such policies and procedures shall be made accessible to prescribers and members through the SMO provider website in a DHH-OBH approved format.

9.2.8. Such policy and procedures shall include, but not be limited to:

9.2.8.1. Requiring and assuring that behavioral health pharmacy prior authorization decisions are rendered before a recipient is discharged from a behavioral health facility, including but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings;

9.2.8.2. Prescribing of medically necessary non-formulary or non-preferred (non-PDL) drugs, including any proposed time constraints associated with prescribing non-formulary or non-preferred drugs;

9.2.8.3. Prescribing inconsistent with FDA approved labeling and nationally-accepted guidelines (e.g., off-label), brand name medications that have A-rated generic equivalents, step therapy and/or fail first protocols;

9.2.8.4. Corrective action relative to potential drug over-utilization;

9.2.8.5. Prescription refills;

9.2.8.6. Prescriber notification of approvals/disapprovals for medication requests; and,

9.2.8.7. Establishing an appeals process, which would involve a "doctor to doctor" communication regarding the rationale for approval or denial of a prescriber request.

9.2.9. The SMO must provide a clear process for a provider to request an override of any/all restrictions related to step therapy and/or fail first protocols, including but not limited to, restrictions on use of more than one agent within a therapeutic class. At a minimum, the SMO should grant the override when the prescribing physician provides evidence that the preferred treatment method has been ineffective in the treatment of the patient's medical condition in the past or will cause or will likely cause an adverse reaction or other physical harm to the patient.

9.2.10. The SMO 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. This call center may be combined with the provider toll-free call center; however, if the SMO operates a separate call center for prior authorization requests, it will be subject to the provider call center standards set forth in the contract.

9.2.11. The SMO must also develop and maintain an electronic prior authorization process which allows prescribers to submit automated prior authorization requests in addition to requests received by phone or fax. The SMO must respond to automated prior authorization requests within twenty-four (24) hours. If a prior authorization decision cannot be immediately rendered, the SMO must have an automated process that allows and reimburses the pharmacy to dispense up to a seventy-two (72)-hour supply of a product without having to obtain an override.

9.2.12. The SMO shall assure that all denials of prior authorization requests or offering of an alternative medication are provided to the prescriber and member in writing, and allow for an appeal through the established appeals process in Section 16 of this RFP. However, all PBM appeals shall be treated as expedited appeals in accordance with the established process for expedited appeals. The SMO shall notify all prescribers of the appeals process via the SMO provider website with the other PBM policies and procedures.

9.2.13. The SMO shall have a specific suboxone, subutex and methadone management program and approach, which shall be approved by DHH-OBH. The policy and procedure must be in accordance with current state and federal statutes in collaboration with the State Opioid Treatment Authority/DHH-OBH.

9.2.14. The SMO shall have a DHH-OBH approved pharmacy management program and approach to stimulant prescribing for girls age 6 or under, boys age five or under, and persons age 18 or older. The SMO shall adhere to DHH-BSHF guidance regarding prescription monitoring of stimulants to minors.

9.2.15. The SMO shall have a DHH-OBH approved PBM program and approach for the prescribing of antipsychotic medications to persons less than 18 years of age.

9.2.16. The SMO 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, stepped therapy, approved prescribing caps, and relevant appeal, expedited appeal, and peer-to-peer procedures and protocols. The SMO shall submit its tentative prescriber training and education schedule or plan to DHH-OBH within 30 days of contract go-live or 7 days before any newly scheduled event.

9.2.17. The SMO 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-OBH.

9.2.18. 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.

9.2.19. The lock-in mechanism must:

9.2.19.1. Ensure appropriate use of Medicaid benefits by recipients and/or providers; and

9.2.19.2. Serve as an educational and monitoring parameter in instructing recipients in the most efficient method of using Medicaid services to ensure maximum health benefits.

9.2.20. The SMO is not required to impose any copay or cost sharing requirements on their members; however, the SMO is not permitted to charge any copay or cost-sharing amount above what exists in the Medicaid State Plan. The SMO or its subcontractors may not:

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

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

9.2.21. Step Therapy and/or Fail First Protocols

9.2.21.1. The SMO is allowed to implement step therapy or fail first protocols to first drive utilization toward the most cost-effective and safest drug therapy.

9.2.21.2. These protocols may be applied to either individual drugs or classes of drugs. However, the SMO must provide a clear process for a provider to request an override of such restrictions. At a minimum, the SMO should grant the override when the prescribing physician provides evidence that the preferred treatment method has been ineffective in the treatment of the patient's medical condition in the past or will cause or will likely cause an adverse reaction or other physical harm to the patient.

9.2.22. Medication Therapy Management

9.2.22.1. Within ninety (90) days of contract go-live, the SMO 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.

9.2.22.2. Reimbursement for MTM services with participating pharmacists should be separate and above dispensing and ingredient cost reimbursement.

9.2.22.3. This program should be developed to identify and target members who would most benefit from these interactions. They should include coordination between the SMO, the member, the pharmacist and the prescriber using various means of communication and education.

9.3. Accreditation

9.3.1. At the request of DHH-OBH, the SMO PBM must be accredited at no additional cost to DHH. If the SMO PBM is not currently accredited by a DHH approved entity, the SMO must attain the accreditation within nine (9) months of the written request from DHH-OBH designating the appropriate accrediting body, unless an exception is approved by DHH-OBH.

9.4. Network Requirements

9.4.1. Only behavioral health specialists with prescriptive authority as per their scope of practice (e.g., psychiatrists, medical psychologists, and Advance Practice Registered Nurses (APRNs) with a psychiatric specialty as specified in the definition for LMHP under RS 40:2153) shall be allowable prescribers under the SMO's pharmacy benefit management program. The SMO shall refer to the Mercer Behavioral Health Data Book for the specific provider types allowable for reimbursement under the LBHP.

9.4.2. The SMO shall provide a pharmacy network that complies with DHH and CMS 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.

9.4.3. The SMO may not 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 SMO.

9.4.4. Distance to Pharmacies

9.4.4.1. Travel distance time for members living in urban parishes shall not exceed 10 miles; and

9.4.4.2. Travel distance for members living in rural parishes shall not exceed 30 miles.

9.4.5. Prescriber Sufficiency Assessment

9.4.5.1. The SMO shall submit to DHH-OBH the written Prescriber Sufficiency Assessment no later than three (3) months from the start of each contract year and on a periodic schedule thereafter to be determined by DHH-OBH.

9.4.5.2. The SMO shall prepare the written Prescriber Sufficiency Assessment to establish network capacity, at any given time, as requested by DHH-OBH, to demonstrate that members have access to psychotropic medications on an outpatient basis throughout the state.

9.4.5.3. Capacity should be compared to the number of enrolled members by geographic location.

9.4.6. The SMO 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:

9.4.6.1. Names, locations and telephone numbers.

9.4.6.2. Any non-English languages spoken.

9.4.6.3. Identification of hours of operation, including identification of providers that are open 24-hours per day.

9.4.6.4. Identification of pharmacies that provide vaccine services.

9.4.6.5. Identification of pharmacies that provide delivery services.

9.4.7. The SMO 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 near real time, but no less than weekly even if there are no changes.

9.4.8. The SMO shall ensure Pharmacy Benefit Manager (PBM)/Pharmacy Benefit Administrator (PBA) has a network audit program that includes, at a minimum:

9.4.8.1. Random audits to determine provider compliance with the program policies, procedures and limitations outlined in the provider's contract. The SMO shall not utilize contingency-fee based pharmacy audits.

9.4.8.2. The SMO shall submit to DHH-OBH the policies of its audit program for approval.

9.4.9. The SMO must educate network providers about how to access their formulary and PDL on their websites. The SMO must also provide provider education on claims processing and payment policies and procedures, and information relative to the Prescription Monitoring Program (PMP).

9.4.10. The SMO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the SMO shall pay a per-prescription dispensing fee, as defined in this contract, at a rate no less than $2.50.

9.4.11. The SMO and the PBM may not charge pharmacy providers claims processing or provider enrollment fees. This section does not prohibit sanctioning pharmacy providers.

9.4.12. The SMO may not require its members to use mail order pharmacy. Additionally, mail order pharmacy shall not exceed 1% of overall pharmacy claims with the SMO.

9.4.13. The SMO shall not steer its members to or away from any network pharmacy provider. Members must have free access to any pharmacy participating in their network.

9.4.14. Prescribers shall utilize the electronic Medicaid Clinical Data Inquiry (e-CDI) system to search for the member's prior prescribed medications to ensure appropriate medication management and prevent potential negative interactions as a result of combining medication or possible over medication.

9.4.15. DHH-OBH strongly recommends that network prescribers utilize and conduct patient specific queries in the Prescription Monitoring Program (PMP) for patients with substance use disorders during each office visit. Depending on the specific member's medical history and diagnosis, other PMP queries should be conducted at the prescriber's discretion, or at the discretion of DCFS for DCFS involved youth.

9.5. Systems Requirements

9.5.1. The SMO will be required to maintain an automated claim and encounter processing system for pharmacy claims that ensures the accurate and timely processing of claims and encounters.

9.5.1.1. The SMO's systems shall support the requirements of PBM claims submission and PBM prior authorization via the provider website and the electronic claims management system.

9.5.1.2. The SMO's systems shall provide identical functionality for PBM claims and PBM prior authorization as provided for regular claims.

9.5.1.3. The system shall provide for an automated update to the National Drug Code file weekly, including all product, packaging, prescription and pricing information.

9.5.1.4. Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits.

9.5.1.5. The system shall provide online access to reference file information and maintain a history of the pricing schedules and other significant reference data. The SMO will be required to update pricing information based on the most recently available information on at least a weekly basis.

9.6. Encounter Data

9.6.1. The SMO's System shall be able to transmit to and receive encounter data from Medicaid FI's system as required for the appropriate submission of encounter data.

9.6.2. DHH's current FI accepts encounters at a document-level, with the exception of Pharmacy encounters, which are accepted at a line-level. The SMO shall be able to transmit encounter data to the FI in this manner.

9.6.3. The SMO shall submit a daily 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. See the SMO Systems Companion Guide for a complete listing of claim fields required.

9.6.4. The SMO must ensure that its pharmacy claims process recognizes claims from 340B pharmacies for products purchased through the 340B discount drug program at the claim level utilizing the NCPDP field designed for this purpose.

9.6.5. The SMO shall ensure that pharmacies submit the NPI of the prescriber on claims.

9.6.6. Disputed Encounter Submissions

9.6.6.1. On a weekly basis, DHH or its designee will review the SMO's pharmacy encounter claims and send a file back to the SMO of disputed encounters that were identified through the drug rebate invoicing process.

9.6.6.2. Within sixty (60) calendar days of receipt of the disputed encounter file from DHH, the SMO shall, if needed, correct and resubmit any disputed encounters and send a response file that includes:

9.6.6.2.1. Corrected and resubmitted encounters as described in the SMO Systems Companion Guide, and/or

9.6.6.2.2. 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 SMO Systems Companion Guide.

9.6.6.3. In addition to the remediation outlined in Section 22 of this RFP, failure of the SMO to submit weekly pharmacy encounter claims files and/or a response file to the disputed encounters file within 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 SMO's capitation payment.

9.6.7. Historical encounter data submissions shall be retained for a period not less than six (6) years, following generally accepted retention guidelines.

9.6.8. 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 provided forty-eight (48) hour turnaround or better on requests for access to information in machine readable form that is between six (6) to ten (10) years old.

9.7. Rebates

9.7.1. The SMO shall submit all drug encounters, with the exception of inpatient hospital pharmacy encounters, to DHH. The SMO shall submit these

pharmacy encounters for rebate from manufacturers under the authority of the DHH Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (PPACA).

9.8. Reporting

9.8.1. The SMO shall provide additional reporting specific to the pharmacy program, including, but not limited to:

9.8.1.1. Pharmacy help desk performance;

9.8.1.2. Prior authorization performance;

9.8.1.3. Prior Authorization request turnaround time;

9.8.1.4. Number of claims submitted as a 72-hour emergency supply;

9.8.1.5. Denials (name of drug, number of requests, number of denials, reason for denial);

9.8.1.6. Pharmacy network access; and

9.8.1.7. Grievance and appeals data as it relates pharmacy, including aggregate standard, expedited, and resolution time.

9.8.2. The SMO shall have the capability to provide routine and ad hoc PBM and drug utilization reports, including for relevant therapeutic classes and diagnoses, and special reports targeting specific age groups (e.g., 0-6 year olds, 7-12 year olds, 13-17 year olds, 18 years or older), pregnant females, foster care youth, OJJ involved youth, member presenting to emergency department with primary health diagnoses, members discharged from psychiatric hospitals, TGH, or PRTF within 30 days.

9.8.3. The SMO shall provide drug utilization reporting, including but not limited to, reports relative to claim counts, unique recipient counts, paid amounts, high dose claim counts, polypharmacy claim counts, brand vs. generic/non-formulary drugs, and other drug utilization reports as identified by DHH during implementation of this PBM.

9.8.4. The SMO shall provide prior authorization/drug utilization and review reporting for relevant therapeutic classes, including, but not limited to reports relative to the number of prior authorizations, number of denials/non-authorizations, number of appeals (standard and expedited), average resolution time for appeals, oldest resolved appeals, and other reports as identified by DHH during implementation of this PBM.

9.8.5. Fraud/Abuse Reporting:

9.8.5.1. The SMO must disclose all financial terms and arrangements for remuneration of any kind that apply between the SMO and any prescription drug manufacturer or labeler, including, without limitation, formulary management, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees. DHH or state auditors may audit such information at any time. DHH agrees to maintain the confidentiality of

information disclosed by the SMO pursuant to the contract, to the extent that such information is confidential under Louisiana or federal law.

9.8.5.2. If the SMO suspects prescription abuse by a contracted provider, it shall contact DHH- Program Integrity for investigation and a decision, which may include excluding the provider from the Louisiana Medicaid program. The SMO shall provide DHH with any and all documentation related to the alleged prescription abuse.

9.9. Drug Utilization Review (DUR) Program:

9.9.1. The SMO shall establish and maintain a drug utilization review (DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act.

9.9.1.1. The SMO shall include review of behavioral health drugs in its DUR program.

9.9.1.2. DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud and abuse, and taking into consideration both the quality and cost of the pharmacy benefit. All DUR standards shall be pre-approved by DHH-OBH.

9.9.1.3. The SMO shall coordinate with Bayou Health, which has implemented an online claims adjudication system, including a prospective review of drug utilization with age-specific edits where appropriate for consideration of drug interactions.

9.9.1.4. The SMO's DUR program shall include the standards for each category of DUR, i.e., therapeutic duplication, drug-drug interaction, insufficient or excessive dose, incorrect duration of therapy, and under or over-utilization.

9.9.1.5. DHH-OBH shall review and approve the SMO's DUR policy and procedures; DUR utilization review process/procedure and the standards included therein; and any revisions. The DUR program and revisions must be submitted to DHH-OBH for prior approval at least forty-five (45) days in advance of the proposed effective date of the DUR program or any changes to the program thereafter.

9.9.2. In the event of an emergency, the SMO may authorize members in impacted areas to obtain *up to a thirty (30) day supply of their prescriptions*. Pharmacies would be authorized to process prescription refills early in those areas.

9.9.2.1. The SMO shall audit early refills during an emergency by requiring pharmacists to document the required drug utilization review information on the prescription (the pharmacist need not contact the prescribing provider).

9.9.2.2. This documentation shall be accomplished either by direct notation of the approval on the hard copy or electronically through such means as pharmacists notes/comments, etc., depending on the particular software, and is readily retrievable when requested by SMO audit staff or DCFS staff for DCFS involved youth.

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10.0 PROVIDER NETWORK REQUIREMENTS

10.1. General Provider Network Requirements

10.1.1. The SMO must maintain a network of qualified Medicaid and non-Medicaid providers in sufficient numbers and locations within the state to provide required access to covered services. The SMO is expected to design a network that provides a comprehensive array of services with a geographically convenient flow of members among culturally-competent, qualified network providers as necessary to meet their identified needs. The provider network shall be designed to reflect the needs and service requirements of the LBHP member population, including both Medicaid and non-Medicaid members, and shall be supported by written provider subcontracts.

10.1.2. The SMO shall design their 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.

10.1.3. The SMO will work to expand or modify the existing network of providers offering services through the LBHP as necessary to address the needs of adults with SMI, members with substance use disorders, members with co-occurring mental health and substance use disorders, and all eligible children, including those eligible for the CSoC. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid and non-Medicaid services.

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

10.1.5. The SMO is required to contract with providers of behavioral health services who:

10.1.5.1. Are appropriately licensed and/or certified,

10.1.5.2. Meet the certification and applicable licensing criteria,

10.1.5.3. Who agree to the standard contract provisions, and

10.1.5.4. Who wish to participate.

10.1.6. The SMO shall ensure that within the provider network, recipients have a choice of providers which offer the appropriate level of care and may change providers in accordance with the Medicaid home and community-based waiver requirements pertaining to Freedom of Choice.

10.1.7. The SMO shall have a full understanding of all LBHP applicable waivers and Medicaid State Plan Amendments and enforce their requirements.

10.1.8. The SMO shall comply with RS 40:2201 et seq., RS 40:2211 et seq, RS 40:2242, which speaks to participation of essential community providers, and RS 40:2241, which lists essential community providers.

10.1.9. The SMO shall maintain a list of qualified providers divided into specific types of services and types of members the provider serves. The updated list will be made available to the public in near real time through the SMO website and to members, the member's family/caregiver, and referring providers in electronic and/or hard copy format. 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 SMO provider types shall match the provider types approved in Louisiana and be delineated by parish.

10.1.10. The SMO shall assure that the network has a sufficient number of prescribers and other qualified service providers to deliver services during evenings and weekends for members or their families/caregivers who are unavailable for appointments during regular business hours.

10.1.11. The SMO shall provide technical assistance and network development training (e.g., billing, LBHP services and authorization, linguistic/cultural competency, etc.) for its providers and maintain records of such training, which shall be made available to DHH-OBH upon request. Providers that primarily serve both Medicaid and non-Medicaid members (e.g., LGEs) shall be given additional support through technical assistance and training due to issues arising from management of dual populations.

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

10.1.12.1. Expeditiously developing provider subcontracts and enforcing the subcontract terms.

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

10.1.12.3. Performing credentialing of qualified service providers consistent with 42 CFR Part 438 and applicable state regulations, including credentialing of prescribers, practitioners, facilities, and WAAs. The process the SMO uses to conduct credentialing and re-credentialing shall be approved by DHH-OBH. The credentialing process shall, in addition, meet all requirements of the DHH-OBH certification process.

10.1.13. The SMO shall evaluate every prospective provider's ability to perform the activities to be delegated prior to contracting with any provider or subcontract. The SMO must ensure the provider has not been found to have committed fraud as per the requirements of Section 18 of this RFP.

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

10.1.15. The SMO shall ensure all subcontracted providers are in compliance with the National Voter Registration Act (NVRA) as applicable, and offer members with each application, admission, re-admission, re-certification, or submission of change of address an opportunity to register to vote.

Under the NVRA, the state has designated voter registration agencies, which must offer voter registration services to each person applying for service or assistance, renewing or recertifying eligibility, or submitting a change of address. SMO responsibilities include, but may not be limited to:

10.1.15.1. Collecting data from provider site coordinators, including, but not limited to, the total number of applications for service or assistance, re-certification renewals, and changes of address relating to such service or assistance received by the provider, the total number of declaration forms received by the provider, and the total number of completed voter registration applications received by the provider;

10.1.15.2. Attending any required NVRA meetings or trainings for NVRA compliance;

10.1.15.3. Ensuring providers train new employees on NVRA processes and compliance within thirty (30) days of hire and annually thereafter;

10.1.15.4. Providing to DHH-OBH all NVRA policies, procedures, and practices in sufficient detail to enable the Louisiana Secretary of State to assess compliance with the NVRA, which shall also be submitted to the Secretary of State upon request; and

10.1.15.5. Reporting all of the above (Sections §10.1.15.1 to §10.1.15.4) in an NVRA Data Report to the Louisiana Secretary of State and DHH-OBH quarterly and as requested in a format approved by the Louisiana Secretary of State and DHH-OBH.

10.1.16. The SMO is not obligated to continue to contract with a provider that:

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

10.1.16.2. Does not provide high quality services, or

10.1.16.3. Demonstrates outlier utilization of services compared to peer providers with similarly acute populations based on the expectations of the SMO and DHH-OBH.

10.1.17. The SMO shall not discriminate.

10.1.17.1. The SMO's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

10.1.17.2. The SMO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

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

10.1.17.3.1. Require the SMO to contract with providers beyond the number necessary to meet the needs of its members.

10.1.17.3.2. Preclude the SMO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members.

10.1.18. If the SMO declines to include individuals or groups of providers in its network, it must notify DHH-OBH and give the affected providers written notice of the reason for its decision within fourteen (14) calendar days of its decision.

10.1.19. The SMO shall provide authorizations based on medical necessity when required, referral and out of home placement services to eligible DHH-OBH, DCFS, and OJJ youth for services offered under the LBHP and in accordance with state law requirements. The SMO shall negotiate a time frame with DCFS and OJJ within which out of home placement will occur.

10.1.20. The SMO shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers. Quarterly validation shall be provided to DHH-OBH upon request.

10.1.21. Have a fully operational network of crisis response providers offering a complete array of crisis services, available 24 hours per day, 7 days per week as of the contract go-live date. The community-based crisis response system may include, but is not limited to, on-call, 24-hour hotline, warm line, crisis counseling, behavioral management and intervention, mobile crisis team, crisis stabilization in an alternative setting, etc.

10.1.22. The SMO shall develop, maintain and provide DHH-OBH and members access to a database that contains near real time information identifying, according to Zip code and by provider type, provider availability, and contracted capacity and any member parameters for service population (e.g., adult, child, Spanish-speaking, etc.).

10.1.23. Unless approved in advance by DHH-OBH, the SMO shall not subcontract network management, network reporting, or assurance of network sufficiency.

10.2. Network Development and Management Plan

10.2.1. The SMO shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of LBHP services will occur consistent with the goals and principles of the LBHP [42 CFR §438.207(b)].

10.2.2. The Network Development and Management Plan shall be submitted to DHH-OBH within thirty (30) days of DOA/OCR approval of the signed contract for evaluation and approval. The plan shall be submitted

annually thereafter, or at the request of DHH-OBH, and annually thereafter.

10.2.3. The Network Development and Management Plan shall include the SMO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access to all required services included in the contract.

10.2.3.1. The plan shall contain separate sections for different provider types, including both Medicaid and non-Medicaid service providers, for covered services described in this RFP for children and adults.

10.2.3.2. The plan shall also include a proposal for network sufficiency based on projections of service usage and the number and location of providers required to provide those services, including a proposed ratio based on industry standards and on the assumption that a percentage of the member population is suffering from mental health and/or a substance use disorder. The final determination of network sufficiency as proposed by the SMO shall be reviewed and approved by DHH-OBH within sixty (60) days of submission.

10.2.3.3. In establishing and maintaining the network, the SMO shall consider the following:

10.2.3.3.1. Medicaid enrollment.

10.2.3.3.2. Utilization of services, taking into consideration the characteristics and behavioral healthcare needs of specific Medicaid and non-Medicaid populations represented in the contract.

10.2.3.3.3. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted LBHP services.

10.2.3.3.4. The numbers of network providers who are not accepting new Medicaid patients.

10.2.3.3.5. The geographic location of providers and Medicaid/non-Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, waiver requirements, and whether the location provides physical access for Medicaid enrollees with disabilities.

10.2.3.3.6. Development of network capacity in collaboration with state agencies (OBH, DCFS, OJJ, and LDOE), with the understanding that the network capacity requirements may change due to the needs of individual children.

10.2.3.3.7. Development and implementation of policies and procedures to monitor and demonstrate that the network is

of sufficient size, scope, and types of providers to deliver all covered behavioral health services and satisfy all the service delivery requirements of this contract, the Services Definition Manual, and the SAPT and MH Block Grants.

10.2.3.3.8. If shortages in provider network sufficiency are identified and verified by DHH-OBH after independent investigation, the SMO must submit a corrective action plan to DHH-OBH within thirty (30) days after formal notice by DHH-OBH.

10.2.3.3.9. If the SMO is not able to deliver a medically necessary covered behavioral health service, the SMO shall timely subcontract with an out-of-network provider to deliver the same service until a network provider is available. The SMO shall expeditiously authorize services and reimburse the out-of-network provider in these circumstances.

10.2.3.3.9.1. The SMO shall report monthly to DHH-OBH on the number and type of out-of-network subcontracts entered for this purpose via an Out-of-Network Provider Report. Additionally, the SMO shall include in this report the number and placement of all members placed in out-of-network treatment.

10.2.3.3.9.2. The SMO will be required to request approval from DHH-OBH, DHH-BHSF, and the custodial agency as applicable (i.e., OJJ, DCFS) to place youth in out-of-state facilities for treatment purposes. The SMO will also provide evidence of what efforts are being made to return these youth to the state and their homes. In year one of the contract, the SMO will have no corrective action plans placed on them due to the number of youth placed out-of-state, however, in year two and beyond, there will be remediation as outlined in Section 22 of this RFP should the number exceed ten (10) out-of-state youth per contract year unless evidence is presented that indicates the out-of-state provider is the most appropriate and necessary option to treat the specialty needs of the member.

10.2.3.3.9.3. If a member needs a specialized service that is not available through the network, the SMO will arrange for the service to be provided outside the network if a qualified provider is available. Transportation will be provided and reimbursed through Medicaid when eligible; otherwise, the SMO shall be responsible for costs of necessary transportation in this circumstance.

10.2.3.3.9.4. The SMO must coordinate with out-of-network providers with respect to payment. The SMO must ensure that cost to the member or state is no greater than it would be if the services were furnished within the network.

10.2.4. The Network Development and Management Plan shall also include the following requirements:

10.2.4.1. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted LBHP services, including providers specializing in services (e.g., DD population, sexual offending behaviors, and early childhood development).

10.2.4.2. A list of all provider rates delineated by provider and by service type which the SMO has agreed to pay the provider under each provider subcontract. Any changes in payment rates by the SMO to the provider shall be reflected in the Quarterly Network Status reports outlined in Section 10.4.2.

10.2.4.3. An annual needs assessment to identify unmet service needs in the service delivery system. The needs assessment shall analyze and include:

10.2.4.3.1. Volume of single case agreements and out-of-network and out-of-state referrals;

10.2.4.3.2. Specialized service needs of members, both Medicaid and non-Medicaid;

10.2.4.3.3. Growth trends in eligibility and enrollment, including:

10.2.4.3.3.1. Current and anticipated numbers of Title XIX and Title XXI eligibles.

10.2.4.3.3.2. Current and anticipated numbers of non-Medicaid children.

10.2.4.3.3.3. Current and anticipated numbers of other non-Medicaid adults.

10.2.4.3.3.4. Current and desired 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-OBH, LBHP Goals and Principles.

10.2.4.3.4. Accessibility of services, including:

10.2.4.3.4.1. The number of current qualified service providers by individual service in the network who are not accepting new referrals and plan for updating on a regular, reoccurring basis as close to real time as possible.

10.2.4.3.4.2. The geographic location of providers and members considering distance, travel time, and available means of transportation.

10.2.4.3.4.3. Availability of services and appointments with physical access for persons with disabilities.

10.2.4.3.4.4. Any service access standards detailed in a SPA or waiver.

10.2.4.4. GEO mapping and coding of all network providers (Medicaid and non-Medicaid) for each provider type by the contract implementation date to geographically demonstrate network capacity. The SMO shall provide updated GEO mapping and coding to DHH-OBH quarterly by contract year, or upon material change (as defined in Section 10.6) or upon request.

10.2.4.5. Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206. See glossary for definition of "culture."

10.2.4.5.1. Provide 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:

10.2.4.5.1.1. Collecting demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, to assist in having the staff reflect the cultural demographics of the area so that the provider will be able to respond appropriately to the cultural needs of the community being served.

10.2.4.5.1.2. Assessing the cultural competence of the providers on an ongoing basis, at least annually.

10.2.4.5.1.3. 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.

10.2.4.5.1.4. Assessing provider satisfaction of the services provided by the SMO at least annually.

10.2.4.5.1.5. Requiring and providing training on cultural competence (or obtaining proof of attendance at other trainings on cultural competence) to staff and providers for a minimum of three (3) hours per year least and as directed by the assessments.

10.2.4.6. For adults, the SMO shall include in the plan strategies for continued transformation of the service delivery system into a comprehensive system that:

10.2.4.6.1. Includes qualified service providers and community resources designed and contracted to deliver care that is strength-based, community-based, and culturally competent.

10.2.4.6.2. Includes specific services for adults eligible for services as defined in this contract.

10.2.4.6.3. Is of sufficient size and scope to offer members a choice of providers for all covered behavioral health services.

10.2.4.6.4. Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models.

10.2.4.6.5. Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.

10.2.4.7. For children and youth, the SMO shall include in the plan for continued transformation of service delivery into a comprehensive system that:

10.2.4.7.1. Includes qualified service providers and community resources designed and contracted to deliver care that is strength-based, family-driven, community-based, and culturally competent.

10.2.4.7.2. Is of sufficient size and scope to offer members a choice of providers for all covered behavioral health services.

10.2.4.7.3. Makes uniformly available over time, recognized EBPs, best practices and culturally competent services that promote resilience through nationally recognized integrated service models.

10.2.4.7.4. Includes specific services for children eligible for the CSoC as defined in this contract.

10.2.4.7.5. Targets the development of family and community-based services for children/youth in out-of-home placements.

10.2.4.7.6. Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of-home placements.

10.2.4.7.7. Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.

10.2.4.8. Maintain minimum standards for certified peer and family support as set by DHH-OBH.

10.2.4.9. Provisions for contracting with a sufficient number of qualified providers certified to deliver services to individuals residing in permanent supportive housing.

10.2.4.10. Documentation of accessibility to a sufficient number of qualified oral interpreters, bilingual staff, and licensed sign language

interpreters to deliver oral interpretation, translation, sign language, disability-related services, provide auxiliary aids and alternative formats, including formats accessible to the visually impaired.

10.2.4.11. A process for expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management, utilization, office audits and provider profiling.

10.2.4.12. An evaluation of the initial Network Development and Management Plan, including evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions.

10.2.5. Upon request and as part of its Network Development and Management Plan, the SMO shall submit provider profiling data to DHH-OBH that includes:

10.2.5.1. Eligibility/enrollment data;

10.2.5.2. Utilization data;

10.2.5.3. The number of single case agreements by service type;

10.2.5.4. Treatment and functional outcome data;

10.2.5.5. Members diagnosed with developmental/cognitive disabilities;

10.2.5.6. Number of prescribers required to meet behavioral health members' medication needs;

10.2.5.7. Grievance, appeal, and request for hearings data; and

10.2.5.8. Issues, concerns, and requests identified by other state agency personnel, local agencies, and community stakeholders.

10.2.6. Upon request, certain SMO Network Development and Management policies shall be subject to approval by DHH-OBH.

10.3. Network Standards and Guidelines

10.3.1. Access Standards

10.3.1.1. The SMO shall ensure access to healthcare services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care, facility wait list) in accordance with the provision of services under this RFP. The SMO shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, and professional personnel for the provision of services, including all emergency services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:

10.3.1.2. Twenty-Four (24) Hour Coverage

10.3.1.2.1. The SMO shall ensure that all emergency behavioral healthcare is available on a twenty-four (24) hours a day, seven (7) days a week basis through its network providers, and shall maintain, twenty-four (24) hours per day, seven (7) days per week telephone coverage to instruct LBHP members on where to receive emergency and urgent behavioral healthcare.

10.3.1.3. Travel Time and Distance

10.3.1.3.1. The SMO shall identify standards for access to services based on distance to behavioral healthcare and present to DHH-OBH for approval as part of its Network Development and Management Plan. The industry standard presented shall be indicated in average mileage distance using an accepted navigational mapping program from communities according to population density (i.e., metropolitan, urban, suburban, rural) to the nearest service divided by subcontracted provider type specifically indicating specialty groupings and ability to prescribe medication.

10.3.1.3.2. The SMO shall report on service accessibility in a manner which allows for comparisons to the industry standards. Calculations for access to behavioral healthcare shall include distance, population density, and provider availability variables.

10.3.1.3.3. Requests for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to DHH-OBH for approval.

10.3.1.3.4. 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.

10.3.1.4. Scheduling/Appointment Waiting Times

10.3.1.4.1. The SMO shall have policies and procedures for appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The SMO shall disseminate these appointment standard policies and procedures to its network providers and to its members and include this on website, in member and provider handbooks, and in provider contracts. The SMO shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.

10.3.1.4.2. The SMO shall require all participants in the provider network to respond to referrals and have an appointment system for contracted services that is in accordance with

prevailing behavioral health community standards as specified below:

10.3.1.4.2.1. Emergent, crisis or emergency services must be available at all times. An appointment shall be arranged within 1 hour of request.

10.3.1.4.2.2. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. An appointment shall be arranged within 48 hours of request.

10.3.1.4.2.3. Routine, non-urgent behavioral health service appointments shall be arranged within 14 days of referral.

10.3.1.4.2.4. None of the above access standards shall supersede the requirements in the waivers or Medicaid State Plan.

10.3.2. The SMO shall submit an attestation ensuring adequate capacity and services at the time it enters into a contract with DHH-OBH and at any time there has been a change in the SMO's operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population in the SMO).

10.3.3. The SMO shall ensure that the network consists of qualified service providers to administer programs and services for priority populations (outlined in Section 8.8) consistent with the requirements of the federal block grants.

10.3.4. Network Guidelines for Subcontracted Providers Needing DCFS Licensing

10.3.4.1. The SMO shall refer and adhere to the Service Definition Manual (see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877) for requirements regarding Therapeutic Foster Care (TFC) and Non-Medical Group Home (NMGH) providers.

10.3.4.2. The SMO shall subcontract with TFC, NMGH, and Mothers with Infant Group Home providers that are compliant with current licensing regulations available through the internet at: http://www.dss.louisiana.gov/.

10.3.4.3. The principle of unconditional support is followed in each residential setting. The SMO must ensure that the child is served at most appropriate level of care.

10.3.4.4. The SMO shall obtain nationwide criminal clearances on all staff prior to employment. This procedure is accomplished at the DCFS regional office through use of the Printrak Livescan equipment. The SMO must ensure that each employee is free of convictions or has successfully passed a criminal background check via attestation from the provider. The SMO shall be

responsible for monitoring compliance with this requirement via random verification sampling.

10.3.4.5. As set forth in 42 CFR §455.436, the SMO must conduct federal database background checks upon provider enrollment and reenrollment, and employee hire.

10.3.4.6. Act 388 of the 2009 Legislative Session mandates that effective January 1, 2010, any owner, operator, current or prospective employee, or volunteer of a Child Residential Care facility licensed by DCFS is prohibited from working in a Child Residential Care facility if the individual discloses, or as the result of information known or received by the DCFS, that the individual's name is recorded on the State Central Registry (SCR) as a perpetrator for a justified (valid) finding of abuse or neglect of a child unless there is a finding by the Risk Evaluation Panel or a ruling by the Division of Administrative Law that the individual does not pose a risk to children.

10.3.4.7. Any owner, operator, current or prospective employee or volunteer of a child residential facility licensed by DCFS must self-disclose whether or not their name is recorded on the State Central Registry as a perpetrator of a justified (valid) finding of abuse or neglect of a child using a SCR form specified by DCFS. Any owner, operator, current or prospective employee, or volunteer of a child residential care facility licensed by the department who knowingly falsifies the information on the State Central Registry Disclosure Form shall be guilty of a misdemeanor offense and shall be fined not more than five hundred dollars, or imprisoned for not more than six (6) months, or both.

10.3.4.8. It is the SMO's responsibility to ensure its subcontracted providers comply with the above requirements and can submit proof of compliance upon request.

10.3.5. If the child meets service authorization criteria for medical necessity and qualifies for a specific level of care that is unavailable in the SMO network, the SMO will be responsible for payment for a higher level of care until appropriate placement is found, even when Medicaid payment is unavailable due to the member no longer meeting service authorization criteria for medical necessity requirements for the higher level of care.

10.4. Other Network Reports

10.4.1. Unmet Service Needs Resolution Plan

10.4.1.1. Within 90 days of submission of the annual needs assessment within the Network Development and Management Plan, the SMO shall submit a Unmet Service Needs Resolution Plan to DHH-OBH to meet the identified unmet service needs.

10.4.1.2. At a minimum, the Unmet Service Needs Resolution Plan shall include the development of a systematic approach for collecting

information from providers and members regarding barriers or gaps in the network with ongoing monthly reports regarding this information and its efforts to address identified network issues.

10.4.2. Quarterly Network Status Reports

10.4.2.1. SMO shall submit written Quarterly Network Status reports in a format approved by DHH-OBH that substantially mirrors the annual Network Development and Management Plan

10.4.2.2. The SMO's Quarterly Network Status reports shall include separate sections reporting changes in qualified service providers (organized by provider type), by zip code with DHH-OBH regions and Act 1225 regions. GEO mapping shall be included in this report to identify compliance with urban and rural access standards. Each section shall include identification of providers lost and gained, prescribers lost and gained and prescriber sufficiency analysis, the name and address of each provider, provider type, contracted capacity, provider identification number, populations served, and an analysis of the effect on network sufficiency.

10.4.2.3. Quarterly Network Status reports shall include populations served delineated by agency involvement (i.e., DCFS, OJJ, LDOE, and/or DHH-OBH).

10.4.2.4. The Quarterly Network Status reports shall also include data for qualified service providers administering programs and services available to priority populations (identified in Section 8.8) consistent with the requirement of the Block Grants.

10.4.2.5. The report shall outline activities the SMO has conducted for the purpose of outreach to members for early identification of at-risk and priority populations and to offer primary prevention services for individuals and families to help prevent disease progression.

10.4.2.6. The report shall also include credentialing/contracting outlier data, with the expectation that barriers or issues negatively impacting completion of the process within 120 days are documented and addressed, ensuring timely provider contracting and beginning of service delivery.

10.4.2.7. The SMO shall maintain and provide to DHH-OBH quarterly documentation of provider status throughout the contracting process, to include credentialing/certification application, Medicaid addendum, and contract processing dates, in an effort to assure provider enrollment process efficiency.

10.4.2.8. The SMO shall identify areas of need around cultural competency, the training topics and materials provided, dates, numbers of individuals and organizations trained, specific to cultural competency.

10.4.3. Provider Performance Review Report

10.4.3.1. A Provider Performance Review Report shall be submitted to DHH-OBH, DCFS, OJJ, and LDOE annually and at additional periodic intervals as requested and approved by DHH-OBH.

10.4.3.2. The report shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits according to a periodic schedule determined by the SMO and approved by DHH-OBH, DCFS, and OJJ. These shall take into account the monitoring responsibilities and efforts of the state agencies.

10.4.3.3. As part of its monitoring activities, at minimum, member surveys and regular member interviews shall be included in the annual report.

10.4.3.4. The report shall include aggregate results; however, upon request, the SMO shall supply the individual provider reports.

10.4.3.5. The report shall include a description of any deficiencies the providers have demonstrated. The SMO will provide detailed information regarding these deficiencies including findings, improvement actions taken, and the effectiveness of said actions to DHH-OBH upon request. A deficient finding in a youth residential facility that affects the health and safety of the youth shall be reported immediately to DHH–OBH and OJJ or DCFS as appropriate.

10.5. Provider Enrollment

10.5.1. At the onset of the SMO contract and periodically as changes are necessary, DHH shall publish at the url: www.lamedicaid.com the list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. To coordinate provider enrollment records, the SMO shall utilize the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with DHH. The SMO shall provide the following:

10.5.1.1. Provider name, address, licensing information, Tax ID, National Provider Identifier (NPI), taxonomy and payment information; and

10.5.1.2. All relevant provider ownership information as prescribed by DHH, federal or state laws.

10.5.2. Provider enrollment systems shall be Affordable Care Act-compliant and include, at minimum, the following functionality:

10.5.2.1. Audit trail and history of changes made to the provider file;

10.5.2.2. Automated interfaces with all licensing and medical boards;

10.5.2.3. Automated alerts and system generated letters to providers when their licenses are within thirty (30) days expiration;

10.5.2.4. Retention of NPI requirements;

10.5.2.5. Linkages of individual providers to groups;

10.5.2.6. Credentialing/certification information;

10.5.2.7. Provider office hours; and

10.5.2.8. Provider languages spoken.

10.6. Material Change to Provider Network

10.6.1. The SMO shall provide written notice to DHH-OBH, no later than seven (7) business days of any network provider contract termination that materially impacts the SMO's provider network, whether terminated by the SMO or the provider, and such notice shall include the reason(s) for the proposed action.

10.6.2. A material change is defined as one which affects, or can reasonably be foreseen to affect, the SMO's ability to meet the performance and network standards as described in the contract, including but not limited to the following:

10.6.2.1. Any change that would cause more than five percent (5%) of members in a parish to change the location where services are received or rendered.

10.6.2.2. A decrease in provider type by more than five percent (5%);

10.6.2.3. A loss of any participating specialist which may impair or deny the members' adequate access to providers;

10.6.2.4. 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-OBH; or

10.6.2.5. Other adverse changes to the composition of the SMO provider network which impair or deny the members' adequate access to providers.

10.6.3. The SMO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.

10.6.4. When the SMO has advance knowledge that a material change will occur, the SMO must submit a request for approval of the material change in their provider network to DHH-OBH, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.

10.6.5. 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:

10.6.5.1. Detailed information identifying the affected provider;

10.6.5.2. Demographic information and number of members currently served and impacted by the event or material change, including

the number of Medicaid and non-Medicaid members affected by program category (e.g., children eligible for the CSoC, adults eligible for the 1915(i), etc.);

10.6.5.3. Location and identification of nearest providers offering similar services; and

10.6.5.4. 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.

10.6.6. If DHH-OBH does not respond within thirty (30) days the request, the notice is deemed approved. A material change in the SMO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, DHH-OBH will expedite the approval process.

10.6.7. The SMO shall notify DHH-OBH within one (1) business day of the SMO 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 SMO, 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:

10.6.7.1. Information about how the provider network change will affect the delivery of covered services, and

10.6.7.2. The SMO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

10.6.8. The SMO shall give providers ninety (90) days' notice prior to a contract termination without cause. Contracts between the SMO and single practitioners are exempt from this requirement.

10.6.9. The SMO shall notify DHH-OBH in writing within five (5) days if a subcontract fails to meet licensing criteria, or if the SMO recommends to terminate, suspend, limit, or materially change a qualified service provider or WAA subcontract and obtain written approval from DHH-OBH. The notice shall include the same requirements outlined under Section 10.6.5 above.

10.6.10. If a provider loss results in a material gap or network deficiency, the SMO shall submit to DHH-OBH a plan with time frames and action steps for correcting the gap or deficiency within thirty (30) days that includes the transitioning of members to appropriate alternative service providers in accordance with the network notification requirements.

10.6.11. The SMO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure service continuity and provide member information as requested by DHH-OBH

(e.g., name, Title XIX or Title XXI status, date of birth, services member receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider). DHH-OBH will require the SMO and its providers, where applicable, to use data elements which match current data systems requirements specified by DHH-OBH.

10.7. Credentialing and Re-credentialing of Providers and Clinical Staff

10.7.1. Prior to contracting with the SMO, providers must be credentialed and certified according to the SMO and DHH-OBH standards. The SMO shall be responsible for the collection of and review of credentialing and certification materials from the providers.

10.7.2. The SMO shall incorporate all requirements of DHH-OBH certification into the SMO credentialing process. From receipt of the providers credentialing application, the SMO will have sixty (60) calendar days to credential the provider (this includes certification).

10.7.3. Once the SMO credentials the provider and determines that the provider meets the requirements as outlined by DHH-OBH, the SMO shall supply electronically to DHH-OBH the following:

10.7.3.1. A recommendation that the provider be certified by DHH-OBH in a format to be determined by DHH-OBH (e.g., may include a check list of items received from credentialing process);

10.7.3.2. An attestation that the provider has met credentialing and certification requirements; and

10.7.3.3. An attestation to the need of the provider in the network.

10.7.4. In the event a provider is denied credentialing by the SMO, the SMO will provide to DHH-OBH electronically a reason for the denial as well as applicable data supporting the denial.

10.7.5. Upon receipt and review of the above requirements from the SMO for the provider, DHH-OBH will review the attestation and recommendation and notify the SMO the provider is eligible for contracting in writing or via electronic mail. The SMO will have thirty (30) calendar days to sign the contract with the provider from the date DHH-OBH certifies the provider for contracting.

10.7.6. The credentialing through contract process should not exceed 120 calendar days per application.

10.7.7. The SMO shall not delegate credentialing of providers, unless approved by DHH-OBH in advance.

10.7.8. The SMO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12; §438.206, §438.214, §438.224 and §438.230 and NCQA Health Plan Accreditation Standards for the review and credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship.

These procedures shall be submitted as part of the proposal, when a change is made, and annually thereafter by contract year.

10.7.9. The Credentialing Application Form will be approved by DHH-OBH within thirty (30) calendar days of the date the signed contract is approved by DOA/OCR and must incorporate all requirements of DHH-OBH certification.

10.7.10. The process for periodic re-credentialing shall be implemented every three (3) years from the date the provider signs the initial contract, unless the SMO or DHH-OBH determines significant quality issues with a provider or a cause for provider termination. In these instances, the provider may need to re-credential on a more frequent basis.

10.7.11. All service providers under subcontract with the SMO shall meet minimum qualification requirements in accordance with the LBHP Services Definition Manual and credentialing requirements in accordance with the process submitted by the SMO for DHH-OBH approval.

10.7.11.1. When selecting qualified service providers for a subcontract, the SMO shall evaluate information from the following sources: quality management data, including at a minimum, appointment availability data; grievances; patterns of concerns reported by eligible or enrolled members; performance on current and previous subcontracts, including outcomes; behavioral health member satisfaction survey data; results from independent case reviews and other reviews/audits; unmet needs data; grievance and appeals data; network management and contracting data (for example, geographic location and cultural or unique service delivery considerations); and issues, concerns, and requests from state agency personnel or system stakeholders.

10.7.11.2. When selecting providers for a subcontract, the SMO shall require providers to:

10.7.11.2.1. Meet DHH-OBH certification requirements, including but not limited to:

10.7.11.2.1.1. Providers requesting to provide substance use services must submit an ASAM checklist attesting to meeting staff requirements for the particular ASAM level the provider is requesting to provide;

10.7.11.2.1.2. For Assertive Community Treatment (ACT), SAMHSA readiness documents to show a provider will meet fidelity standards;

10.7.11.2.1.3. For Permanent Supportive Housing, the provider will meet SAMHSA fidelity standards and PSH orientation, training, certification, and annual review requirements;

10.7.11.2.1.4. For rehabilitation services (i.e., Community Psychiatric Support and Treatment, Crisis Intervention, and Psychosocial Rehabilitation), the provider's accreditation body application and proof of payment of

the initial accreditation fee, budget and proof of ninety (90) days operating expenses, documentation of profession and general liability insurance, registration with Louisiana Secretary of State for corporations, public health and fire marshal inspections;

10.7.11.2.1.5. A health standards license and subsequent DHH-OBH approval for Crisis Stabilization, Therapeutic Foster Care, Therapeutic Group Home (TGH), and Short Term Respite curriculum;

10.7.11.2.1.6. Documentation of fidelity to evidence-based practice standards for Functional Family Therapy, Homebuilders and Multi-Systemic Therapy;

10.7.11.2.1.7. Accreditation for Psychiatric Residential Treatment Facility (PRTF) and TGH as applicable;

10.7.11.2.1.8. Unlicensed staff of non-accredited, non-licensed providers must complete the DHH-OBH Standard Basic Training packet for treatment planning, Community Psychiatric Support and Treatment, Crisis Intervention, and Psychosocial Rehabilitation; and

10.7.11.2.1.9. Any additional organizational certification documentation that DHH-OBH deems it necessary that the SMO review.

10.7.11.2.2. Obtain a unique national provider identifier (NPI).

10.7.11.2.3. Operate within their license and scope of practice.

10.7.11.2.4. Obtain and maintain all applicable insurance coverage, in accordance with the Terms and Conditions of this contract.

10.7.11.2.5. Require network providers to disclose the health-related criminal conviction information that is required from FFS providers under 42 CFR §455.106, or any legal actions brought against them in the last five (5) years regardless of provider accreditation.

10.7.11.3. The SMO network provider application shall include all information outlined in 42 CFR §455.104 for disclosure by Medicaid providers and fiscal agents regarding information on ownership and control interests.

10.7.11.4. The SMO shall make any collected information on providers through the credentialing process available to DHH-OBH upon request in a DHH-OBH approved format.

10.7.11.5. The SMO shall obtain and keep on file copies of complete and valid provider insurance certificates for each subcontracted qualified service provider in the region and shall make available these certificates to DHH-OBH upon request.

10.7.11.6. The SMO shall evaluate and make a determination to retain providers utilizing performance and QI data acquired while delivering services under this contract.

10.7.11.7. The SMO shall clearly describe and disseminate the process and criteria to be used for terminating provider participation. If the SMO declines to subcontract with individuals or groups of providers as part of the network, it shall give the affected providers prior written notice of the reason for its decision.

10.7.11.8. The SMO shall concurrently notify DHH-OBH, BHSF, and Health Standards of its decision to terminate a provider.

10.7.11.9. The SMO shall conduct credentialing in accordance with the DHH-OBH Service Definitions Manual, assuring that providers meet the documented qualifications for the services provided, abide by the service limitations and exclusions, meet any additional service criteria listed, and serve those individuals listed under eligibility criteria.

10.7.11.10. Up to six (6) months from contract go-live, the SMO, when necessary and upon DHH-OBH approval, shall utilize processes to expedite temporary (or provisional) credentialing to maintain network sufficiency or to add specialty providers. In such instances, the SMO shall notify DHH-OBH of the provisional or temporary status of the provider when they supply the recommendation for approval and attestation to the need of the provider in the network to DHH-OBH. This process will abide by the timelines as set in Section 10.7.1 through 10.7.6.

10.7.11.11. The SMO's credentialing process will include verification of provider's use of DHH-OBH approved curriculum or equivalent standards, compliance with EBP fidelity monitoring as appropriate, and provider compliance with training requirements as documented in the DHH-OBH Service Definitions Manual for select services.

10.7.11.12. The SMO's credentialing process shall include appropriate provider enrollment information that requires allowable prescribing providers as outlined in Section 10.7.1 through §10.7.6 to indicate a psychiatric specialty by provider type for necessary billing under the pharmacy benefit management program.

10.7.11.13. The SMO shall maintain a sufficient number of qualified staff to expeditiously process the credentialing (DHH-OBH certification) and privileging of qualified service providers.

10.7.11.14. The SMO shall give all qualified service providers and subcontracts access to the LBHP Service Definitions Manual and the SMO's Provider Manual, and any updates, either through the SMO's website, or by providing paper copies to providers who do not have Internet access.

10.7.11.15. 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.

10.7.11.16. The SMO shall provide, in accordance with national standards, claims inquiry information to qualified service providers and subcontracts via the SMO's website.

10.7.11.16.1. The SMO shall not restrict or inhibit providers in any way from freely communicating with or advocating for a member regarding behavioral healthcare, medical needs, and treatment options, even if the person needs services that are not covered or if an alternate treatment is self-administered. The SMO may not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of an member who is his or her patient:

10.7.11.16.1.1. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

10.7.11.16.1.2. For any information the member needs in order to decide among all relevant treatment options;

10.7.11.16.1.3. For the risks, benefits, and consequences of treatment or non-treatment; and

10.7.11.16.1.4. For the member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

10.7.11.17. The SMO shall require providers to communicate information to assist a member to select among relevant treatment options, including the risks, benefits, and consequences of treatment or non-treatment; the right to participate in decisions regarding his or her behavioral healthcare; and the right to refuse treatment and to express preferences about future treatment decisions.

10.7.11.18. The SMO 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.

10.7.11.19. The SMO shall develop and implement a mechanism, with DHH-OBH's approval, for reporting quality deficiencies which result in suspension or termination of a network provider/subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the contract is signed and at the time of any change.

10.7.11.20. The SMO shall develop and implement a provider dispute and appeal process, with DHH-OBH's approval, for sanctions, suspensions, and terminations imposed by the SMO 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.

10.8. Permanent Supportive Housing Credentialing and Certification

10.8.1. The SMO shall be responsible for credentialing PSH providers including incorporating all requirements necessary for DHH PSH Program provider certification.

10.8.2. The SMO shall accept all PSH provider credentialing requests, review them for completeness, forward the requests to the DHH PSH Program for review and certification, and maintain a roster and records of qualified providers.

10.8.3. The SMO shall assist the DHH PSH Program in PSH Provider Certification (fidelity) reviews and audits as requested, including the mutual sharing of SMO audit and PSH Program monitoring reports for certified PSH providers.

10.8.4. The SMO shall contract with a sufficient number of qualified providers certified by the DHH PSH Program to deliver services to individuals selected for pre-tenancy or residing in permanent supportive housing.

10.8.5. The SMO shall also advertise the PSH Provider Orientation to interested providers in each region where there is a need to expand PSH as agreed upon by the DHH PSH Program.

10.9. Network and Provider Subcontracts

10.9.1. The SMO shall enter into written subcontracts with qualified service providers to deliver covered behavioral health services to members. The contract shall specify the activities and reporting responsibilities delegated to the provider; and provide for revoking delegation, terminating contracts, or imposing other sanctions if the provider's performance is inadequate.

10.9.2. Upon request, DHH-OBH shall be given copies of any subcontracts entered into by the SMO regarding the LBHP, including provider subcontracts. Any proprietary information regarding rate setting may be redacted by the SMO.

10.9.3. The SMO shall have written policies and procedures for the selection and retention of providers in accordance with 42 CFR §438.214.

10.9.4. The SMO 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 service providers.

10.9.5. All provider subcontracts shall include the following provisions:

10.9.5.1. The name and address of the subcontracted provider.

10.9.5.2. The method and amount of compensation, reimbursement, payment, and other considerations provided to the provider.

10.9.5.3. Identification of the population to be served by the provider, including the number of members the provider is expected to serve.

10.9.5.4. The amount, duration, and scope of covered behavioral health services to be provided.

10.9.5.5. The provider's treatment site shall be a smoke-free environment.

10.9.5.6. The term of the provider's subcontract, including beginning and ending dates, and procedures for extension, termination, and renegotiation.

10.9.5.7. In the event the provider opts out of using the SMO's Electronic Health Record (EHR), the provider is responsible for ensuring any patient data (including data for the uninsured populations) required by the SMO that would be captured in the SMO's EHR is provided through an EHR interface, an ongoing data file submission, or by entering data directly into the SMO's EHR.

10.9.5.8. Specific provider subcontract duties relating to coordination of benefits and determination of third-party liability.

10.9.5.9. 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 SMO, when applicable.

10.9.5.10. Maintenance of an appropriate clinical record keeping system that ensures appropriateness of billing.

10.9.5.11. 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 appropriate medication management is conducted.

10.9.5.12. Compliance with the requirements in the SMO QAPI and UM plans/program including PIP and Corrective Action Plans.

10.9.5.13. Uniform terms and conditions of the contract.

10.9.5.14. Language that requires a written contract amendment and prior approval of DHH-OBH, if the provider participates in any merger, reorganization, or changes in ownership or control, that is related to or affiliated with the SMO.

10.9.5.15. The HIPAA Business Associate Addendum (Attachment IV).

10.9.5.16. 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-OBH shall have no responsibility or liability for any taxes or insurance coverage.

10.9.5.17. Incorporation by reference of the DHH-OBH Service Definitions Manual and the SMO's Provider Manual and language that the provider subcontract complies with all requirements stated in this contract and CMS waiver and SPA.

10.9.5.18. A requirement that all 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.

10.9.5.19. A requirement that the provider shall contact the SMO for prior authorization relative to mixed service protocol.

10.9.5.20. A requirement that provider notify the SMO when it is not accepting new clients, or if it does not accept a client and the associated cause.

10.9.5.21. Compliance with encounter reporting and claims submission requirements in accordance with this RFP (to be detailed in the SMO's Provider Manual), including payment withhold provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting.

10.9.5.22. A provision that the SMO will not offset DHH recouped payments on the provider when DHH has verified that the SMO was at fault for the error in payment.

10.9.5.23. A requirement that providers adopt the utilization management guidelines, and to measure compliance with the guidelines.

10.9.5.24. The right of a provider to appeal a claims dispute in accordance with this RFP (to be detailed in the SMO's Provider Manual).

10.9.5.25. The provider shall be responsible for assisting members in understanding their right to file grievances and appeals in accordance with the SMO's Provider Manual. The SMO must provide the information specified at 42 C.F.R. §438.10(g)(1).

10.9.5.26. Compliance by the subcontract with audits, inspections and reviews in accordance with the SMO's Provider Manual, including any reviews the SMO or DHH-OBH may conduct.

10.9.5.27. Cooperation of the provider with the SMO, other providers and/or state employees in scheduling and coordinating its services with other related service providers that deliver services to members.

10.9.5.28. 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.

10.9.5.29. Development of and compliance with adverse incident reporting policy and standards approved by DHH-OBH. The SMO, upon request by DHH-OBH, will 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 SMO. It shall be the SMO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management.

10.9.5.30. Timely implementation by the provider of DHH-OBH or SMO decisions related to a grievances, member appeal, claims dispute or adverse incident mitigation recommendations.

10.9.5.31. 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).

10.9.5.32. Compliance with National Voter Registration Act (NVRA) and LAC 31:II. Chapter 4 (Emergency Rule) to ensure offices in the state that provide public assistance and offices that provide state-funded programs primarily engaged in providing services to persons with disabilities, referred to as "mandatory voter registration agencies", offer with each application, admission, re-admission, re-certification or submission of change of address the opportunity to register to vote. In addition, providers shall track and supply required data to support compliance with the NVRA.

10.9.5.33. Submission to DHH-OBH and/or the SMO as determined by DHH-OBH of the NOMs, including access to services, engagement in services, independent and stable housing, employment, and employment training rates.

10.9.5.34. Members reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in providers.

10.9.5.35. The DHH-OBH definition of medically necessary covered behavioral health services and the DHH-OBH levels of care are incorporated by reference.

10.9.5.36. 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.

10.9.5.37. A requirement that the providers attend trainings on cultural competence. The SMO shall include a cultural competency component in each training topic.

10.9.5.38. Language for supplying business transaction information upon request as required by 42 CFR §455.105. The credentialing forms and provider agreements used by the SMO will require

network providers to disclose business transactions with wholly owned suppliers or any subcontractors upon request.

10.9.6. As required by 42 CFR §438.6(l), §438.230(a) and §438.230(b)(1),(2),(3) the SMO 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:

10.9.6.1. All provider subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract;

10.9.6.2. The SMO must evaluate the prospective subcontractor's ability to perform the activities to be delegated;

10.9.6.3. The SMO must have a written agreement between the SMO 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;

10.9.6.4. The SMO shall conduct audits of subcontractor compliance with contract terms;

10.9.6.5. The SMO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards and waiver and Medicaid State Plan requirements;

10.9.6.6. The SMO shall identify deficiencies or areas for improvement, and take corrective action; and

10.9.6.7. The SMO shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this RFP to DHH-OBH 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.

10.9.7. Notification of amendments or changes to any provider subcontract which materially affects this contract shall be provided to DHH-OBH prior to the execution of the amendment in accordance with Section 26.2 of this RFP.

10.9.8. The SMO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 (42 U.S.C. §1320a-7) or §1156 (42 U.S.C. §1320 c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The SMO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders. The SMO shall conduct regular checks as per 42 CFR §455.436 and notify DHH-OBH of subcontracted providers found.

10.9.9. The SMO shall give written notice of termination of a subcontract provider, within fifteen (15) days after receipt of issuance of the termination notice, to each LBHP member who received his or her care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).

10.9.10. The SMO shall report to DHH-OBH and the DHH Program Integrity Unit any program integrity-related (fraud, integrity, or quality) adverse action taken on provider participation in their network. These reportable actions will include denial of credentials, enrollment, or contracts. Additionally, when the state executes permissive exclusions to terminate a provider for program integrity issues, the public will be notified as required by 42 CFR §1002.212.

10.9.11. All subcontracts executed by the SMO pursuant to this section shall, at a minimum, include the terms and conditions listed in Section 26 of this RFP. No other terms or conditions agreed to by the SMO and its subcontractor shall negate or supersede the requirements in Section 26.

10.10. Provider-Member Communication Anti-Gag Clause

10.10.1. Subject to the limitations described in 42 CFR §1932(b)(3)(D), the SMO shall not prohibit or otherwise restrict a healthcare provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the contract, for the following:

10.10.1.1. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

10.10.1.2. Any information the member needs in order to decide among relevant treatment options;

10.10.1.3. The risks, benefits and consequences of treatment or non-treatment; and

10.10.1.4. The member's right to participate in decisions regarding their healthcare, including, the right to refuse treatment, and to express preferences about future treatment decisions.

10.10.2. Any SMO that violates the anti-gag provisions set forth in 42 CFR §438.102(a)(1) shall be subject to remediation.

10.10.3. The SMO 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.

10.11. Mainstreaming

10.11.1. DHH considers mainstreaming of LBHP members into the broader health delivery system to be important. The SMO therefore must ensure that all LBHP providers accept members for treatment and that SMO providers

do not intentionally segregate members in any way from other persons receiving services.

10.11.2. To ensure mainstreaming of members, the SMO shall take affirmative action so that members are provided covered services without regard to race, color, creed, gender, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or intellectual/developmental, physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

10.11.2.1. Denying or not providing to a member any covered service or availability of a facility.

10.11.2.2. 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.

10.11.2.3. Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay members.

10.11.3. Once the SMO becomes aware of a provider's failure to comply with this section, the SMO shall develop a formal corrective action plan with the provider within thirty (30) calendar days and notify DHH-OBH.

10.11.4. If the SMO knowingly executes a contract with a provider with the intent of allowing or permitting the provider to implement barriers to care, DHH shall consider the SMO to have breached the provisions and requirements of the contract.

10.11.5. The SMO shall ensure that providers do not exclude treatment or placement of members for authorized LBHP services solely on the basis of state agency (DCFS, LDOE, and OJJ) involvement or referral.

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11.0 CARE AND UTILIZATION MANAGEMENT

11.1. Care Management General Requirements

11.1.1. Care management is the overall system of medical and psychosocial management encompassing, but not limited to, Utilization Management (UM), care coordination, discharge planning following restrictive levels of care, continuity of care, and care transition. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for members requiring behavioral health services and linkages to primary medical care services as needed. These activities shall include scheduling assistance, monitoring, and follow-up for member(s) requiring behavioral health services.

11.1.2. The SMO shall develop and maintain a care management function that ensures covered behavioral health services are available when and where individuals need them. The SMO shall provide services that are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. The care management system shall have LMHP care managers (CMs) that respond 24 hours per day, 7 days per week, and 365 days per year to members, their families/caregivers, legal guardians, or other interested parties calling on behalf of the member. Failure to meet this standard due to network insufficiency as verified by DHH-OBH will subject the SMO to remediation outlined in Section 22 of this RFP.

11.1.3. The SMO shall develop and implement a care management program through a process which provides that clinically appropriate and cost-effective behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon clinically appropriate and cost-effective service plan that meets the behavioral health needs of the member.

11.1.4. Care Management program functions shall include but not be limited to:

11.1.4.1. Early identification of members who have or may have special needs;

11.1.4.2. Assessment of a member's risk factors;

11.1.4.3. Development of an individualized treatment plan which must be in compliance with applicable State Plan, SPA, waivers, and with applicable Quality Assurance (QA) and Utilization Management (UM) standards;

11.1.4.4. Referrals and assistance to ensure timely access to providers;

11.1.4.5. Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;

11.1.4.6. Monitoring;

11.1.4.7. Continuity of care; and

11.1.4.8. Follow-up and documentation.

11.2. Care Management Policies and Procedures

11.2.1. The SMO shall submit Care Management Program policies and procedures to DHH-OBH for approval within thirty (30) days from DOA/OCR approval of signed contract, annually by contract year, and prior to any revisions. Care Management policies and procedures shall include, at a minimum, the following elements:

11.2.1.1. Identification criteria, process, and triggers for referral and admission into a specialized Care Management Program;

11.2.1.2. The provision of an individual needs assessment and diagnostic assessment;

11.2.1.3. The development of an individual treatment plan, as necessary, based on the needs assessment, and the establishment of short and long term treatment objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary;

11.2.1.4. Treatment planner training and certification requirements;

11.2.1.5. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the SMO's members. Procedures must describe collaboration processes with member's treatment providers;

11.2.1.6. A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning;

11.2.1.7. Procedures to ensure that CM services are conflict-free;

11.2.1.8. Processes for required reporting as outlined in Section 3.7 and §17.5 of this RFP;

11.2.1.9. Procedures and criteria for making referrals to specialists and subspecialists; and

11.2.1.10. Procedures in compliance with SP, SPA, and waiver.

11.2.2. The Care Manager (CM) shall make referrals to qualified providers for emergent, urgent, and routine needs within the following appointment access standards:

11.2.2.1. Emergent appointments within one hour of request. An individual in need of an emergent appointment is at serious or extreme risk of harm, such as current suicidal ideation with expressed intentions, recent use of substances resulting in decreased inhibition of harmful behaviors, repeated episodes of violence toward self and/or others, or extreme compromise of ability to care for oneself leading to physical injury.

11.2.2.2. Urgent appointments within 48 hours of referral. An individual in need of an urgent appointment is at moderate risk of harm, such as suicidal ideation without intent or binge use of substances resulting in potentially harmful behaviors; and

11.2.2.3. Routine appointments within 14 calendar days. An individual in need of a routine appointment is at minimal to low risk of harm, such as absence of current suicidal ideation or substance use without significant episodes of potentially harmful behavior.

Note: At minimum, children/youth eligible for CSoC will meet the urgent appointment standard

11.2.3. The SMO and its providers shall meet care management standards for timely access to care and services, taking into account the urgency of need for services as defined as either emergent, urgent or routine. Failure to meet this standard due to network insufficiency as verified by DHH-OBH will subject the SMO to remediation outlined in Section 22 of this RFP.

11.2.4. The network providers shall offer hours of operation that are no less than the hours of operation offered to commercial members.

11.2.5. The SMO shall establish mechanisms to ensure that network providers comply with the timely access requirements; will monitor regularly to determine compliance; and take corrective action if there is a failure to comply.

11.2.6. The CM shall determine if the individual has a PCP through the PCP Linkage Directory with Bayou Health when it becomes available. If the individual does not currently have an assigned PCP, the CM shall refer the individual to Bayou Health to allow each member to choose his or her PCP.

11.2.7. The SMO shall document the individual's PCP in the care management record, or if none, follow up on the PCP referral as part of the ongoing care management process. This will be the SMO's procedure for ensuring that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the member.

11.2.8. The SMO shall obtain signature for release of information from the member or the family/caregiver or legal guardian for children to coordinate care with the PCP and other healthcare providers.

11.2.9. The SMO shall require that all 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, and that network providers, having received such a release, provide timely notification, as necessary, to primary care physicians of the member's treatment throughout the time the member receives behavioral health treatment from the network provider. Special emphasis shall be placed on

notifying the member's primary care physician of the initiation of, or change in, psychotropic medication.

11.2.10. The SMO shall coordinate care with the PCP, with the individual's authorization, to promote overall health and wellness, including:

11.2.10.1. Coordination of services that the SMO furnishes to the member with the services the member receives from any other MCO (e.g., Bayou Health).

11.2.10.2. Timely sharing of clinical information relative to the member's needs with other health care entities serving the member (e.g., Bayou Health Plans) in order to prevent duplication of those activities.

11.2.10.3. Ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR §160 and §164.

11.2.10.4. If requested, as per 42 CFR §438.206, the SMO shall offer a second opinion from a qualified healthcare professional within the network or arrange for a second opinion outside the network at no cost to the member.

11.2.11. The SMO is required to focus coordination for the treatment programs of those who are considered high risk or high needs, including the needs of individuals with co-occurring disorders. The SMO shall identify people with high needs and initiate ongoing treatment planning and service coordination with the member and others working with the member.

11.2.12. In order to identify members with special mental healthcare or substance use treatment needs, the SMO is required to screen all members to identify those with special needs who meet the following criteria:

11.2.12.1. Any individual with IV drug use, pregnant women with substance use disorders, substance using women with dependent children or co-occurring disorders;

11.2.12.2. Children with behavioral health needs in contact with other child serving systems who are not eligible for CSoC;

11.2.12.3. Children eligible for CSoC in regions where CSoC capacity is not available; and

11.2.12.4. Adults eligible for the 1915(i) HCBS services.

11.2.13. The SMO is required to produce a treatment plan for members determined to need a course of treatment or regular care monitoring. The treatment plan shall be:

11.2.13.1. Developed in collaboration with the member's primary care physician (PCP) with member participation, and in consultation with any specialists caring for the member. If the PCP is not available or willing to participate, then the SMO, its staff or

subcontractors will develop the plan informing the PCP of the final plan.

11.2.13.2. Approved by the entity primarily responsible for coordinating healthcare services in a timely manner, if this approval is required.

11.2.13.3. In accord with any applicable state quality assurance and utilization review standards.

11.2.14. In the CSoC when a WAA is available, the plan of care is developed by the WAA. For all other members identified as special needs individuals, the SMO or subcontracted provider shall develop the treatment plan in accordance with SPA or waiver requirements.

11.2.15. 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 1915(i), 1915(b), and 1915(c) 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.

11.2.16. Service authorization based on medical necessity of any Medicaid State Plan services shall be determined by a licensed mental health professional or physician conducting an assessment consistent with state law, regulation and policy.

11.2.17. For children and youth, the SMO shall follow the process outlined in the 1915(b) and 1915(c) waivers for CSoC relative to care management.

11.2.18. The SMO shall provide the following care management functions if the child/youth is either 1) ineligible for CSoC services under the 1915(c) or 1915(b)(3) waiver but is involved with DCFS or OJJ; 2) if the child/youth is part of a priority population (i.e., IV drug user, pregnant woman with substance use disorder, a substance using woman with dependent children or the child/youth has a dual diagnosis); or 3) eligible for CSoC but there is no available opening at the local WAA:

11.2.18.1. Ensure the completion of an independent evaluation and then ensures development of a treatment plan that is consistent with the findings of the evaluation.

11.2.18.2. Refer the child/youth and his/her family/caregiver to providers offering clinically appropriate and medically necessary services, including a choice of credentialed providers that offer services identified in the POC. Provider choice options should be documented.

11.2.18.3. Outreach to the child/youth or his/her family/caregiver if there is no follow-through with recommended services.

11.2.18.4. Review the individualized treatment plans developed by assigned providers to fulfill the POC and confirm: 1) timely development; 2) the adequacy and quality of care; and 3) participation of the child/youth, family/caretaker, providers, and stakeholders in service planning, when clinically appropriate and subject to the approval of the child/youth family/caregiver or legal guardian.

11.2.18.5. Consult with the qualified service providers to address treatment plan changes that are consistent with promoting resiliency and sustainability and to request changes in the treatment plan to address the needs of the child/youth.

11.2.18.6. Provide ongoing care management to review the appropriateness, quality and level of care, discharge, and transition planning.

11.2.18.7. The SMO will prior authorize necessary services for the child/youth based on medical necessity.

11.2.19. For adults, the SMO shall follow the process outlined in the 1915(b) waiver, the Medicaid State Plan, and the 1915(i) Medicaid State Plan Amendment relative to care management.

11.2.19.1. If the adult is not eligible for the 1915(i) and if the adult is an IV drug user, pregnant woman with substance use disorders, or substance using woman with dependent children or dual diagnosis, the SMO or a subcontracted provider, who will not provide services to the adult, provides an independent evaluation consistent with the American Society for Addiction Medicine (ASAM-PPC) criteria for addiction and develops an individualized treatment plan consistent with DHH-OBH specified treatment planning requirements found in the Service Definitions Manual.

11.2.19.2. If the adult is a substance user not meeting treatment planning requirements, not eligible for the 1915(i), then the SMO will determine if the adult is eligible for medically necessary services and prior authorize necessary services. If the adult needs substance use services, the SMO will refer the adult to a provider who will develop a service plan consistent with the Medicaid State Plan requirements and the ASAM-PPC for addiction. The service plan shall be prior authorized by the SMO.

11.2.19.3. If the adult is eligible for the 1915(i) criteria, the SMO will refer the member to a LMHP for an independent evaluation, utilizing an assessment tool determined by DHH-OBH (e.g., the LOCUS) for adult mental disorders and development of a treatment plan consistent with the requirements specified in this section and 1915(i) SPA including, but not limited to:

11.2.19.3.1. Reviewing all treatment plans to confirm: 1) timely development; 2) the adequacy and quality of care; and 3)

participation of the member and desired participants in treatment planning, when clinically appropriate and subject to the approval of the member.

11.2.19.3.2. Referring the member to appropriate provider/providers offering clinically appropriate and medically necessary services and ensuring a choice of credentialed providers.

11.2.19.3.3. Providing outreach to members that do not follow through with recommended services.

11.2.19.3.4. Coordinating care with medical providers to assess and address medical-behavioral co-morbidities.

11.2.19.3.5. Providing ongoing care management to ensure appropriateness, quality and level of care, discharge, and transition planning.

11.2.20. For all members, the SMO's CM shall develop and implement strategies to reduce risk to members and families/caretakers or legal guardians, including, at a minimum:

11.2.20.1. Identifying members who are in need of more intensive monitoring or support, or that have high-risk needs that have not been addressed.

11.2.20.2. Offering alternative services when requested services are denied.

11.2.20.3. Following up with members who do not appear for appointments or adhere to service plans.

11.2.20.4. Initiation of aftercare planning prior to discharge including, but not limited to:

11.2.20.4.1. Setting up appointments for members before they are discharged from facilities providing 24-hour levels of care (e.g., nursing homes, hospitals) to ensure access to, and attendance at, ambulatory follow-up appointments;

11.2.20.4.2. Providing information to members regarding walk-in clinics and crisis services prior to discharge from a facility providing 24-hour levels of care;

11.2.20.4.3. Expediting approval of prior authorization for members being discharged including medications;

11.2.20.4.4. Ensuring adequacy of medication supplies until such time that follow-up is scheduled; and

11.2.20.4.5. Ensuring the discharge plan is finalized at least 72 hours before the scheduled discharge.

11.2.20.4.6. Following up with members who are discharged from facilities providing 24-hour levels of care (e.g., hospitals and nursing homes) within 72 hours post-discharge, to

ensure access to and attendance at ambulatory follow-up appointments.

11.2.20.5. Conducting treatment planning with individuals that frequently depend on crisis services. For children enrolled in CSoC, collaborate with the appropriate WAA to review the individual POC and adjust services to address over-reliance on crisis services.

11.2.21. Referrals for Permanent Supportive Housing (PSH)

11.2.21.1. The SMO shall verify PSH service eligibility under 1915(i) or other behavioral health services managed by the SMO, assist qualified members in applying for PSH housing, prior authorize services for PSH tenancy and pre-tenancy supports as applicable, and assure that such supports are delivered in a timely and effective fashion. The referral requirements are defined in the LHA/DHH Interagency Partnership Agreement and CEA *(*see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877*).*

11.2.21.1.1. PSH eligibility is established by a household being in need of PSH. A household is considered to be in need of PSH if the member of the household has a physical, mental, or emotional impairment which is:

11.2.21.1.1.1. Expected to be of a long, continued or indefinite duration;

11.2.21.1.1.2. Substantially impedes ability to live independently without supports; and

11.2.21.1.1.3. Of a nature that such ability could be improved by more suitable housing conditions.

11.2.21.2. Service arrangements include making a choice of qualified providers, timely and adequate provider response with assisting consumers to select housing, making housing applications, requesting reasonable accommodation as necessary, moving, meeting the requirements of tenancy, negotiating with a property manager or landlord to meet the terms of a lease, providing necessary services and supports to sustain housing and achieve community integration, moving when necessary, and completing housing eligibility re-determinations as necessary.

11.2.21.3. The SMO shall provide UM staff specifically assigned to PSH to ensure appropriateness, quality, intensity and level of care, and transition planning for PSH recipients including identifying PSH recipients that have high-risk needs or are in need of more intensive monitoring.

11.2.22. Referrals for Tobacco Cessation and Problem Gaming

11.2.22.1. SMO Care Managers shall screen for problem gaming and tobacco usage of each member during its 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.

11.2.22.2. Information regarding treatment services and/or referral to care shall be entered into the SMO'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-OBH request in a format and frequency as determined by DHH-OBH.

11.2.22.3. The SMO shall require that providers utilizing the SMO's systems to input the associated tobacco cessation and/or problem gaming screening, treatment and referral information as appropriate into the EHR.

11.3. Care Coordination, Continuity of Care, and Care Transition

11.3.1. The SMO shall develop and maintain effective care coordination for all LBHP eligible members, continuity of care, and care transition activities to ensure a holistic approach to providing behavioral healthcare services to SMO members. The SMO shall establish a process to coordinate the delivery of benefits and services. The SMO shall ensure member-appropriate provider choice within the SMO and interaction with providers outside the SMO. 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 activities shall be demonstrated via work flows with specific decision points, and shall be provided to DHH-OBH within thirty (30) days of the go-live date and upon subsequent changes in the established processes.

11.3.2. Continuity of care activities shall provide processes by which SMO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The SMO shall ensure that service delivery is properly monitored through member surveys, treatment record reviews and Explanation of Benefits (EOB) to identify and overcome barriers to care that an SMO member may encounter. EOB responses shall be tied to the SMO's grievance and appeal system. Corrective action shall be undertaken by the SMO on an as needed basis and as determined by DHH-OBH.

11.3.3. The SMO shall be responsible for the coordination and continuity of care of behavioral healthcare services for all members consistent with 42 CFR §438.208.

11.3.4. The SMO is responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the DD co-occurring population.

11.3.5. The SMO shall implement DHH-OBH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:

11.3.5.1. Ensure that each member has an ongoing source of care appropriate to their needs;

11.3.5.2. Coordinate care for out-of-network services;

11.3.5.3. Coordinate SMO provided services with services the member may receive from other primary or behavioral healthcare providers;

11.3.5.4. Coordinate discharge planning, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay. SMO shall follow-up with the member within seven 72 hours following discharge;

11.3.5.5. Coordinate with DHH and other state agencies following an inpatient, PRTF, or other residential stay when a return to home placement is not possible;

11.3.5.6. Share with other healthcare entities serving the member with special healthcare needs the results from identification and assessment of that member's needs to prevent duplication of those activities;

11.3.5.7. Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 42 CFR Part 2, 45 CFR Parts 160 and 164, and other applicable state or federal laws;

11.3.5.8. Maintain and operate a discharge planning program;

11.3.5.9. Provide aftercare planning for members prior to discharge from a 24-hour facility;

11.3.5.10. Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate;

11.3.5.11. Identify members using emergency department and inpatient psychiatric services inappropriately to assist in scheduling follow-up care with appropriate providers;

11.3.5.12. Document authorized referrals in its utilization management system; and

11.3.5.13. Provide active assistance to members receiving treatment for behavioral health conditions to transition to another provider when their current provider has terminated participation with the SMO. The SMO shall provide continuation of such services for at least ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less.

11.4. Utilization Management

11.4.1. Utilization Management (UM) is the component of care management that evaluates the medical necessity of healthcare services according to established criteria and practice guidelines to ensure the right amount of

services are provided when the member needs them. UM also focuses on individual and system outliers that require review to assess if individual members are meeting their goals and if service utilization across the system is meeting the goals for delivery of community-based services.

11.4.2. The SMO shall implement a UM program that has sufficient 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 SMO 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 SMO shall provide UM staff, both experienced and specifically assigned to children, youth, adults, and older adults.

11.4.3. The SMO 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 SMO shall submit UM policies and procedures within thirty (30) days from the date the contract is signed and approved by DOA/OCR to DHH-OBH for written approval, annually by contract year thereafter, and prior to any revisions.

11.4.4. The SMO's UM program shall comply with federal utilization control requirements, including the certification of need and recertification of need for continued stay inpatient settings and psychiatric residential treatment facilities (PRTFs). The SMO shall require inpatient hospital and PRTFs to comply with federal requirements regarding utilization review plans, utilization review committees, plans of care, and medical care evaluation studies as prescribed in 42 CFR Parts 441 and 456. The SMO shall actively monitor UM activities for compliance with federal, state, and DHH-OBH requirements. The UM Program policies and procedures shall meet the National Committee for Quality Assurance (NCQA) standards and include medical management criteria and practice guidelines that:

11.4.4.1. Are adopted in consultation with a contracting healthcare professional;

11.4.4.2. Are objective and based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field;

11.4.4.3. Consider the needs of the members; and

11.4.4.4. Are reviewed annually and updated periodically as appropriate.

11.4.5. The policies and procedures shall include, but not be limited to:

11.4.5.1. The methodology utilized to grant service authorization based on medical necessity, appropriateness, efficacy, or efficiency of healthcare services;

11.4.5.2. The data sources and clinical review criteria used in decision making;

11.4.5.3. The documentation reflecting the appropriateness of the clinical review process;

11.4.5.4. The process for conducting informal reconsiderations for adverse determinations;

11.4.5.5. Mechanisms to ensure consistent application of review criteria and compatible decisions;

11.4.5.6. Data collection processes and analytical methods used in assessing utilization of healthcare services;

11.4.5.7. Provisions for assuring confidentiality of clinical and proprietary information;

11.4.5.8. A mechanism for monitoring members' utilization of behavioral health services to ensure Title XIX and Title XXI reimbursement is not made beyond the service limitations specified in Section 8 for Covered Benefits and Services;

11.4.5.9. Addressing the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the SMO may deny authorization of the requested service(s);

11.4.5.10. Monitoring and analyzing utilization data from DHH for members that have received behavioral health services from other sources besides the SMO (e.g., managed care for long-term supports and services, Bayou Health). The SMO shall monitor data to identify any previous or concurrent services for its members in order to coordinate care, and track utilization and quality of care concerns;

11.4.5.11. Providing the WAA and contracted service providers with technical assistance regarding UM policies and procedures and the application of services authorization criteria and practice guidelines;

11.4.5.12. Assisting the WAA with specialized training to develop and manage sustainable Plans of Care, consistent with UM policies and procedures;

11.4.5.13. Collaborating with OJJ and 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;

11.4.5.14. 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;

11.4.5.15. Collaborating with jails and prisons in Louisiana to coordinate the discharge and transition of members involved in the justice system for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and

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

11.4.6. The SMO shall develop and disseminate clinical practice guidelines to all providers as appropriate and, upon request, to members and potential members.

11.4.7. The SMO shall take steps to require adoption of the clinical practice guidelines by subcontracted providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers are consistently in compliance, based on SMO measurement findings. The SMO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.

11.4.8. The SMO shall have staff with clinical expertise and training to apply service authorization criteria based on medical necessity and practice guidelines. Determinations of service authorization must be made by qualified and trained LMHPs in accordance with state and federal regulations.

11.4.9. The SMO shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for service authorization determinations. The SMO shall make service authorization determinations that are consistent with the state's definition of medical necessity.

11.4.10. The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the reviewer's physical, mental, professional or moral character.

11.4.11. 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.

11.4.12. The SMO shall provide a mechanism to reduce inappropriate and duplicative use of behavioral healthcare services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. The SMO 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.

11.4.13. The SMO shall report fraud and abuse information identified through the UM program to DHH's Program Integrity Unit in accordance with 42 CFR §455.1(a)(1), DHH-OBH, and the Attorney General's Office when applicable.

11.4.14. In accordance with 42 CFR §456.111 and §456.211, the SMO Utilization Review plan must provide that each member's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:

11.4.14.1. Identification of the member;

11.4.14.2. The name of the member's provider;

11.4.14.3. If in a facility, the date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;

11.4.14.4. The plan of care required under 42 CFR §456.80 and §456.180;

11.4.14.5. If in a facility, initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133; §456.233 and §456.234;

11.4.14.6. Justification of emergency admission, if applicable.

11.5. Service Authorization

11.5.1. Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.

11.5.2. The SMO UM Program policies and procedures shall include service authorization policies and procedures consistent with the State Plan, 1915(i) SPA, other SPAs, and 1915(b) and 1915(c) waivers, 42 CFR §438.210, and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

11.5.2.1. Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;

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

11.5.2.3. 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 healthcare professional who has appropriate clinical expertise in treating the member's condition and shall be submitted by the SMO to the provider and member in writing;

11.5.2.4. 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 the SMO's member manual and incorporated in the grievance procedures;

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

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

11.5.3. For all modalities of care, the duration of treatment should be determined by the member's needs and his or her response to treatment. The SMO shall ensure continuation of higher level services (e.g., inpatient hospital) until the SMO can provide the next appropriate level of care (e.g., intermediate/long-term, PRTF, TGH, residential, etc.). Note: In the absence of medical necessity, Medicaid cannot be the payment source for these services.

11.6. Utilization Management Committee

11.6.1. The UM program shall include a Utilization Management (UM) Committee that integrates with other functional units of the SMO as appropriate and supports the Quality Assessment and Performance Improvement (QAPI) Program (refer to the Quality Management subsection for details regarding the QAPI Program).

11.6.2. The UM Committee shall provide utilization review and monitoring of UM activities of both the SMO and its providers and is directed by the SMO Chief Medical Officer. The UM Committee shall convene no less than quarterly and shall submit the meeting agenda, sign-in sheets, handouts and presentations, and minutes to DHH-OBH within five (5) business days of each meeting. If minutes are not approved within five (5) business days after meeting, minutes must be submitted within five (5) business days of final approval or draft minutes will be submitted within two (2) weeks of meeting, whichever is sooner. UM Committee responsibilities include:

11.6.2.1. Monitoring providers' requests for prior authorizations;

11.6.2.2. Monitoring the medical appropriateness and necessity of services provided to its members utilizing provider quality and utilization profiling;

11.6.2.3. Reviewing the effectiveness of the utilization review process and making changes to the process as needed;

11.6.2.4. Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;

11.6.2.5. Monitoring consistent application of service authorization criteria to determine medical necessity;

11.6.2.6. Monitoring of the application of clinical practice guidelines;

11.6.2.7. Monitoring over- and under-utilization;

11.6.2.8. Review of outliers; and

11.6.2.9. Monitoring of Treatment Record Review (TRR) process.

11.7. Treatment Record Review Process

11.7.1. Treatment Record Reviews are reviews of member medical and treatment records shall be conducted to ensure that providers render high quality healthcare that is documented according to established standards.

11.7.1.1. The SMO shall maintain a written strategy for conducting treatment record reviews, reporting results and the corrective action process. The strategy shall be provided to DHH-OBH for approval within ninety (90) days from the date the contract is signed and approved by DOA/OCR and annually by contract year thereafter or upon changes to the process, selection or tools mentioned below. The strategy shall include, at a minimum, the following:

11.7.1.1.1. Designated staff to perform this duty;

11.7.1.1.2. The method of case selection;

11.7.1.1.3. The anticipated number of reviews by practice site;

11.7.1.1.4. A schedule of reviews by provider types by month;

11.7.1.1.5. The tool the SMO shall use to review each site;

11.7.1.1.6. A telephonic or face-to-face interview of a sampling of recipients within the treatment records selected for review for verification of benefits;

11.7.1.1.7. How the SMO shall link the information compiled during the review to other SMO functions (e.g., QI, credentialing, peer review);

11.7.1.1.8. The standards, which shall include all treatment record documentation requirements addressed in the contract, shall be distributed to all providers.

11.7.1.1.9. The SMO shall provide to DHH-OBH a quarterly summary report which provides aggregate data by provider types. Upon request by DHH-OBH, the SMO shall provide a report that details the TRR of a single provider and/or provider type. The report shall include a description of any deficiencies the providers have demonstrated. The SMO will provide detailed information regarding these deficiencies including findings, improvement actions taken,

and the effectiveness of said actions to DHH-OBH upon request.

11.7.2. The SMO shall conduct reviews at all provider sites with fifty (50) or more members encountered and practice sites which include both individual offices and large group facilities. The SMO shall review each site at least one (1) time during each two (2) year period.

11.7.3. The SMO shall review records at each site to determine compliance. The number of records reviewed will be established according to industry standards and approved by DHH-OBH within 30 days of the go-live date.

11.8. Utilization Management Reports

11.8.1. The SMO shall report the results of all treatment record reviews to DHH-OBH quarterly with an annual summary.

11.8.2. The SMO shall submit utilization management reports as specified by DHH-OBH. DHH reserves the right to request additional reports as deemed by DHH-OBH.

11.8.3. The SMO shall actively monitor and analyze utilization and cost data for covered behavioral health services, including by provider type. The SMO shall report complete and accurate utilization data to DHH-OBH in a manner and format prior approved by DHH-OBH.

11.9. Timing of Service Authorization Decisions

11.9.1. There shall be 24-hour, 7 days per week, 365 days per year capacity for service authorization by LMHP care managers.

11.9.2. Standard Service Authorization

11.9.2.1. As per 42 CFR §438.210(d), the SMO shall provide notice as expeditiously as the member's health condition requires and within state-established timeframes that may not exceed 14 calendar days following receipt of the request for service unless an extension is requested. As per the 1915(b) waiver and 42 CFR §438.206, the SMO shall ensure its providers meet established standards for timely access to care and services, taking into account the urgency of the need for services.

11.9.2.2. An extension may be granted for service authorization determination for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the SMO justifies to DHH-OBH a need for additional information and the extension for service authorization determination is in the member's best interest. In no instance shall any determination of standard service authorization be made later than twenty-eight (28) calendar days from receipt of the request.

11.9.2.3. The SMO shall make concurrent review determinations within one (1) business day of obtaining the appropriate medical information that may be required.

11.9.2.4. The SMO shall create a quarterly report on standard service authorizations and denials in a format to be approved by DHH-OBH. Changes in the frequency and format of this report shall be upon the approval and at the discretion of DHH-OBH.

11.9.3. Expedited Service Authorization

11.9.3.1. In the event a provider indicates, or the SMO 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 SMO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than three (3) calendar days after receipt of the request for service.

11.9.3.2. The SMO may extend the three (3) calendar day time period by up to fourteen (14) calendar days when there is serious jeopardy to the member's life or health and if the member or SMO justifies to DHH-OBH a need for additional information and how the extension is in the member's best interest.

11.9.3.3. The SMO shall include in the quarterly report (see Section 11.7.1.1.8) expedited service authorizations and denials in a format to be approved by DHH-OBH. Changes in the frequency and format of this report shall be upon approval and at the discretion of DHH-OBH.

11.9.4. Post Authorization

11.9.4.1. The SMO 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.

11.9.4.2. The SMO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission, or the provider misrepresented the member's health condition.

11.9.5. Timing of Notice

11.9.5.1. Notice of Action

11.9.5.1.1. The SMO shall provide draft letters to DHH-OBH for approval within thirty (30) days of DOA/OCR approval of the signed contract. The SMO shall comply with all state and federal requirements for notice of action notifications.

11.9.5.1.2. Approval

11.9.5.1.2.1. For service authorization approval for a routine or non-urgent admission, procedure, or service, the SMO

shall make the determination for approval as expeditiously as the member's health condition requires (14 days for routine) but shall notify the provider within 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.

11.9.5.1.2.2. For service authorization approval for extended stay or additional services, the SMO shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.

11.9.5.1.3. Authorization denial

11.9.5.1.3.1. The SMO shall notify the member in writing, using language that is easily understood at a fifth-grade reading level, of decisions and reasons to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 16 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404(a) and (c) and 42 CFR §438.210(b)(c)(d) and Section 15 of this RFP for member written materials. The notice shall contain information regarding the SMO's grievance and appeals process.

11.9.5.1.3.2. The SMO shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested within one (1) working day as per RS 22:1128.

11.9.5.2. Informal Reconsideration

11.9.5.2.1. As part of the SMO appeal procedures, the SMO should include an Informal Reconsideration process that allows the member (or a provider on behalf of the member or an 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.

11.9.5.2.2. The Informal Reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the SMO's staff who made the adverse determination or a clinical peer designated by the medical director if the person who made the adverse determination is not available.

11.9.5.2.3. The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.

11.9.5.3. Exceptions to Requirements

11.9.5.3.1. The SMO shall not require service authorization for emergency services.

11.9.5.3.2. The SMO shall not require service authorization or referral for EPSDT behavioral health screening services.

11.10. Medical History Information

11.10.1. The SMO is responsible for eliciting pertinent medical record information from the treating healthcare provider(s) as needed for purposes of making service authorization determinations based on medical necessity.

11.10.2. The SMO shall take appropriate action when a treating healthcare provider does not cooperate with providing complete medical history information within the requested timeframe.

11.10.3. Providers who do not provide requested medical information for purposes of making service authorization determinations for a particular item or service, shall not be entitled to payment for the provision of such item or service.

11.10.4. Should a provider fail or refuse to respond to the SMO's request for medical record information, at the SMO's discretion or directive by DHH-OBH, the SMO shall, at a minimum, impose financial penalties against the provider as appropriate.

11.11. Provider Utilization and Quality Profiling

11.11.1. The SMO shall profile all its providers, including but not limited to addiction, mental health, residential, etc., and analyze utilization data to identify provider utilization and/or quality of care issues. The state and LBHP consumers have a vested interest in having open access to efficiency and quality provider profiles. The CMS hierarchical condition categories risk adjustment model and standard Quality Indicator composites should be used to compare providers and provider organizations. This data shall be reported to DHH pursuant to La.R.S. 40:1300.111 through 1300.114.

11.11.2. The SMO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.

11.11.3. The SMO shall provide individual provider profiles or a comprehensive provider profile report upon request from DHH-OBH.

11.12. Provider Utilization & Quality Profile Reporting Requirements

11.12.1. The SMO shall submit provider profile reports to DHH-OBH quarterly. SMO provider profiling activities shall include, but are not limited to, the following:

11.12.1.1. Emergency department utilization – The SMO shall maintain a procedure to identify and evaluate member emergency department referral utilization;

11.12.1.2. Hospital admits, lab services and medications – The SMO shall maintain a procedure to identify and evaluate member's utilization; and

11.12.1.3. Individual provider clinical quality performance measures as established by the SMO.

11.12.2. The SMO shall submit profile reports quarterly with an Annual Summary to DHH-OBH. The SMO shall have the ability to report on individual provider profiles at the request of DHH-OBH. DHH-OBH reserves the right to request additional reports as deemed necessary.

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12.0 PROVIDER PAYMENTS

12.1. General Provisions

12.1.1. The SMO shall administer an effective, accurate and efficient claims processing function that adjudicates and settles provider claims for covered services that are filed within the time frames specified by this Section and in compliance with all applicable state and federal laws, rules and regulations.

12.1.2. The SMO shall submit deliverables in accordance with established timelines and shall submit required information for payment as described in the terms below.

12.1.3. The SMO shall train all contracted providers on provider payment topics, including, but not limited to, claims processing procedures, timelines, grievances and appeals, common claims denial issues, and claims system operations. Training shall occur prior to the first claims submission or within thirty (30) days following completed contract with the SMO, whichever is shorter.

12.2. Minimum Reimbursement to Contracted Providers

12.2.1. The SMO shall provide reimbursement for defined core benefits and services provided by a contracted provider. The SMO shall negotiate risk payments with providers, but no payment shall be less than the minimum Medicaid fee-for-service rate.

12.2.2. The SMO is responsible for monitoring changes made to state Medicaid rates and shall make changes to ensure rates comply with the minimum Medicaid rate.

12.3. Reimbursement to Non-Contracted Providers

12.3.1. The SMO shall make prompt payment for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the SMO for the provision of such services. The SMO 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 SMO to non-contracted providers for the provision of emergency services shall be no more than what would be paid under Medicaid FFS by DHH.

12.3.2. For services that do not meet the definition of emergency services, the SMO is not required to reimburse more than ninety percent (90%) of the published Medicaid FFS rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts (see Glossary) to include the provider in their network (except as noted in Section 10.1.16).

12.3.3. When the SMO is not able to deliver a medically necessary covered behavioral health service, the SMO shall timely enter an ad hoc subcontract with a provider to deliver the service. The SMO shall

expeditiously authorize services and reimburse the non-contracted provider in these circumstances.

12.4. FQHC Contracting and Reimbursement

12.4.1. The SMO shall attempt to contract with all FQHCs in the state that provide substance use or specialty mental health under state law and to the extent that the FQHCs meet the provider qualifications outlined in the Medicaid State Plan/waivers for those services. However, the SMO shall contract and reimburse no less than one FQHC providing these services in each Bayou Health geographical service area of the state (according to the practice patterns within the state). The SMO shall be exempted from this requirement if there is no FQHC providing these specialty behavioral health services in the designated area.

Note: 638 Tribal clinics providing basic behavioral healthcare (e.g., physician, APRN, or PA) are reimbursed through the Bayou Health or any eligible Indian Managed Care Entity (IMCE), using the prospective rate for any Bayou Health member. If there are any 638 clinics providing behavioral health, the SMO will be required to contract with and reimburse that clinic consistent with the SMDL #10-001 and allow any Indian to choose to receive covered services from an eligible and qualified behavioral health I/T/U provider, consistent with that guidance and any forthcoming regulations.

12.4.2. The SMO shall reimburse an FQHC the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.

12.4.3. The SMO may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical records information required to update the member's medical records.

12.4.4. The SMO shall inform members of these rights in the Member Handbook.

12.5. Effective Date of Eligibility for New Members

12.5.1. The SMO is not responsible for payment for core benefits and services prior to the effective date of a member's SMO eligibility.

12.5.2. Upon approval of a member's Medicaid application, the SMO may be required by DHH to reimburse the member or contracted provider for any out of pocket expenses incurred for the member's behavioral healthcare, as covered by Medicaid via a retroactive PMPM payment for the month during which the service was provided, for dates of service after the member's Medicaid application was submitted and in processing with DHH.

12.6. Claims Processing Requirements (Provider Payments)

12.6.1. A clean claim means 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 the state or SMO's claims system. It does not include a claim from a provider who is under

investigation for fraud and abuse or a claim under review for medical necessity.

12.6.2. All provider claims that are clean and payable must be paid according to the following schedule:

12.6.2.1. Ninety percent (90%) of all clean claims of each provider type must be paid within thirty (30) business days of the date of receipt (the date the SMO receives the claim as indicated by the date stamp on the claim.)

12.6.2.2. Ninety-nine percent (99%) of all clean claims of each provider type must be paid within forty-five (45) calendar days of the date of receipt.

12.6.2.3. The date of payment is the date of the check or other form of payment.

12.6.3. The SMO shall run one (1) provider payment cycle per week, on the same day each week, as determined by the SMO. The SMO and its subcontractors may, by mutual agreement, establish an alternative payment schedule.

12.6.4. The SMO shall support an Automated Clearinghouse (ACH) mechanism that allows Providers to request and receive electronic funds transfer (EFT) of claims payments.

12.6.5. The SMO 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), i.e., electronic claims. Electronic claims must be processed in adherence to information exchange and data management requirements specified in Section 19 of this RFP. As part of this Electronic Claims Management (ECM) function, the SMO shall also provide online and phone-based capabilities to obtain claims processing status information.

12.6.6. The SMO shall generate Explanation of Benefits (EOBs) and Remittance Advices (RAs) in accordance with DHH standards for formatting, content and timeliness. Claims included in the EOBs shall be paid prior to transmission of the associated EOB.

12.6.7. The SMO shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or MCHIP and 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 SMO shall not pay any claim submitted by a provider that is on payment hold under the authority of DHH or its authorized agent(s).

12.6.8. Not later than the fifteenth (15th) business day after the receipt of a provider claim that does not meet clean claim requirements, the SMO shall deny the claim and request in writing (notification via e-mail, the SMO website/provider portal or an interim explanation of benefits satisfies this requirement) all outstanding information such that the claim can be

deemed clean. After receipt of the requested information from the provider, the SMO must process the claim within fifteen (15) business days of the date of receipt of requested information (the date the SMO receives the claim as indicated by the date stamp on the claim).

12.6.9. Claims denied for additional information must be closed (paid or denied) by the thirtieth (30th) calendar day following the date the claim is denied if all requested information is not received prior to the expiration of the thirty (30)-day period. The SMO shall send providers written notice (notification via e-mail, the SMO website/provider portal or an explanation of benefits satisfies this requirement) for each claim that is denied, including the reason(s) for the denial and the date the SMO notified the provider to adjudicate the claim.

12.6.10. The SMO shall pay provider's interest at twelve percent (12%) per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the thirty (30)-day claims processing deadline. Interest owed the provider must be paid on the same date that the claim is adjudicated.

12.6.11. The SMO shall process all appealed claims to a paid or denied status within thirty (30) business days of receipt of the appealed claim.

12.6.12. The SMO shall adjudicate all claims, including appealed claims, within twenty-four (24) months of the date of service.

12.6.13. The SMO must deny any claim not initially submitted to the SMO within three hundred sixty five (365) calendar days from the date of service, unless the SMO or its vendors created the error. If a provider files erroneously with the SMO, another managed care organization, or with the Medicaid FI, but produces documentation verifying that the initial filing of the claim occurred within the three hundred sixty five (365) calendar day period, the SMO shall process the provider's claim without denying for failure to timely file.

12.6.14. The SMO shall deny payment for provider preventable conditions as defined by DHH (e.g., Healthcare-Acquired Conditions for any inpatient hospital settings in Medicaid).

12.6.15. The SMO shall inform all providers about the information required to submit a clean claim at least thirty (30) calendar days prior to the operational start date. The SMO shall make available to network providers claims coding and processing guidelines for the applicable provider type.

12.6.16. The SMO shall notify providers ninety (90) calendar days before implementing changes to claims coding and processing guidelines.

12.6.17. In addition to the specific website requirements outlined within this RFP, the SMO's website shall be fully capable of interfacing with the website maintained by the Medicaid FI.

12.6.18. For the purposes of SMO reporting on payments to providers, an adjustment to a paid claim shall not be counted as a claim. Electronic claims shall be treated as identical to paper-based claims.

12.7. Inappropriate Payment Denials

12.7.1. If the SMO has a pattern of inappropriately denying or delaying provider payments for services, the SMO may be subject to corrective action, penalties, 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).

12.8. Payment for Emergency Services and Post-stabilization Services

12.8.1. The SMO shall follow the provisions of Sections §7.11 and §7.15 of this RFP regarding payment for emergency and post-stabilization services.

12.8.2. Expenditures for the behavioral health services as previously described have been factored into the capitation rate described in Section 7 of this RFP and the SMO will not receive any additional payments.

12.9. Physician Incentive Plans

12.9.1. In accordance with 42 CFR §422.208 and §422.210, the SMO 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.

12.9.2. The SMO's incentive plans for its network providers/subcontractors shall be in compliance with 42 CFR §438.6(h), §422.208 and §422.210.

12.9.3. The SMO shall receive prior DHH-OBH approval of the Physician Incentive Plan and shall submit to DHH-OBH any contract templates that involve a Physician Incentive Plan for review as a material modification. The SMO shall disclose the following:

12.9.3.1. Services that are furnished by a physician/group that are covered by the incentive plan;

12.9.3.2. Whether services not furnished by the physician/group are covered by the incentive plan. No further disclosure is required if the physician incentive plan does not cover services not furnished by the physician/group.

12.9.3.3. Type of incentive arrangement, e.g., withhold, bonus, capitation;

12.9.3.4. Percent of withhold or bonus (if applicable);

12.9.3.5. Panel size, and if patients are pooled, the approved method used;

12.9.3.6. 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; and

12.9.3.7. Any information regarding incentives as may be required by DHH-OBH.

12.9.4. The SMO shall conduct periodic surveys of current members where substantial financial risk exists (in accordance with 42 CFR §422.208(h). A summary of the results must be provided to any beneficiary who requests it (42 CFR §422.210(b)).

12.9.5. The SMO shall provide information on its incentive plans to any Medicaid member upon request (this includes the right to adequate and timely information on the plan).

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13.0 PROVIDER SERVICES

13.1. Provider Relations

13.1.1. The SMO shall, at a minimum, provide a provider relations function to provide support and assistance to all providers in the LBHP network. The SMO shall:

13.1.1.1. Be available Monday through Friday from 7am to 7pm Central Time to address non-emergency provider issues and on a 24/7 basis for urgent or emergency/crisis prior authorization requests;

13.1.1.2. Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and

13.1.1.3. Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate, including provider training and technical assistance. Documentation of these visits will be provided to DHH-OBH upon request and shall include sign-in sheets, agendas, documented follow-up action items (as appropriate), and any distributed materials. Materials are subject to DHH-OBH approval upon request.

13.1.2. The SMO shall submit all provider informational materials and formal communications to DHH-OBH for written approval prior to distribution.

13.2. Provider Toll-free Telephone Line

13.2.1. The SMO must operate a toll-free telephone line to respond to provider questions, comments and inquiries. The toll-free number may be the same number members use to contact the SMO.

13.2.2. The provider access component of the toll-free telephone line must be staffed between the hours of 7am to 7pm Central Time Monday through Friday to respond to provider questions in all areas, including provider grievances and appeals and regarding provider responsibilities.

13.2.3. The SMO's call center system must have the capability to track provider call management metrics, including:

13.2.3.1. Average speed to answer –All calls (pooled) answered within an average of thirty (30) seconds. This is measured using monthly system-generated reports from first ring to live answer on 24/7 single point of entry 800 line.

13.2.3.2. Separate call tracking and record keeping shall be established for tracking and monitoring provider and member phone lines.

13.2.3.3. Nature of calls shall be tracked and reported.

13.2.3.4. Call abandonment rates should not exceed three percent (3%). Call abandonment rate is defined as the number of calls abandoned by callers after being placed in the Automated Call

Distribution (ACD) call queue and before being answered by a live customer service representative.

13.2.4. The SMO shall supply DHH-OBH, upon request, a call center report with outcomes in a format determined by DHH-OBH.

13.2.5. The toll-free number shall be submitted to DHH-OBH. The SMO shall:

13.2.5.1. Agree that once the toll-free number is established, DHH-OBH shall own the rights to the toll-free call center number. It is anticipated that this number will be transitioned from the incumbent SMO to a new SMO, or to the state, at the end of the contract term.

13.2.5.2. Ensure that the toll-free number shall be publicized throughout Louisiana and listed in the directory of all local telephone books. All publications shall be funded by the SMO.

13.2.6. After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment in Medicaid for any LBHP 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.

13.2.7. The SMO call center shall interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner, and respect the caller's privacy during all communications and calls. This measure shall be assessed on the provider satisfaction survey.

13.2.8. As part of its established grievance process, the SMO call center shall provide information on how to file a grievance or appeal, log all grievances given through the provider toll-free telephone line, assist as appropriate in the resolution of grievances, and notify the provider regarding the resolution. These activities shall be required for grievances for providers on behalf of members and for provider specific issues.

13.2.9. The SMO shall physically locate the call center in the state of Louisiana, with a primary site in Baton Rouge. After-hour call center services shall also be performed at a site physically located in Louisiana, with exceptions approved by DHH-OBH for after-hours call center services only.

13.2.10. The provider call center shall have a language line translation system for callers whose primary language is not English (to at least include Spanish and Vietnamese) and a TDD and/or relay system available. Both services shall be available 24/7/365.

13.2.11. The SMO shall provide periodic live monitoring of provider service calls for QM purposes upon request by DHH-OBH.

13.3. Provider Website

13.3.1. The SMO shall have a provider website. The provider website shall be a comprehensive, integrated, secure internet-based behavioral health information management system (IMS).

13.3.2. The SMO provider website shall include general and up-to-date information about the SMO as it relates to the Louisiana Behavioral Health Partnership. Any new materials posted on the website shall be approved by DHH-OBH. This shall include, but is not limited to:

13.3.2.1. LBHP provider manual;

13.3.2.2. SMO-relevant DHH-OBH, LBHP bulletins;

13.3.2.3. Information on upcoming provider trainings;

13.3.2.4. Information on the provider grievance and appeal system;

13.3.2.5. Information on obtaining prior authorization and referrals;

13.3.2.6. Information on how to contact SMO Provider Relations;

13.3.2.7. Information on all programs and services provided through the SMO within the LBHP; and

13.3.2.8. A list of all LBHP providers.

13.3.3. The SMO provider website shall also provide the ability for the following actions/activities:

13.3.3.1. Practice Management – providing e-tools for providers including scheduling, billing, and patient panels;

13.3.3.2. Clinical Health Records – the capture of protected health information to generate a HIPAA-compliant 837 file;

13.3.3.3. Care Management – an information system that allows internal/external case workers and external state contract monitors to manage the coordination of care across multiple levels of care and providers;

13.3.3.4. Claims Payment;

13.3.3.5. Interface with DHH-OBH and other child-serving agencies financing the LBHP (DCFS, LDOE, OJJ); and

13.3.3.6. Interface with the Louisiana Medicaid program (DHH-BHSF).

13.3.4. The SMO must keep eligibility data accurate based on the daily feed from the Medicaid Fiscal Intermediary. Failure to keep systems accurate and up to date shall make the SMO subject to remediation.

13.3.5. The provider website shall provide capacity for electronic data collection, analysis, transfer, and reporting of data at the member level (not just aggregate) and will provide the required data to the Medicaid

Management Information System (MMIS) for Medicaid claims processing, reporting, and auditing.

13.3.6. The provider website shall support claims processing and administration, membership management and services, provider network management (including provider profiling, outcomes, and quality of care information), care management, utilization management, and grievances and appeals.

13.3.7. The SMO shall use current state and federal standards and procedures (e.g., HL7, HIPAA, CMS, CPT, ICD-10, DSM-5) for this system and will maintain a uniform service and provider (credentials) taxonomy for billing and information management purposes.

13.3.8. The SMO shall provide online accessible methodology for providers to review and update staff rosters to include educational backgrounds and credentials. This update shall be made directly to a provider registry system or via batch transfer from other public-facing web-based systems.

13.3.9. The SMO shall provide technical assistance and consultation to providers on establishing the means for effective, ongoing electronic collection and transfer of required data.

13.3.10. The SMO shall be responsible for maintaining standardized data collection process and procedures and provide training and support all provider staff.

13.3.11. The SMO shall perform data quality management, in conjunction with DHH-OBH and the state agencies in order to demonstrate that the data are accurate, appropriate, complete, and timely reported across all program units.

13.3.12. The SMO shall maintain disaster recovery and business continuity of this system, as well as the provisions for the state to have continued access to and use of these data in the event of a separation of service with the contracted SMO.

13.3.13. The SMO provider website must be submitted to DHH-OBH for review within thirty (30) days after the signed contract is approved by DOA/OCR. The website must be approved in writing by DHH-OBH prior to 'going live'.

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

13.3.15. The SMO provider 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.

13.3.16. The SMO shall grant user-defined DHH-OBH access to the provider website. User access under this provision shall be determined by DHH-OBH.

13.4. Provider Handbook

13.4.1. The SMO shall develop and issue for DHH-OBH approval a provider handbook specific to the LBHP within thirty (30) days of the date the SMO signs the contract with DHH. The SMO may choose not to distribute the provider handbook via surface mail, provided the SMO submits a written, mailed notification and an email notification to all providers that explains how to obtain the provider handbook from the SMO's website. This notification shall also detail how the provider can request a hard copy from the SMO 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 LBHP covered services, SMO policies and procedures, state or federal statutes, regulations, telephone access and special requirements to ensure all provider requirements are met. At a minimum, the provider handbook shall include the following information:

13.4.1.1. Description of the SMO and LBHP;

13.4.1.2. LBHP services;

13.4.1.3. Emergency/Crisis service responsibilities;

13.4.1.4. Policies and procedures that cover the provider inquiries, grievances, and appeals system. This information shall include, but not be limited to, specific instructions regarding how to contact the SMO to file a provider grievance and which individual(s) has the authority to review a provider grievance;

13.4.1.5. Information about the SMO's Grievance System, that the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers (including the Provider Compliance Hotline) and the member's right to request continuation of services while utilizing the grievance system;

13.4.1.6. Service authorization criteria to make medical necessity determinations as defined by DHH-OBH and practice guidelines;

13.4.1.7. Information on accessing/using the SMO formulary and PDL;

13.4.1.8. Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

13.4.1.9. Provider rights and responsibilities;

13.4.1.10. Prior authorization and referral procedures;

13.4.1.11. Behavioral Health/Medical records standards;

13.4.1.12. Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim submissions and samples of clean and complete claims (troubleshooting tips, common reasons for claim denials, and other helpful information for submitting claims);

13.4.1.13. SMO prompt pay requirements (see Section 12: Provider Payments);

13.4.1.14. Notice that provider grievances regarding claims payment shall be sent to the SMO;

13.4.1.15. Quality performance requirements; and

13.4.1.16. Information on reporting suspicion of member fraud, waste or abuse.

13.4.2. The SMO shall disseminate bulletins as needed to incorporate any changes to the provider handbook.

13.5. Provider Education and Training

13.5.1. The SMO shall have a sufficient number of qualified staff and allocate sufficient financial resources to provide training to all service providers.

13.5.2. The SMO shall provide training to all providers and their staff regarding the requirements of the contract. The SMO shall conduct initial training within thirty (30) days after finalizing enrollment of a newly contracted provider, or provider group. The SMO shall also conduct ongoing training, as deemed necessary by the SMO or DHH-OBH, in order to ensure compliance with program standards and the contract. All training will be documented with agendas, written training materials, invited attendees, and sign-in sheets (including documentation of absent attendees). Training to be provided will include but not be limited to:

13.5.2.1. Cultural Competency;

13.5.2.2. Evidence-Based practices, promising practices, emerging best practices;

13.5.2.3. Billing and documentation requirements;

13.5.2.4. Utilizing the CANS and LOCUS assessment tools;

13.5.2.5. Use of SMO systems and website; and

13.5.2.6. Additional topics as determined through provider/member surveys and/or as directed by DHH-OBH.

13.5.3. The SMO will provide technical assistance and training for the CSoC providers inclusive of the WAAs, the FSO and other contracted providers. In order to provide adequate training and technical assistance to the WAAs and the FSO, the SMO is required to develop and demonstrate deep knowledge on system of care values and Wraparound Process.

13.5.4. The SMO shall ensure that providers are trained and/or meet training requirements in accordance with the Service Definitions Manual for the services contracted to be delivered including curriculum or equivalent standards, and DHH-OBH standard training.

13.5.5. The SMO shall develop within thirty (30) days of DOA/OCR approval of the signed contract, implement, and provide DHH-OBH 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.

13.5.6. The SMO shall submit a copy of any initial provider training materials and a training schedule to DHH-OBH for approval within thirty (30) calendar days after the date the signed contract is approved by DOA/OCR. Any changes to the materials or schedule shall be submitted to DHH-OBH for approval prior to the scheduled change and dissemination of such change.

13.5.7. The SMO shall provide thirty (30) days advance notice of all trainings to DHH-OBH, and DHH-OBH shall be permitted to attend any and all provider sessions. The SMO shall maintain and provide upon DHH-OBH request all provider training reports identifying training topics provided, dates, sign-in sheets, invited/attendees lists, and organizations trained.

13.5.8. The SMO shall submit all provider informational and training materials and presentations to DHH-OBH for written approval prior to distribution.

13.6. Provider Grievance and Appeal System

13.6.1. The SMO shall establish a Provider Grievance and Appeal System for providers to dispute the SMO's policies, procedures, or any aspect of the SMOs administrative functions. As part of the Provider Grievance and Appeal System, the SMO shall:

13.6.1.1. Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file provider grievances and appeals and resolve problems;

13.6.1.2. Identify a staff person specifically designated to receive and process provider grievances and appeals;

13.6.1.3. Thoroughly investigate each provider grievance and appeal using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the SMO's written policies and procedures;

13.6.1.4. Ensure that SMO executives with the authority to require corrective action are involved in the provider grievance and appeal process as necessary; and

13.6.1.5. Remain in compliance with all SPA and waiver grievance and appeal requirements and Section 16 of this RFP relative to grievance and appeals procedures.

13.6.2. The SMO shall distribute the SMO's policies and procedures to network providers at time of subcontract. The SMO 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 SMO's website. This summary shall also detail how

the provider can request a hard copy from the SMO at no charge to the provider.

13.6.3. The SMO shall maintain all of the above information and forms on its provider website to allow submittal of grievances and appeals electronically. In addition, the SMO shall provide providers with an address to submit grievances and appeals in writing and a phone number to submit grievances and appeals by telephone.

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14.0 ENROLLMENT

14.1. Specific SMO enrollment requirements:

14.1.1. Upon eligibility determination by Medicaid, all eligible Medicaid beneficiaries are automatically enrolled by the state into the SMO. The 1915(b) prepaid inpatient health plan (PIHP) mandates enrollment and selective services contracting with the SMO.

14.1.2. The SMO shall accept individuals in the order in which they are enrolled, without restriction.

14.1.3. The SMO shall not discriminate against SMO members on the basis of their health history, health status, need for healthcare services or adverse change in health status; or on the basis of age, race, color, national origin, religious belief, sex/gender, or sexual orientation.

14.1.4. The SMO shall not use any policy or practice that has the effect of discriminating on the basis of race, color, gender or national origin.

14.1.5. The SMO shall not request disenrollment of any member for any reason, including requests because of a change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

14.1.6. The SMO may not disenroll recipients for any reason. Eligible recipients may not disenroll from the SMO, but the state may disenroll Medicaid recipients whose eligibility changes to a Medicaid coverage group excluded from the SMO, or who otherwise lose Medicaid eligibility, consistent with the terms of this contract and the related waivers, and are not covered under one of the enrolled non-Medicaid coverage groups.

14.2. SMO Enrollment Procedures

14.2.1. Change in Status

14.2.1.1. The SMO shall agree to report in writing to DHH's Medicaid Customer Service Unit any changes in contact information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address if outside Louisiana, e-mail address, telephone number and insurance coverage.

14.2.2. Enrollment Updates

14.2.2.1. DHH Medicaid shall make available to the SMO weekly via electronic media (with nightly updates), updates on members enrolled in Medicaid in the format established between Medicaid and the SMO. The SMO shall have written policies and procedures for receiving these updates, incorporating them into its system, distinguishing which members are eligible for service provision through the SMO, and ensuring this information is available to their providers. Policies and procedures shall be available for review at the pre-implementation readiness review

and upon request by DHH-OBH. The file shall contain the names addresses, and phone numbers of all new members.

14.2.2.2. DHH will use its best efforts to ensure that the SMO receives accurate enrollment and disenrollment information. In the event of discrepancies or irresolvable differences between DHH and the SMO regarding enrollment, disenrollment and/or termination, DHH's decision is final.

14.2.3. Weekly Reconciliation

14.2.3.1. Enrollment

14.2.3.1.1. The SMO is responsible for weekly reconciliation of the membership list of enrollments and disenrollments received from the Medicaid program Office against its internal records. The SMO shall provide written notification to the Medicaid program Office and DHH-OBH Contract Monitor of any data inconsistencies within ten (10) calendar days of receipt of the data file.

14.2.3.2. Payment

14.2.3.2.1. The SMO will receive the monthly electronic file (as determined by DHH-BHSF) from the Medicaid Fiscal Intermediary (FI) and DHH-OBH, which lists all members for whom the SMO received a capitation payment and the amount received. The SMO is responsible for reconciling this listing against its internal records. It is the SMO's responsibility to notify the FI and DHH-OBH of any discrepancies within ten (10) calendar days. Lack of compliance with reconciliation requirements may result in the withholding of a portion of future monthly payments and/or remediation as defined in Section 22 of this RFP until requirements are met.

14.2.3.2.2. The SMO system must be configured to accept the data in the format established by the Medicaid FI.

14.2.3.2.3. The SMO will refund payments received from DHH for a deceased member's effective month of service that is after the month of death. DHH will recover the payment as specified in the contract from subsequent capitation payments.

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

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15.0 MEMBER EDUCATION AND COMMUNICATIONS

15.1. General Requirements

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

15.1.1.1. 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; and

15.1.1.2. Attend or organize activities that benefit the entire community such as health fairs or other health education and promotion activities. Notification to DHH-OBH must be made of the activity and details must be provided about the planned outreach activities at least ten (10) business days prior to any event.

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

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

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

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

15.1.6. All marketing and member education guidelines are applicable to the SMO, its agents, subcontractors, volunteers and/or providers.

15.1.7. The SMO is responsible for creation, production and distribution of its own marketing and member education materials to its members.

15.1.8. The SMO 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 members.

15.1.9. All postage for required written communication and notice to members shall be included in the contract price. No extra payment shall be made to the SMO for postage.

15.1.10. The SMO may be subject to remediation for marketing and member education violations as determined in Section 22 of this RFP.

15.1.11. The SMO shall include in all materials the following:

15.1.11.1. The date of issue;

15.1.11.2. The date of revision; and/or

15.1.11.3. If prior versions are obsolete.

15.1.12. The SMO and all subcontractors are subject to the marketing and member education requirements set forth in this RFP.

15.1.13. Neither the SMO nor any subcontractor is allowed to steer members to certain network providers. DHH retains the discretion to deny the use of marketing and member education material that it deems to promote undue patient steering.

15.2. Marketing and Education Materials Approval Process

15.2.1. The SMO must obtain prior written approval from DHH-OBH for all marketing, informational, and educational materials at least thirty (30) days prior to distribution. This includes, but is not limited to, print, television and radio advertisements; member handbooks, identification cards and provider directories; SMO website screen shots; promotional items; brochures; letters and mass mailings and e-mailings. Neither the SMO nor its subcontractors may distribute any SMO materials without DHH-OBH consent.

15.2.2. The SMO must also obtain prior written approval from DHH-OBH of all provider marketing and education materials prior to distribution.

15.3. Review Process for Materials

15.3.1. DHH-OBH will review the submitted marketing and member education materials and either approve, deny or submit changes;

15.3.2. Prior to modifying any approved member material, the SMO shall submit for written approval by DHH-OBH, a detailed description of the proposed modification, how it differs from the original approved material, and accompanied by a draft of the proposed modification;

15.3.3. DHH-OBH reserves the right to require the SMO to discontinue or modify any marketing or education materials after approval;

15.3.4. SMO materials used for the purpose of member education, except for the original SMO member education plan, are deemed approved if a

response from DHH-OBH is not returned within thirty (30) calendar days following receipt of materials by DHH-OBH; and

15.3.5. The SMO must review all marketing and member education materials on an annual basis and revise materials, if necessary, to reflect current practices. Any revisions must be approved by DHH-OBH prior to distribution.

15.4. Review Process for Events and Activities

15.4.1. DHH-OBH will review the submitted marketing and member education events and activities and either approve or deny within fourteen (14) business days from the date of submission.

15.4.2. DHH-OBH reserves the right to require the SMO to discontinue or modify any marketing or member education events after approval.

15.4.3. Any revisions to approved events and activities must be resubmitted for approved by DHH-OBH prior to the event or activity.

15.5. Member Education Plan

15.5.1. The SMO shall develop and implement a plan detailing the member education activities it will undertake and materials it will create during the contract period, incorporating DHH's requirements for participation in the LBHP. The detailed plan must be submitted to DHH-OBH for review within thirty (30) calendar days from the date the contract is signed and approved by DOA/OCR.

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

15.5.3. The SMO shall not begin member education activities prior to approval by DHH-OBH.

15.5.4. The SMO's shall take into consideration projected enrollment levels for equitable coverage of the state. Informational materials shall be distributed to its entire membership, unless otherwise approved by DHH-OBH. The plan shall include, but is not limited to:

15.5.4.1. Stated member education goals and strategies;

15.5.4.2. The SMO's plans for new member outreach, including welcome packets (see Section 15.9);

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

15.5.4.4. A member education calendar, which begins with the date the signed contract, between DHH and the SMO, is approved by DOA/OCR and runs through the first calendar year of providing services to members: website development, printed materials, material distribution plans (including specific locations), outreach activities (health fairs, area events, etc.);

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

15.5.4.6. How the SMO plans to meet the informational needs, relative to member education, for the physical and cultural diversity of the state. This may include, but is not limited to: a description of provisions for non-English speaking individuals, interpreter services, alternate communication mechanisms (such as sign language, Braille, audio tapes);

15.5.4.7. A list of all subcontractors engaged in marketing or member education activities for the SMO;

15.5.4.8. The SMO's plans to monitor and enforce compliance with all marketing and member education guidelines among internal staff and subcontractors; and

15.5.4.9. Copies of all marketing and member education materials (print and multimedia) the SMO or any of its subcontractor's plans to distribute that are directed at potential eligibles.

15.5.5. Any changes to the member education plan or included materials or activities must be submitted to DHH-OBH for approval at least thirty (30) days before contract go-live of the marketing or member education activity, unless the SMO can demonstrate just cause for an abbreviated timeframe.

15.6. Written Materials Guidelines

15.6.1. The SMO 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.):

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

15.6.1.1.1. Flesch – Kincaid;

15.6.1.1.2. Fry Readability Index;

15.6.1.1.3. PROSE The Readability Analyst (software developed by Educational Activities, Inc.);

15.6.1.1.4. Gunning FOG Index;

15.6.1.1.5. McLaughlin SMOG Index; or

15.6.1.1.6. Other computer generated readability indices accepted by DHH-OBH.

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

15.6.1.3. All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, unless otherwise approved by DHH-OBH.

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

15.6.1.5. 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.

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

15.7. SMO Website Guidelines

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

15.7.1.1. The SMO must notify DHH-OBH when the website, which has been prior approved by DHH-OBH, is in place and when approved updates are made.

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

15.7.1.3. The SMO 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 SMO website must follow all written materials guidelines included in this section.

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

15.7.1.5. Forms on which members may file grievances, appeals, feedback or recommendations to the SMO shall be available through the SMO, and must be provided upon request of the member. The SMO shall make all forms easily available on the SMO's website.

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

15.7.1.6.1. The most recent version of the member handbook;

15.7.1.6.2. Telephone and email contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number, with hours of operation;

15.7.1.6.3. A searchable list of network providers shall be updated in near real time, but at a minimum weekly, upon changes to the network;

15.7.1.6.4. The link to the DHH-OBH and CSoC websites;

15.7.1.6.5. The capability for members to submit questions and comments to the SMO and receive responses;

15.7.1.6.6. Member eligibility information;

15.7.1.6.7. Information on how to access behavioral health services;

15.7.1.6.8. Explanation of available services;

15.7.1.6.9. Crisis response information and toll-free crisis telephone numbers;

15.7.1.6.10. General customer service information;

15.7.1.6.11. Information on how to file grievances and appeals;

15.7.1.6.12. Updates on emergency situations that may impact the public, such as natural and human-caused disasters that would require time sensitive action by members, such as evacuation from their homes or communities or other preparedness-related activities. The website shall include hyperlinks to state and federal emergency preparedness websites;

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

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

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

15.7.1.6.16. Instructions on how to report suspected provider fraud and abuse; and

15.7.1.6.17. Any other documents as required by DHH-OBH.

15.8. Member Communication/Education Required Materials and Services

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

15.8.2. New Member Orientation

15.8.2.1. The SMO shall have written policies and procedures for the following, but not limited to:

15.8.2.1.1. Orienting new members to its benefits and services;

15.8.2.1.2. How to utilize services;

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

15.8.2.1.4. How to a file a grievance and appeal.

15.8.2.2. The SMO shall identify and educate members who access the system inappropriately and provide continuing education as needed.

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

15.8.3. Welcome Packets

15.8.3.1. The SMO must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two (2) or more new members, the SMO is only required to send one (1) welcome packet.

15.8.3.2. The SMO shall send a welcome packet, including the member handbook to new members within ten (10) business days from the date of receipt of the file from the Medicaid FI identifying the new member. During the phase-in implementation of the SMO contract, the SMO may have up to twenty-one (21) days to provide welcome packets.

15.8.3.3. The welcome packet shall include, but is not limited to:

15.8.3.3.1. A member handbook; and

15.8.3.3.2. A Provider Directory when specifically requested by the member (at least available in searchable format online).

15.8.3.4. The SMO shall adhere to the requirements for the member handbook and Provider Directory as specified in this RFP, its attachments/appendices, and in accordance with 42 CFR §438.10 (f)(6).

15.8.3.5. The SMO 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 will always be the 1st day of a month.

15.8.4. Additional Member Educational Materials and Programs

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

15.8.4.1.1. Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to providers and other information that is helpful to members;

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

15.8.4.1.3. Notification to its members of any change that DHH-OBH defines as significant at least thirty (30) calendar days before the intended effective date; and

15.8.4.1.4. All materials distributed must comply with the relevant guidelines established by DHH-OBH for these materials and/or programs.

15.9. SMO Member Handbook

15.9.1. The SMO shall develop and maintain a Member Handbook that adheres to the requirements in 42 CFR §438.10 (f)(6) and the written materials requirements listed in this section.

15.9.2. At a minimum, the Member Handbook shall include the following information:

15.9.2.1. Table of contents;

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

15.9.2.3. Member's right to change providers within the SMO (and how to);

15.9.2.4. The member's freedom of choice among SMO providers and any restrictions;

15.9.2.5. Member's rights and responsibilities, as specified in 42 CFR §438.100 and this RFP under the Member Bill of Rights (Section 15.14);

15.9.2.6. Information regarding the member call center and the Provider Compliance Hotline;

15.9.2.7. The amount, duration, and scope of benefits available to the member under the contract between the SMO and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled;

15.9.2.8. Procedures for obtaining benefits, including prior authorization requirements;

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

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

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

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

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

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

15.9.2.10.5. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the SMO; and

15.9.2.10.6. That, subject to the provisions of 42 CFR Part 438, which the SMO shall summarize in the member handbook, the member has a right to use any hospital or other setting for emergency care.

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

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

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

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

15.9.2.14.1. The right to file grievances and appeals;

15.9.2.14.2. The requirements and timeframes for filing a grievance or appeal;

15.9.2.14.3. The availability of assistance in the filing process;

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

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

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

15.9.2.14.5.2. 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.

15.9.2.14.5.3. In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of DHH who has final authority to determine whether services must be provided.

15.9.2.14.6. For State Fair Hearing:

15.9.2.14.6.1. The right to a hearing;

15.9.2.14.6.2. The method for obtaining a hearing; and

15.9.2.14.6.3. The rules that govern representation at the hearing.

15.9.2.15. A description of advance directives which shall include:

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

15.9.2.15.2. Information that members can file grievances about the failure to comply with an advance directive with the DHH Health Standards Section, Louisiana's Survey and Certification agency;

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

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

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

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

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

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

15.9.2.20. Information on contacting a Bayou Health Plan for primary healthcare needs;

15.9.2.21. 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;

15.9.2.22. For CSoC members, how to identify and contact the WAAs and the FSO;

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

15.9.2.24. Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

15.9.2.25. Instructions on how to request multi-lingual interpretation (oral) and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English, Spanish and Vietnamese;

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

15.9.2.27. Cost sharing, if any and upon approval by DHH, imposed on Medicaid enrollees shall be in accordance with 42 CFR §447.50 through 42 CFR §447.60, excluding categories pursuant to La.R.S. 42:447.56;

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

15.9.2.29. Any additional text provided to the SMO by DHH-OBH or deemed essential by the SMO;

15.9.2.30. The date of the last revision; and

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

15.9.2.31.1. Information on the structure and operation of the SMO;

15.9.2.31.2. Pharmacy location or medication information availability;

15.9.2.31.3. Physician incentive plans [42 CFR §438.6(h)]; and

15.9.2.31.4. Service utilization policies.

15.9.3. The SMO shall review the member handbook at least annually by contract year. The SMO shall distribute an updated version to each member or his/her family/caregiver, all LBHP partners, and others designated by DHH-OBH within forty-five (45) days of update approval by DHH-OBH. If there are no changes at the annual update, then the SMO shall notify members of the right to request information listed, at least once a year. If the SMO makes changes to the Member Handbook, at a time other than the annual update, the SMO shall distribute the revisions on a timely basis via regular U.S. Postal Service mail to each member or his/her family/caregiver. Documentation of the handbook's distribution shall be included in the care management record.

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

15.9.5. Unless otherwise instructed by DHH-OBH, the SMO shall distribute, in sufficient quantities, the member handbook to WAAs and other CSoC system partners at least thirty (30) days prior to contract go-live and when requested. The SMO shall also distribute the Member Handbook to high-volume providers, LGEs, and other providers, as designated by DHH-OBH, to assist with distributing materials to adult members.

15.10. Provider Directory for Members

15.10.1. The SMO shall develop and maintain a Provider Directory in three (3) formats:

15.10.1.1. A hard copy directory (abbreviated and comprehensive versions);

15.10.1.2. Web-based, searchable, online directory for members and the public; and

15.10.1.3. Electronic file.

15.10.2. DHH-OBH or its designee shall approve the file layout for the electronic directory provided by the SMO after approval of the contract. The SMO

shall submit templates of its provider directory to DHH-OBH within thirty (30) days from the date the contract is signed and approved by DOA/OCR.

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

15.10.4. In accordance with 42 CFR §438.10(f)(6), the Provider Directory shall include, but not be limited to:

15.10.4.1. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers, including identification of providers, specialists, and hospitals that are not accepting new patients;

15.10.4.2. Indication of populations served by the provider (e.g., age range of clients, OJJ and DCFS specializations);

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

15.10.4.4. 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).

15.11. Member Call Center

15.11.1. Member Service Representatives (MSRs) provide the single point of entry for all individuals that seek information about the SMO's services. This includes members or others calling on behalf of members. MSRs obtain demographic information and emergency contact information from members and their families/caretakers; gather insurance information, including Medicaid eligibility; and assist callers in accessing information on member rights and benefits, obtaining services, and filing grievances. The MSR determines the reason for the call and transfers the call to the appropriate party within the SMO's operations. For members seeking services or information related to their ISP, the MSR will transfer the call to a Care Manager for care coordination and referral to services.

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

15.11.3. The SMO's member services department shall operate as the common single point of entry for all children, adults, and their families/caregivers or legal guardians (including children and adults already receiving services) and perform the following functions:

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

15.11.3.1.1. Explanation of SMO policies and procedures;

15.11.3.1.2. Prior authorizations;

15.11.3.1.3. Access information;

15.11.3.1.4. Information on specialists;

15.11.3.1.5. Referrals to and/or placement instructions for participating specialists;

15.11.3.1.6. Resolution of service and/or service delivery problems; and

15.11.3.1.7. Member grievances and appeals.

15.11.3.2. Exceptions for after-hour call center location shall be approved by DHH-OBH; otherwise, it shall also be performed at a site physically located in Louisiana.

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

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

15.11.6. There shall be twenty-four (24) hour access to board certified physicians to provide clinical consultation, including a psychiatrist, addictionologist, and child psychiatrist. A licensed doctoral level child psychologist may provide clinical consultation when a child psychiatrist is unavailable, as long as a board-certified psychiatrist is also available.

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

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

15.11.9. The SMO must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and

compliance with standards. The SMO shall submit these telephone help line policies and procedures to DHH-OBH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The SMO call center must have the capability to produce an electronic record to document a synopsis of all calls.

15.11.10. The SMO 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 SMO shall submit call center quality criteria and protocols to DHH-OBH for review and approval annually. The SMO shall provide a member service approach that ensures working with all parties involved with the member to establish program eligibility. The SMO shall interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner. The SMO shall provide to DHH-OBH upon request copies of the member call center script and any screening, evaluation, and assessment tool used in coordinating any caller's care or needs.

15.11.11. The SMO shall work with individuals and their families/caregivers/guardians to obtain eligibility for other support services, including but not limited to those available from Medicaid and community organizations. For complex eligibility matters, members should be referred to the SMO's care management staff.

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

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

15.11.14. The SMO shall facilitate access to information on available service requirements and benefits.

15.11.15. The SMO shall be able to receive data/referrals from, integrate with, and transfer data to the Louisiana Balancing Incentives Program (BIP) vendor as directed by DHH-OBH. The BIP utilizes a No Wrong Door concept in which individuals can inquire about home and community-based services and receive comprehensive information, preliminary eligibility assessments, and referral services in a consistent manner at designated access points. The designated access points include the Single Point of Entry contractor for the Office of Aging and Adult Services, Local Governing Entities for the Office for Citizens with Developmental Disabilities, and the SMO for the Office of Behavioral Health. Individuals may complete the preliminary screen (Level I screen) online or by contacting one of the designated access points. See http://www.balancingincentiveprogram.org/ for more information.

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

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

15.11.18. Call abandonment rates should not exceed three percent (3%). Call abandonment rate is defined as the number of calls abandoned by callers after being placed in the Automated Call Distribution (ACD) call queue and before being answered by a live customer service representative.

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

15.11.20. The SMO shall have available, at all times, a Telecommunications Device for the Deaf (TDD) and/or relay systems.

15.11.21. DHH-OBH shall own the rights to the toll-free call center number. It is anticipated that this number will be transitioned from the incumbent SMO to a new SMO, or to the state, at the end of the contract term.

15.11.22. The SMO shall ensure the toll-free number shall be publicized throughout Louisiana and listed in the directory of all local telephone books. All costs of publication shall be paid by the SMO.

15.11.23. The SMO 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 SMO shall respect the caller's privacy during all communications and calls.

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

15.11.25. The SMO shall supply DHH-OBH, upon request, a call center report call management metrics in a format determined by DHH-OBH.

15.12. Automated Call Distribution (ACD) System

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

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

15.12.1.2. Transfer calls to other telephone lines;

15.12.1.3. Provide detailed analysis as required for the reporting requirements including but not limited to: the quantity, length and

types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred, hold time, abandonment rate, wait time, busy rate, response time, and call volume;

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

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

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

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

15.12.1.8. Measure the average hours of use per day;

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

15.12.1.10. Record calls to assess whether answered accurately;

15.12.1.11. Record average speed to answer – all calls (pooled) answered within an average of thirty (30) seconds. This is measured using monthly system-generated reports from first ring to live answer on 24/7 single point of entry 800 line;

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

15.12.1.13. Track and report on nature of calls;

15.12.1.14. Track and report on call abandonment rates, which should not exceed three percent (3%). Call abandonment rate is defined as the number of calls abandoned by callers after being placed in the Automated Call Distribution (ACD) call queue and before being answered by a live customer service representative;

15.12.1.15. 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;

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

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

15.12.2. The SMO must conduct ongoing quality assurance to ensure these standards are met.

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

15.13. Members' Rights and Responsibilities

15.13.1. Member Rights

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

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

15.13.1.1.2. The right to receive information as described in 42 CFR §438.10 and as outlined in the contract.

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

15.13.1.1.4. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

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

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

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

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

15.13.1.1.6.3. Assistance with care coordination.

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

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

15.13.1.1.9. The right of the member or his/her legal guardian to receive a copy of medical records, including, if the HIPAA Privacy Rule applies, the right to request that the records be amended or corrected as allowed in 45 CFR Part 164.

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

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

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

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

15.13.1.1.14. The right to be furnished behavioral healthcare services in accordance with 42 CFR §438.206 through §438.210.

15.13.1.1.15. Freedom to exercise the rights described herein without any adverse effect on the member's treatment by DHH, the SMO, or the SMO's subcontracts or providers.

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

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

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

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

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

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

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

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

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

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

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

15.13.2. Member Responsibilities

15.13.2.1. The SMO shall encourage each member to be responsible for his/her healthcare by becoming an informed and active participant in their care, including parents/caretakers/guardians for child and youth members. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their healthcare provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

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

15.13.2.3. The SMO members' responsibilities shall include but are not limited to:

15.13.2.3.1. Being familiar with SMO procedures to the best of the member's abilities;

15.13.2.3.2. Calling or contacting the SMO to obtain information and have questions answered;

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

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

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

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

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

15.13.2.3.8. Keeping 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.

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

15.14. Notice to Members of Provider Termination and Changes

15.14.1. Provider Contract Termination and Changes

15.14.1.1. When the SMO terminates a contract, provider agreement, or suspends or terminates referrals to a qualified service provider, the SMO shall deliver written recommendation of termination to and approval from DHH-OBH no later than seven (7) calendar days prior to the effective date of termination.

15.14.1.2. If a member has been receiving a prior authorized course of treatment, the SMO shall provide notice to the member or the parent/legal guardian as appropriate and the involved state agency when the treating provider becomes unavailable or is terminated. The written notice shall be provided to the member and DHH-OBH within seven (7) calendar days from the termination of the provider contract or from the date the SMO becomes aware of the unavailability of the provider, if it is prior to the change occurring.

15.14.1.3. A provider becomes unable to care for members for reasons including but not limited to an illness, if a provider dies, the

provider moves from the service area and fails to notify the SMO, or when a provider is displaced as a result of a natural or man-made disaster.

15.14.1.4. When the termination was initiated by the provider, the SMO shall make a good faith effort to give written notice of a provider's termination to each member who received care from or was seen on a regular basis by the provider.

15.15. Oral and Written Interpretation Services

15.15.1. In accordance with 42 CFR §438.10(c)(4) and (5), the SMO must make real-time oral and signing interpretation services (bilingual staff and licensed sign language interpreters to deliver oral interpretation, translation, sign language, disability-related services, provide auxiliary aids and alternative formats) available free of charge to each member and their family. This applies to all non-English languages not just those that Louisiana specifically requires in written translation (Spanish and Vietnamese). The member is not to be charged for interpretation services. The SMO must notify its members that oral and signing interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.

15.15.2. Member education materials shall be available in English, Spanish, and Vietnamese. In addition, the SMO shall ensure that translation services are provided for written member education materials and provided in any language that is spoken as a primary language by at least five percent (5%) of SMO members. DHH-BHSF will provide the SMO with a list of prevalent non-English languages spoken by members by parish. Written materials must also be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Within ninety (90) calendar days of notice from 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 SMO and use services appropriately.

15.15.3. The SMO must notify members, in writing, that alternative formats are available and how to access them.

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16.0 GRIEVANCE AND APPEALS PROCEDURES

16.1. General Requirements

16.1.1. The SMO must have a grievance system that complies with 42 CFR Part 438, Subpart F. The SMO shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws and Medicaid State Plan, 1915(i), 1915(b), and 1915(c) waiver .

16.1.2. The SMO's grievance and appeals procedures and any changes thereto must be approved in writing by DHH-OBH prior to implementation and must include at a minimum the requirements set forth in this RFP.

16.1.3. The SMO shall refer all SMO members who are dissatisfied with the SMO or its subcontractors in any respect to the SMO's staff authorized to review and respond to grievances and appeals and require corrective action.

16.1.4. The member or provider must exhaust the SMO's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.

16.1.5. The SMO shall not create barriers to timely due process. The SMO may be subject to remediation under Section 22 of this RFP if it is determined by DHH-OBH that the SMO has created barriers to timely due process, and/or, if ten percent (10%) or higher of grievance decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers include but are not limited to:

16.1.5.1. Labeling grievances as inquiries or complaints and funneled into an informal review;

16.1.5.2. Failing to inform members of their due process rights;

16.1.5.3. Failing to log and process grievances and appeals;

16.1.5.4. Failure to issue a proper notice including vague or illegible notices;

16.1.5.5. Failure to inform of continuation of benefits; and

16.1.5.6. Failure to inform of right to State Fair Hearing.

16.1.6. In addition to the member grievance and appeals process detailed in this section, the SMO shall have and implement written policies and procedures which detail the operation of the Provider Grievance and Appeal System. The SMO shall submit its Provider Grievance and Appeal System policies and procedures to DHH-OBH for review and approval within thirty (30) Calendar Days of the date the contract with DHH-OBH is signed and approved by DOA/OCR. The policies and procedures shall include, at a minimum:

16.1.6.1. Allowing providers thirty (30) days to file a written grievance and a description of how providers file grievance with the SMO and the resolution time;

16.1.6.2. A description of how and under what circumstances providers are advised that they may file a grievance with the SMO for issues that are SMO Provider Grievances;

16.1.6.3. A description of how provider relations staff are trained to distinguish between a provider grievance and a member grievance or appeal in which the provider is acting on the member's behalf;

16.1.6.4. A process to allow providers to consolidate grievances 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 grievance;

16.1.6.5. A process for thoroughly investigating each grievance using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation within the same timeframes established for member grievances and appeals as indicated in Section 16 of this RFP;

16.1.6.6. A description of the methods or process workflows used to ensure that SMO executive staff with the authority to require corrective action are involved in the grievance process, as necessary;

16.1.6.7. A process for giving providers (or their representatives) the opportunity to present their cases in person;

16.1.6.8. Identification of specific individuals who have authority to administer the provider grievance process;

16.1.6.9. A system to capture, track, and report the status and resolution of all provider grievances, including all associated documentation. This system must capture and track all provider grievances, whether received by telephone, in person, or in writing; and

16.1.6.10. A provision requiring the SMO to report the status of all provider grievances and their resolution to DHH-OBH on a monthly basis in the format required by DHH-OBH.

16.1.7. The SMO website must allow members and providers to initiate a grievance or appeal through the availability of optional forms to be submitted via the website or via and automated email submission built into the form.

16.1.8. The SMO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers and how to instruct a member or provider to file a grievance/appeal.

16.2. Applicable Definitions

16.2.1. Definition of Grievance

16.2.1.1. For purposes of this RFP, a grievance is defined as an expression of dissatisfaction about any matter other than an action, as “action” is defined below.

16.2.1.2. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

16.2.1.3. The term is also used to refer to the overall system that includes grievances and appeals handled at the SMO level.

16.2.2. Definition of Appeal

16.2.2.1. For purposes of this RFP an appeal is defined as a request for review of an action, as “action” is defined below.

16.2.3. Definition of Action

16.2.3.1. For purposes of this RFP an action is defined as:

16.2.3.1.1. The denial or limited authorization of a requested service, including the type or level of service; or

16.2.3.1.2. The reduction, suspension, or termination of a previously authorized service; or

16.2.3.1.3. The denial, in whole or in part, of payment for a service (e.g., denial of a claim);

16.2.3.1.4. The failure to provide services in a timely manner, as defined by Section 10.3 of this RFP; or

16.2.3.1.5. The failure of the SMO to act within the timeframes provided in Section 16 of this RFP.

16.2.4. Definition of Timely Filing

16.2.4.1. As used in this section, “timely'' filing means filing on or before the later of the following:

16.2.4.1.1. Within thirty (30) days of the SMO mailing the notice of action.

16.2.4.1.2. The intended effective date of the SMO's proposed action.

16.3. General Grievance System Requirements

16.3.1. Grievance System

16.3.1.1. The SMO must have a system in place for members that includes: a grievance process, an appeal process, and access to

the State Fair Hearing system, once the SMO's appeal process has been exhausted.

16.3.2. Filing Requirements

16.3.2.1. Authority to File

16.3.2.1.1. A member, or authorized representative acting on the member's behalf, may file a grievance and an SMO level appeal, and may request a State Fair Hearing, once the SMO's appeals process has been exhausted.

16.3.2.1.2. A network provider, acting on behalf of the member and with the member's written consent, may file a grievance. The provider may also file an SMO level appeal and may request a State Fair Hearing on behalf of a member with written consent, once the SMO's appeals process has been exhausted.

16.3.2.1.3. A provider may file an appeal of an action including, but not limited to, denied claims.

16.3.2.2. Time Limits for Filing

16.3.2.2.1. Within thirty (30) calendar days from the date on the SMO's notice of action or inaction, the member or a representative acting on their behalf must be allowed to file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.

16.3.2.2.2. The member, the member's representative, or the provider on the member's behalf with written consent, may file a grievance at any time.

16.3.2.3. Procedures for Filing

16.3.2.3.1. The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's written consent, may file a grievance either orally or in writing with the SMO.

16.3.2.3.2. The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's written consent, may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow the oral filing with a written, signed appeal request.

16.4. Notice of Grievance and Appeal Procedures

16.4.1. The SMO shall ensure that all SMO members and providers are informed of the SMO's grievance and appeal procedures and the State Fair Hearing process.

16.4.2. The SMO shall provide to each member a member handbook that shall include descriptions of the SMO's grievance and appeal procedures.

16.5. Grievance/Appeal/State Fair Hearing Records and Reports

16.5.1. The SMO must maintain records of all grievances and appeals and resolutions. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.

16.5.2. The SMO shall provide DHH-OBH with a monthly Grievance and Appeal and Fair Hearing Log Report in a format prior approved by DHH-OBH of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to:

16.5.2.1. The total number of grievances, appeals and State Fair Hearing Records held for the month broken out by members, providers filing on behalf of members, and providers;

16.5.2.2. The status and resolution of all claims disputes;

16.5.2.3. A listing of individual outstanding filed grievances and appeals with date of filing, description, current status, resolution, and resulting corrective action;

16.5.2.4. Notices of State Fair Hearing to be held within the next thirty (30) days;

16.5.2.5. Monthly number trends and types of grievances and appeals; and

16.5.2.6. The number of grievances and appeals in which the SMO did not meet timely disposition or resolution.

16.5.3. Reports with redacted personally identifying information will be made available for public inspection upon request.

16.6. Handling of Grievances and Appeals

16.6.1. General Requirements

16.6.1.1. In handling grievances and appeals, the SMO must meet the following requirements:

16.6.1.1.1. Acknowledge receipt of each grievance and appeal in writing. Send an acknowledgement letter via the U.S. Postal Service to the originator of the appeal or grievance within three (3) business days;

16.6.1.1.2. Give members or the member’s representative 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;

16.6.1.1.3. The SMO shall complete the investigation and final resolution process for grievances within thirty (30) calendar days or less (as per applicable waivers) of the date the grievance is received by the SMO and shall include a resolution letter to the grievant.

16.6.1.1.4. Ensure that the individuals who make decisions on grievances and appeals are individuals:

16.6.1.1.4.1. Who were not involved in any previous level of review or decision-making; and

16.6.1.1.4.2. Who, if deciding any of the following, are healthcare professionals who have the appropriate clinical expertise, as determined by DHH-OBH, in treating the member's condition or disease:

16.6.1.1.4.3. An appeal of a denial that is based on lack of medical necessity.

16.6.1.1.4.4. A grievance regarding denial of expedited resolution of an appeal.

16.6.1.1.4.5. A grievance or appeal that involves clinical issues.

16.7. Special Requirements for Appeals/Grievances

16.7.1. The process for appeals must:

16.7.1.1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing.

16.7.1.2. Provide the member or the member’s representative a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The SMO must inform the member of the limited time available for this in the case of expedited appeal).

16.7.1.3. 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. Members should be given reasonable assistance in reviewing and understanding the member’s case file, their medical records, and any other documents and records considered during the appeals process.

16.7.1.4. Include, as parties to the appeal:

16.7.1.4.1. The member and his or her representative; or

16.7.1.4.2. The legal representative of a deceased member's estate.

16.7.2. Special requirements for grievances involving quality of care (QOC) concerns

16.7.2.1. The SMO shall address quality of care concerns through the grievance process. This includes investigating, analyzing, tracking, trending, disposing, and reporting, including adherence to all relevant DHH-OBH, DCFS and OJJ critical incident reporting requirements and the following:

16.7.2.1.1. Conducting follow-up with the member, family/caregiver and custodial state agency (i.e., DCFS or OJJ) to determine the immediate behavioral healthcare needs are met, including follow up after discharge from inpatient levels of care within seventy-two (72) hours.

16.7.2.1.2. Referring grievances with quality of care issues to the SMO's peer review committee, when appropriate.

16.7.2.1.3. Referring or reporting the grievance quality of care issue(s) to the appropriate regulatory agency, child or adult protective services and DHH-OBH for further research, review, or action, when appropriate.

16.7.2.1.4. Notifying DHH-OBH and the appropriate regulatory or licensing board or agency when the affiliation of a qualified service provider is suspended or terminated due to quality of care concerns.

16.7.3. Failure to Make a Timely Decision

16.7.3.1. Appeals shall be resolved no later than the time frames specified in Section 16.8.6 and all parties shall be informed of the SMO's decision.

16.7.3.2. If a determination is not made in accordance with the timeframes specified in Section 16.8.6 of this RFP, the member's appeal will be deemed to have been approved as of the date upon which a final determination should have been made.

16.7.4. Right to State Fair Hearing

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

16.8. Notice of Action

16.8.1. Notice of Action is defined as written notification advising the beneficiary of the action and providing information on the beneficiary's right to appeal the decision. Notice of Action is required when the SMO takes any of the following actions:

16.8.1.1. Denies or gives limited authorization of a requested service, including the type or level of service;

16.8.1.2. Reduces, suspends, or terminates a previously authorized service;

16.8.1.3. Denies, in whole or in part, payment for a service;

16.8.1.4. Fails to provide services in a timely manner, as defined by Section 10.3 of this RFP; or

16.8.1.5. Fails to act within the timeframes provided in Section 16.8.6 of this RFP.

16.8.2. Language and Format Requirements

16.8.2.1. The notice must be in writing and must meet the language and format requirements of 42 CFR §438.10(c) and (d) and content requirements of Section 16.8.3 of this RFP to ensure ease of understanding. Specifically, the notice shall be translated and provided in the language spoken by the member with notice that translation services are available free of charge to the member if needed.

16.8.2.2. Notice of Action letters must be approved by DHH-OBH prior to use or changes.

16.8.3. Content of Notice of Action

16.8.3.1. The Notice of Action must explain the following:

16.8.3.1.1. The action the SMO has taken or intends to take;

16.8.3.1.2. The reasons for the action;

16.8.3.1.3. The member's or the provider's right to file an appeal with the SMO;

16.8.3.1.4. The member's right to request a State Fair Hearing, after the SMO's appeal process has been exhausted;

16.8.3.1.5. The procedures for exercising the rights specified in this section;

16.8.3.1.6. The circumstances under which expedited resolution is available and how to request it;

16.8.3.1.7. 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

16.8.3.1.8. Oral interpretation is available for all languages and how to access it.

16.8.4. Timing of Notice of Action

16.8.4.1. The SMO must mail the Notice of Action within the following timeframes:

16.8.4.1.1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except as permitted under 42 CFR §431.213 and §214.

16.8.4.1.2. For denial of payment, at the time of any action affecting the claim.

16.8.4.1.3. For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires (up to fourteen (14) calendar days for routine/urgent, 48 hours for urgent, and 1 hour for emergent) following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:

16.8.4.1.3.1. The member, the member's representative, or the provider acting on behalf of the member and with the member's written consent, requests an extension; or

16.8.4.1.3.2. The SMO justifies (to DHH-OBH upon request) a need for additional information and how the extension is in the member's interest.

16.8.4.2. If the SMO extends the timeframe in accordance with Section 16.8.7, it must:

16.8.4.2.1. 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

16.8.4.2.2. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

16.8.4.3. Untimely service authorizations constitute a denial and are thus adverse actions.

16.8.4.4. For expedited service authorization decisions where a provider indicates, or the SMO 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 SMO 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.

16.8.4.5. The SMO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the SMO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

16.8.5. Resolution and Notification

16.8.5.1. The SMO 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 16.8.6 below.

16.8.6. Specific Timeframes

16.8.6.1. Standard Disposition of Grievances

16.8.6.1.1. For standard disposition of a grievance and notice to the affected parties, the timeframe is established as thirty (30) calendar days or less (depending on applicable waivers) from the day the SMO receives the grievance.

16.8.6.2. Standard Resolution of Appeals

16.8.6.2.1. For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the SMO receives the appeal. This timeframe may be extended under Section 16.8.7 of this section.

16.8.6.3. Expedited Resolution of Appeals

16.8.6.3.1. For expedited resolution of an appeal and notice to affected parties, the timeframe is established as three (3) working days after the SMO receives the appeal. This timeframe may be extended under Section 16.8.7 of this section.

16.8.6.3.2. Process for Expedited Resolution

16.8.6.3.2.1. The SMO 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, the member's representative, or the provider acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing.

16.8.6.3.2.2. The SMO 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.

16.8.6.3.3. If the SMO denies a request for expedited resolution of an appeal, it must:

16.8.6.3.3.1. Transfer the appeal to the timeframe for standard resolution;

16.8.6.3.3.2. 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.

NOTE: The denial of a request for expedited resolution of an appeal does not constitute an Action and therefore does not require a Notice of Action.

16.8.6.4. Failure to Make a Timely Decision

16.8.6.4.1. Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the SMO's decision.

16.8.6.4.2. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

16.8.6.5. Authority to File Expedited Appeal

16.8.6.5.1. The Medicaid member, the member's representative, 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.

16.8.7. Extension of Timeframes

16.8.7.1. The SMO may extend the timeframes of this section by up to fourteen (14) calendar days if:

16.8.7.1.1. The member requests the extension; or

16.8.7.1.2. The SMO shows (to the satisfaction of DHH-OBH, upon its request) that there is need for additional information and how the delay is in the member's interest.

16.8.7.2. Requirements Following Timeframe Extension

16.8.7.2.1. If the SMO extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

16.8.8. Format of Notice of Disposition

16.8.8.1. Grievances

16.8.8.1.1. The SMO will provide written notice to the member of the disposition of a grievance via a letter to the originator of the grievance containing, at a minimum:

16.8.8.1.1.1. Sufficient detail to foster an understanding of the quality of care resolution, if grievance was a quality of care issue;

16.8.8.1.1.2. A description of how the member's behavioral healthcare needs will or have been met; and

16.8.8.1.1.3. A contact name and telephone number to call for assistance or to express any unresolved concerns.

16.8.8.2. Appeals

16.8.8.2.1. For all appeals, the SMO must provide written notice of appeal resolution to the member, the member's representative, and/or the authorized provider requesting on behalf of the member or the provider filing the appeal.

16.8.8.2.2. For notice of an expedited resolution, the SMO must also make reasonable efforts to provide oral notice to the member, the member's representative, and/or the authorized provider requesting on behalf of the member.

16.8.9. Content of Notice of Appeal Resolution

16.8.9.1. The written notice of the resolution must include the results of the resolution process and the date it was completed.

16.8.9.2. For appeals not resolved wholly in favor of the members, the written notice must include:

16.8.9.2.1. The right to request a State Fair Hearing, and how to do so;

16.8.9.2.2. The right to request to receive benefits while the hearing is pending, and how to make the request; and

16.8.9.2.3. That the member may be held liable for the cost of those benefits if the hearing decision upholds the SMO's action.

16.8.10. State Fair Hearings

16.8.10.1. DHH shall comply with the requirements of 42 CFR §431.200(b), §431.220(5) and 42 CFR §438.414 and §438.10(g)(1) and all other requirements as outlined in this RFP.

16.8.10.2. If the member has exhausted the SMO level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the SMO's notice of resolution.

16.8.10.3. The parties to the State Fair Hearing include the SMO as well as the member and his or her representative or the representative of a deceased member's estate.

16.9. Prohibition Against Punitive Action

16.9.1. The SMO shall not take punitive action against a provider acting on behalf of the member and with the member's written consent that requests an expedited resolution or supports a member's appeal.

16.10. Continuation of Benefits

16.10.1. Terminology. As used in this section, “timely'' filing means filing on or before the later of the following:

16.10.1.1. Within ten (10) days of the SMO mailing the notice of action;

16.10.1.2. By the intended effective date of the SMO’s proposed action, if less than thirty (30) days; or

16.10.1.3. Within thirty (30) days.

16.10.2. The SMO must continue the member's benefits if:

16.10.2.1. The member, the member’s representative, or the provider acting on behalf of the member and with the member's written consent, files the appeal timely;

16.10.2.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

16.10.2.3. The services were ordered by an authorized provider;

16.10.2.4. The original period covered by the original authorization has not expired; and

16.10.2.5. The member requests extension of benefits.

16.10.3. Duration of Continued or Reinstated Benefits

16.10.3.1. If, at the member's request, the SMO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

16.10.3.1.1. The member withdraws the appeal.

16.10.3.1.2. Ten (10) days pass after the SMO 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. Under such circumstances, benefits shall continue until a State Fair Hearing decision is reached.

16.10.3.1.3. A State Fair Hearing Officer issues a hearing decision adverse to the member.

16.10.3.1.4. The time period or service limits of a previously authorized service has been met.

16.10.4. Member Responsibility for Services Furnished While the Appeal is Pending

16.10.4.1. If the final resolution of the appeal is adverse to the member, that is, upholds the SMO's action, the SMO 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).

16.10.5. Services Not Furnished While the Appeal is Pending

16.10.5.1. If the SMO 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 SMO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.

16.10.6. Services Furnished While the Appeal is Pending

16.10.6.1. If the SMO 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 SMO must pay for those services, in accordance with this contract.

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17.0 QUALITY MANAGEMENT

17.1. Quality Assessment and Performance Improvement Program

17.1.1. The SMO shall maintain an internal quality assessment and performance improvement (QAPI) program for all covered services that complies with state and federal standards specified in 42 CFR §438.200, the Medicaid State Plan and waiver applications relative to the LBHP, and any other requirements as issued by DHH-OBH. The SMO shall:

17.1.1.1. Establish a QAPI program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria.

17.1.1.2. Recognize that the QAPI process shall be data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements and requiring re-measurement of effectiveness and continuing development and implementation of improvements as appropriate.

17.1.1.3. Have sufficient mechanisms in place to assess the quality and appropriateness of care furnished to members with special healthcare needs.

17.1.1.4. Collect data on race, ethnicity, primary language, gender, age, and geography (e.g., urban/rural).

17.1.1.5. Develop QAPI activities to improve health disparities identified through data collection.

17.1.1.6. Detect and address under-and-over utilization of services.

17.1.1.7. Verify members' receipt of services.

17.1.1.8. Monitor sub-contracted provider activities to ensure compliance with federal and state laws, regulations, waiver and Medicaid State Plan requirements, this RFP/contract, and all other quality management requirements.

17.1.1.9. Have a fidelity monitoring system in place to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained. 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. 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 SMO and approved by DHH-OBH, DCFS, and OJJ. These shall take into account the monitoring responsibilities and efforts of the state agencies.

17.1.1.10. Conduct peer review to assess quality of care.

17.1.1.11. Take appropriate action to address service delivery, provider, or other QAPI issues as they are identified.

17.1.1.12. Have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, subcontracts, members and their families/caregivers, and providers and use the feedback and recommendations to improve performance.

17.1.1.13. Disseminate information about findings and improvement actions taken and their effectiveness to DHH-OBH, the CSoC Governance Board, and other participating agencies, members and their families/caregivers, providers, committees, and other key stakeholders and post the information on the SMO's website in a timely manner.

17.1.1.14. Ensure that the ultimate responsibility for the QAPI is with the SMO and shall not be delegated to subcontractors.

17.1.1.15. Participate in the DHH-OBH Inter-Departmental Monitoring Team meetings and other quality improvement meetings as directed by DHH-OBH.

17.1.1.16. Participate in recurring business review meetings and present information to DHH representatives in a format approved or issued by DHH-OBH. The SMO shall submit materials to DHH-OBH at least three (3) business days prior to the scheduled meeting date.

17.1.1.17. Participate in the review of quality findings and take action as directed by DHH-OBH.

17.2. QAPI Committee

17.2.1. The SMO shall form a QAPI committee that shall, at a minimum include:

17.2.1.1. The SMO's Medical Director, who must serve as the chair or co-chair;

17.2.1.2. Appropriate SMO staff representing the various departments of the SMO organization; and

17.2.1.3. DHH representatives, designated by DHH-OBH, as non-voting members.

17.2.2. QAPI committee responsibilities shall include:

17.2.2.1. Meet on a quarterly basis;

17.2.2.2. Direct and review quality improvement activities;

17.2.2.3. Assure QAPI activities take place throughout the SMO;

17.2.2.4. Suggest new and/or improved quality improvement activities;

17.2.2.5. Direct task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;

17.2.2.6. Report findings to appropriate executive authority, staff, and departments within the SMO;

17.2.2.7. Direct and analyze periodic reviews of members' service utilization patterns;

17.2.2.8. Maintain minutes of all committee and sub-committee meetings and submit meeting minutes and agendas to DHH-OBH.

17.2.3. QAPI Work Plan and Evaluation

17.2.3.1. The QAPI committee shall develop and implement a written QAPI work plan, which must be submitted to DHH-OBH within thirty (30) days of DOA/OCR approval of the signed contract and thereafter at the beginning of each contract year. The QAPI work plan, at a minimum, shall:

17.2.3.1.1. Include immediate objectives for each contract year and long-term objectives for entire contract term, inclusive of detailed activities and associated timeframes.

17.2.3.1.2. Describe the methods for ensuring data collected and reported to DHH-OBH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.

17.2.3.1.3. Specify remediation actions that will be implemented when system performance is less than the required threshold.

17.2.3.1.4. Demonstrate that active processes are in place that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention's effectiveness.

17.2.3.1.5. Include a description of the SMO staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.

17.2.3.1.6. Describe how the SMO will obtain feedback from providers and members.

17.2.3.1.7. Describe how the SMO will collect data on race, ethnicity, gender, age, primary language, and geography and ensure said data is accurate.

17.2.3.1.8. 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.

17.2.3.1.9. Be exclusive to the LBHP and shall not contain documentation from other state Medicaid programs or product lines operated by the SMO.

17.2.3.2. The QAPI committee shall submit an annual QAPI written evaluation to DHH-OBH no more than three (3) months following the end of each contract year that includes, but is not limited to:

17.2.3.2.1. A description of the ongoing and completed QAPI activities;

17.2.3.2.2. Performance improvement project results;

17.2.3.2.3. Service utilization, including outliers, trends, and length of stay by service;

17.2.3.2.4. Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of care;

17.2.3.2.5. Development of future work plans based on incorporation of previous year findings of the overall effectiveness of the QAPI program; and

17.2.3.2.6. The following items, which shall all be individually reported according to demographic variables such as race, ethnicity, age, gender, and other demographics that have been identified as important to quality monitoring by the SMO and DHH-OBH:

17.2.3.2.6.1. Measures as outlined in *Appendix E: SMO Performance Measures* (see Procurment Library at http://new.dhh.louisiana.gov/index.cfm/page/1877) and their associated outcomes as applicable that are trended to assess performance over the reporting period in conjunction with analysis of what the trend indicates;

17.2.3.2.6.2. Satisfaction survey results;

17.2.3.2.6.3. Member compliance with medication administration and appointments, broken down by diagnosis.

17.2.3.2.6.4. Members served in each level of care, broken down by member population.

17.2.3.2.6.5. Planned and unplanned discharges.

17.2.3.2.6.6. Critical incidents, including runaways and elopements, by member population.

17.2.3.3. Quality Reporting Requirements

17.2.3.3.1. The SMO shall provide data reports, including ad-hoc reports, to DHH-OBH, DCFS, OJJ, and LDOE using the specifications and format approved by each respective agency to be submitted on agreed upon dates between the SMO and each respective agency.

17.2.3.3.2. All quantitative reports shall include a summary table that presents data over time including monthly, quarterly, and/or year-to-date summaries as directed by DHH-OBH.

17.2.3.3.3. Each report must include the sampling approach, data collection methods, and validation methods, as requested by DHH-OBH.

17.2.3.3.4. The SMO shall ensure performance data demonstrates adherence to clinical practice guidelines, as applicable.

17.2.3.3.5. The SMO shall stratify data reports as directed and requested by DHH-OBH.

17.2.3.3.6. DHH-OBH's requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of the contract. The SMO shall comply with all changes as requested by DHH-OBH. In particular, quality data is expected to be analyzed and reported by demographic variables including, but not limited to, race, ethnicity, age, gender, etc.

17.2.3.3.7. The SMO shall ensure tools and reports are flexible and adaptable to changes in the quality measurements required by DHH-OBH.

17.2.3.3.8. All reports shall identify the data source and the applicable systems utilized.

17.3. Performance Measures

17.3.1. Medicaid State Plan and Waiver Measures

17.3.1.1. The SMO shall collect data, perform data analysis, and report data for the performance measures identified in the Medicaid State Plan and waiver applications relative to the LBHP and in accordance with the specifications set forth within, as directed by DHH-OBH.

17.3.1.1.1. When system performance is less than 100% for any measure, the SMO shall provide a remediation report within 30 calendar days of the reporting period to DHH-OBH to include the remedial action taken, timeline for when remediation is effectuated, and responsible person/unit for addressing remedial activities.

17.3.1.1.2. The SMO shall report individual-level remediation actions taken for critical incidents involving substantiated abuse, neglect, and/or exploitation.

17.3.1.1.3. When system performance is less than 86% for any measure, the SMO shall conduct further analysis to determine the cause and complete a quality improvement project, subject to the review and approval of DHH-OBH. Each quality improvement project must measure the

impact to determine whether the project was effective. If the project is deemed not effective by DHH-OBH, the SMO shall employ other interventions to ensure the needs of members served are addressed and resolved in a systemic manner.

17.3.2. Incentive Based Measures

17.3.2.1. Healthcare Effectiveness Data Information Set (HEDIS)

17.3.2.1.1. The SMO shall calculate and submit specified HEDIS measures in accordance with NCQA HEDIS methods and technical specifications for the purpose of comparing the SMO's performance to national benchmarks.

17.3.2.1.1.1. Antidepressant Medication Management

17.3.2.1.1.2. Follow-Up After Hospitalization for Mental Illness

17.3.2.1.1.3. Initiation and Engagement of Alcohol and Other Drug Dependence

17.3.2.1.1.4. Follow-Up Care for Children Prescribed ADHD Medication

17.3.2.1.1.5. Adherence to Antipsychotic Medications for Individuals with Schizophrenia

17.3.2.1.2. The SMO shall fund an external audit of the HEDIS measures according to NCQA HEDIS protocols.

17.3.2.1.3. A failed audit that nullifies a required measure is considered non-compliant with this standard and may subject the SMO to penalties as referenced in Section 16.3.2.5.

17.3.2.2. The Joint Commission Measures

17.3.2.2.1. DHH-OBH or its designee shall calculate the following Joint Commission measures for the purpose of comparing the SMO's performance to benchmarks established by DHH-OBH.

17.3.2.2.1.1. Percent of patients who identified with alcohol or drug use disorder who received a prescription for an FDA approved medication for alcohol or drug use disorder or a referral for addictions treatment.

17.3.2.2.1.2. Percent of patients who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected.

17.3.2.3. The required measures shall be submitted to DHH-OBH, in a format defined by DHH-OBH, on June 30th of each contract year for the previous reporting contract year.

17.3.2.4. DHH-OBH will establish benchmarks for incentive based performance measures utilizing the prior year statewide data for the LBHP population. Minimum performance goals shall be established by DHH-OBH following the contract award date. Final determination of goals is at the sole discretion and approval of DHH-OBH.

17.3.2.5. Based on the SMO's performance measure outcomes, a penalty of $250,000 per measure will be withheld from payment or retainage, as determined by DHH-OBH, if performance measures fall below DHH-OBH's established benchmarks for improvement.

17.3.2.6. A corrective action plan will be required for performance measures that do not reach DHH-OBH's performance benchmark. The SMO must submit a corrective action plan (CAP) to DHH-OBH within thirty (30) calendar days of notification by DHH-OBH, incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. DHH-OBH must prior approve the CAP and will monitor the SMO's progress in correcting deficiencies.

17.3.3. Permanent Supportive Housing Measures

17.3.3.1. The SMO shall report the following PSH quality measures to DHH-OBH, in a DHH-OBH approved format and frequency, including but not limited to:

17.3.3.1.1. Number of referrals by eligibility type and type of housing;

17.3.3.1.2. Application data and timeliness of PSH referrals;

17.3.3.1.3. PSH network provider availability in comparison to level of need (e.g., PSH members, applications, and waiting list volume); and

17.3.3.1.4. PSH tenure, separations, costs of service, fidelity adherence, and positive outcomes.

17.3.3.2. DHH-OBH may add or remove performance measure reporting requirements with a thirty (30) day advance notice.

17.3.4. Quality Improvement Strategy (QIS) Measures

17.3.4.1. The SMO shall collect data, perform data analysis, and report data for the performance measures identified in the LBHP QIS prepared by DHH-OBH.

17.3.4.2. The SMO shall submit a corrective action plan within thirty (30) calendar days of notification by DHH-OBH, incorporating a timetable within which it will correct deficiencies identified when it fails to meet performance measure benchmarks set by DHH-

OBH. DHH-OBH must prior approve the CAP and will monitor the SMO's progress in correcting deficiencies.

17.4. Performance Improvement Projects

17.4.1. The SMO shall conduct Performance Improvement Projects (PIPs) that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.

17.4.2. The SMO shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for PIPs are documented.

17.4.3. The SMO shall provide a general and detailed description of each PIP to DHH-OBH within three (3) months of the contract go-live date and within three (3) months of the beginning of each contract year thereafter.

17.4.3.1. Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.

17.4.3.2. The SMO shall conduct at least two (2) PIPs during the first contract year, which include:

17.4.3.2.1. Coordination of Physical and Behavioral Health; and

17.4.3.2.2. Follow-Up After 24 Hour Admission for mental health and substance use.

17.4.3.3. PIPs for the second and third contract years will be determined jointly by DHH-OBH and the SMO and will not exceed four (4) PIPs during any contract year.

17.4.3.4. If CMS specifies Performance Improvement Projects, the SMO will participate and this will count toward the state-approved PIPs. In addition, if CMS identifies more than the contract required number of PIPs, the SMO shall comply.

17.4.3.5. The SMO shall submit PIP outcomes annually to DHH-OBH within three (3) months of the beginning of each contract year, including but not limited to:

17.4.3.5.1. Results with quantifiable measures;

17.4.3.5.2. Analysis with time period and the measures covered;

17.4.3.5.3. Analysis and identification of opportunities for improvement; and

17.4.3.5.4. An explanation of all interventions to be taken with associated anticipated timelines.

17.5. Quality Reporting

17.5.1. The SMO shall collect data and conduct data analysis with the goal of improving quality of care within the behavioral health system. The SMO's information system will support the QAPI process by collecting, analyzing, integrating, and reporting data necessary to DHH. All collected data shall be available to the state and upon request to CMS. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. The system shall also collect data on member and provider characteristics and on services furnished to members through an encounter data system and any other data as specified by the state. The system shall ensure that data received from providers is accurate and complete by:

17.5.1.1. Verifying the accuracy and timeliness of reported data.

17.5.1.2. Screening the data for completeness, logic, and consistency.

17.5.1.3. Collecting service information in standardized formats to the extent feasible and appropriate.

17.5.2. The SMO shall provide an integrated behavioral health quality and outcome measurement system for collection, analysis, and reporting of both aggregate and member-level data not collected and reported through the system described above. Quality reporting will be submitted in a consistent format as approved by DHH-OBH. This includes, but may not be limited to the requirements set forth in Section 19.9.6.

17.5.3. In addition to the care management record, the measurement data set forth in Section 19.9.6 shall be transmitted in member-level form to the DHH-OBH data warehouse.

17.6. Member Satisfaction Surveys

17.6.1. The SMO shall conduct an annual member survey that assesses member satisfaction with the quality, availability, and accessibility of care and experience with his/her providers and the SMO.

17.6.2. The survey shall provide a statistically valid sample of members who have at least three (3) months of continuous enrollment.

17.6.2.1. The survey tool and methodology must be approved by DHH-OBH prior to administration.

17.6.2.2. The survey results are due to DHH-OBH within three (3) months following the end of the contract year.

17.7. Provider Satisfaction Surveys

17.7.1. The SMO shall conduct an annual provider satisfaction survey that follows NCQA guidelines to the extent applicable and which assesses provider satisfaction with provider enrollment, communication, education, complaint processes and procedures, claims processing, claims reimbursement, and utilization management processes and procedures.

17.7.1.1. The survey tool and methodology must be submitted to DHH-OBH for approval prior to administration.

17.7.1.2. The survey results are due to DHH-OBH within three (3) months following the end of the contract year.

17.8. Quality Reviews

17.8.1. The SMO and its subcontractors shall fully cooperate in quality reviews conducted by DHH-OBH or its designee.

17.8.1.1. The SMO shall comply with external independent reviews of quality outcomes, timeliness of, and access to the services covered under this contract. The external review may include, but not be limited to all or any of the following: treatment record review, performance improvement projects and studies, surveys, calculation and audit of quality and utilization indicators, data analyses and review of individual cases.

17.8.1.1.1. The SMO shall make available records and other documentation and be fully responsible for obtaining records from subcontractors, as directed by DHH-OBH.

17.8.1.2. The SMO and its subcontractors shall cooperate with and participate, as required, in SAMHSA core reviews of services and programs funded through federal grants.

17.8.2. The SMO shall use quality review findings to improve the QAPI program and shall take action to address identified issues in a timely manner, as directed by DHH-OBH.

17.8.3. The standards by which the SMO will be surveyed and evaluated will be at the sole discretion and approval of DHH-OBH. If deficiencies are identified, the SMO must formulate a corrective action plan (CAP), within thirty (30) calendar days of notification by DHH-OBH, incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. DHH-OBH must prior approve the CAP and will monitor the SMO's progress in correcting deficiencies.

17.9. NCQA Accreditation

17.9.1. The SMO must be accredited by NCQA as a Health Plan or Managed Behavioral Healthcare Organization. If the SMO is not currently accredited, the SMO must attain NCQA accreditation as a Health Plan or Managed Behavioral Healthcare Organization within nine (9) months of the contract go-live date, unless otherwise approved by DHH-OBH.

17.9.1.1. The SMO's application for accreditation must be submitted at the earliest point allowed by the organization. The SMO must provide DHH-OBH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements, upon request from DHH-OBH.

17.9.1.2. 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 may result in remediation including termination of the contract.

17.9.1.3. The SMO shall submit its NCQA Accreditation Report immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA, to DHH-OBH.

17.10. Member Advisory Council

17.10.1. The SMO 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.

17.10.2. The Council is to be chaired by the SMO's Administrator/CEO/COO or designee as approved by DHH-OBH and will meet at least quarterly.

17.10.2.1. The SMO shall advise DHH-OBH at least ten (10) days in advance of meetings to be held.

17.10.2.2. Any cancellations of quarterly meetings shall be reported to DHH-OBH with reason for meeting cancellation.

17.10.3. The SMO shall include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.

17.10.4. The SMO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.

17.10.5. The SMO 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 the date the signed contract is approved by DOA/OCR and annually thereafter by contract year. Each subsequent annual report shall also include a summary of previous years' activities.

17.10.6. The SMO shall include DHH-OBH in all official correspondence to the Council. Additionally, all agenda and Council minutes shall be posted to the SMO's website.

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18.0 PROGRAM INTEGRITY

18.1. Fraud, Abuse, and Waste Prevention

18.1.1. General Requirements

18.1.1.1. The SMO shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste and DHH established policies and procedures.

18.1.1.2. The SMO shall develop and maintain internal controls to prevent and detect fraud.

18.1.1.3. The SMO shall require that all providers and all subcontractors take such actions as are necessary to permit the SMO to comply with Program Integrity, Fraud, Abuse, and Waste Prevention requirements listed in this contract. To the extent that the SMO delegates oversight responsibilities to a third party, the SMO shall require that such third party complies with provisions of this contract relating to Fraud, Abuse, and Waste Prevention. Although all providers with whom the SMO subcontractors are enrolled in the program and subject to regulations, the SMO agrees to require, via contract, that such providers comply with regulations and any enforcement actions directly initiated by DHH-OBH under its regulations, including but not limited to termination and restitution. The SMO shall require program integrity disclosure on provider enrollment forms as mandated by DHH.

18.1.1.4. The SMO shall meet with DHH and the Medicaid Fraud Control Unit (MFCU) at least quarterly, or more frequently upon DHH request, to discuss program integrity issues, fraud, abuse, neglect and overpayment issues and receive fraud and abuse prevention detection training.

18.1.1.5. For purposes of this section, the SMO's compliance officer shall be the point of contact for the SMO.

18.1.1.6. In accordance with 42 CFR §438.608(b)(2), the SMO shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the SMO's board of directors and shall answer directly to the Chief Executive Officer or to the board of directors and senior management.

18.1.1.7. The SMO shall have a sufficient number of qualified staff and accounting personnel to develop and maintain an internal controls system that adequately safeguards resources, promotes the effectiveness and efficiency of operations, and assures the reliability of financial reporting and compliance with applicable laws and regulations to account for all revenue sources and expenses associated with those revenue sources separately.

18.1.1.8. The SMO shall confirm that its officers understand this contract involves the receipt by the SMO of state and federal funds. Further, the SMO's officers understand that they are subject to criminal prosecution, civil action, or administrative actions for any intentional false statements or other fraudulent conduct related to their obligations under this contract.

18.1.1.9. The SMO shall maintain a self-balancing set of records in accordance with Generally Accepted Accounting Procedures. The SMO agrees to maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of SMO invoices. Such documents, including all original claim forms, shall be maintained and retained by the SMO for a period of six (6) years after the contract expiration date or until the resolution of all litigation, claims, financial management reviews or audits pertaining to the contract, whichever is longer.

18.1.1.10. The SMO shall not have restrictions on the right of the state and federal government to conduct inspections and audits as deemed necessary to assure quality, accuracy, appropriateness or timeliness of services and the reasonableness of their costs. DHH-OBH may inspect and audit any financial records of the entity or its subcontracts. Upon reasonable notice (as defined by DHH-OBH based upon the request), the SMO shall provide the officials and entities identified in this section on Program Integrity with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the scope of work. The SMO shall provide access described in this section upon DHH-OBH request for the purposes of examination, audit, investigation, contract administration; making of copies, excerpts, or transcripts or any other purposes as deemed necessary by DHH-OBH. The SMO agrees to provide the access described within the state regardless of where the SMO maintains such books, records, and supporting documentation. The SMO further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this section. The SMO shall require its contractors to provide comparable access and accommodations.

18.1.1.11. The SMO and its employees shall cooperate fully and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. Such cooperation shall include providing access to all necessary case information, computer files, and appropriate staff. In addition, such cooperation may include participating in periodic fraud and abuse training sessions, meetings, and joint reviews of subcontracted providers or members. At any time during normal business hours, the United States Department of Health and Human Services; the Office of Inspector General; the Louisiana

Legislative Auditor; the Office of the Attorney General; the General Accounting Office (GAO); the Comptroller General of the United States; a local, state or federal law enforcement agency; a special or general investigating committee of the Louisiana Legislature; DHH-OBH; any independent verification and validation contractor or quality assurance contractor acting on behalf of DHH-OBH; and/or any of the designees of the above, and as often as they may deem necessary during the contract period and for a period of six (6) years from the expiration date of the contract (including any extensions to the contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the contract and any other applicable rules.

18.1.1.12. The SMO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. 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 conducting audits, examinations, excerpts and transcriptions, contact and conduct private interviews with SMO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The SMO 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.

18.1.1.13. The SMO shall provide DHH-OBH and its designees, which may include auditors and inspectors, with access to SMO service locations, facilities, or installations; and software including any and all files produced by this software and equipment. Access described in this section shall be for the purpose of examining, auditing, or investigating:

18.1.1.13.1. Capacity to bear the risk of potential financial losses.

18.1.1.13.2. Services and deliverables provided.

18.1.1.13.3. Determination of the amounts payable under the contract.

18.1.1.14. If, as a result of an audit or review of payments made to the SMO, DHH-OBH and its designees discover a payment error or overcharge, DHH-OBH and its designees shall notify the SMO of such error or overcharge. DHH-OBH and its designees shall be entitled to recover such funds as an offset to future payments to the SMO, or to collect such funds directly from the SMO. The SMO shall return funds owed to DHH-OBH within thirty (30) days

after receiving notice of the error or overcharge, or interest may accrue on the amount due beginning on the 31st day after notice. DHH-OBH and its designees shall calculate interest at the Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which liability is assessed. In the event that an audit reveals that errors in reporting by the SMO have resulted in errors in payments to the SMO, the SMO shall indemnify DHH-OBH for any losses resulting from such errors, including the cost of audit.

18.1.1.15. The SMO understands that the State Legislative Auditor, Office of the Governor, Division of Administration and DHH Auditors of those designated by DHH shall have the option of auditing all accounts pertaining to this contract during the contract and for a six (6) year period following final payment. The SMO grants to the state, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, federal government and/or other such officially designated by the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours. The SMO shall ensure that this clause concerning the authority to audit funds received indirectly by the SMO through the SMO and the requirement to cooperate is included in any contract it awards, and in any third party agreements.

18.1.1.16. The SMO shall ensure compliance with and/or outline corrective action plans (CAP) for any finding of noncompliance based on law, regulation, audit requirement, or generally accepted accounting principles or any other deficiency contained in any audit, review, or inspection conducted. This action shall include the SMO's delivery to DHH-OBH, for approval, a corrective action plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) shall be submitted within thirty (30) calendar days of the close and final report of the audit(s), review(s), or inspection(s). Upon receipt and review of the submitted CAP, DHH-OBH will notify the SMO that its CAPs are accepted, rejected, or require modification of any portion found to be unacceptable. The SMO shall bear the expense of compliance with any finding of noncompliance under this contract.

18.1.1.17. Upon DHH-OBH request, the SMO shall provide a copy of those portions of the SMO's and its contractors' internal audit reports relating to the services and deliverables provided to DHH-OBH under the contract.

18.1.1.18. The SMO's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

18.1.1.19. The SMO shall provide access to DHH and/or its designee to all information related to grievances and appeals filed by its members. The SMO shall ensure proper implementation of grievance procedures, in compliance with 42 CFR §438.228.

18.1.1.20. The SMO shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The SMO 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.

18.1.1.21. DHH-OBH will seek all appropriate remedies for fraud, abuse and violation of law if it determines that a SMO, provider, employee, or subcontract has committed "Fraud" or "Abuse" as defined in this Agreement or has otherwise violated applicable law.

18.1.2. Fraud and Abuse Compliance Plan

18.1.2.1. In accordance with 42 CFR §438.608(a), the SMO shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.

18.1.2.2. The SMO shall submit the written Fraud and Abuse Compliance Plan within thirty (30) days from the date the contract is signed and approved by DOA/OCR and annually thereafter by contract year. The SMO shall submit requests for revision(s) to the Plan in writing to DHH-OBH for approval at least thirty (30) days prior to Plan implementation of such revision(s). DHH-OBH, at its sole discretion, may require that the SMO modify its compliance plan. The Fraud and Abuse Compliance Plan shall include the following:

18.1.2.2.1. Written policies, procedures, and standards of conduct that articulate the SMO's commitment to comply with all applicable federal and state standards;

18.1.2.2.2. Procedures for ongoing monitoring and auditing of the SMO's systems, including, but not limited to, claims processing, encounters, billing and financial operations, member services, continuous quality improvement activities, and provider activities;

18.1.2.2.3. A description of the methodology and standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;

18.1.2.2.4. The SMO shall have administrative and management policies and procedures that are designed to prevent,

reduce, detect, correct and report known or suspected fraud, abuse, and waste both with the SMO's key staff and with subcontracted providers and in accordance with the requirements specified in this contract. These written policies, procedures, and standards of conduct that articulates the SMO's commitment to comply with all applicable federal and state standards and regulations shall include the following:

18.1.2.2.4.1. Enforcement of standards through well-publicized disciplinary guidelines (e.g., member/provider manuals, trainings, newsletters, bulletins);

18.1.2.2.4.2. Provisions for internal monitoring and auditing of the SMO's providers, subcontractors, employees, and others;

18.1.2.2.4.3. Provisions for prompt response to detected offenses and for development of corrective action initiatives relating to this contract;

18.1.2.2.4.4. Procedures for timely and consistent exchange of information and collaboration with DHH Program Integrity, DHH-OBH, the Louisiana Attorney General, Medicaid Fraud Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if appropriate, regarding suspected fraud and abuse occurrences;

18.1.2.2.4.5. The SMO shall establish a policy and procedures for referral of suspected Fraud and Abuse to the DHH Program Integrity Office and DHH-OBH. A standardized referral process will be developed to expedite information for appropriate disposition.

18.1.2.2.4.6. The SMO's Fraud and Abuse policies and procedures shall provide and certify that the SMO's Fraud and Abuse unit has access to records of providers. These policies along with the designation of the Compliance Officer and committee shall be submitted to DHH-OBH for approval thirty (30) days prior to contract go-live and then thirty (30) days prior to whenever changes occur. The SMO's submission of new or revised policies and procedures for review and approval by DHH-OBH shall not act to void any existing policies and procedures which have been prior approved by DHH-OBH for operation. Unless otherwise required by law, the SMO may continue to operate under such existing policies and procedures until such time as DHH-OBH approves the new or revised version thereof. The SMO shall develop an approval process that demonstrates the policies and procedures were reviewed and approved by the SMO's senior management. The SMO shall, in order

to remain in compliance with the Agreement, comply with its Fraud and Abuse policies and procedures;

18.1.2.2.4.7. Comply with LAC 50:I.Chapter 41 relative to the Surveillance and Utilization Review Subsystem (SURS);

18.1.2.2.4.8. The SMO shall create and disseminate written materials for the purpose of educating employees, managers, providers, subcontractors and subcontractors' employees about healthcare fraud laws, the SMO's policies and procedures for preventing and detecting Fraud and Abuse and the rights of employees to act and be protected as whistleblowers. The SMO's education materials shall comply with all requirements of §1902(a)(68) of the Social Security Act regarding Employee Education About False Claims Recovery. This information shall also be contained in any employee handbook;

18.1.2.2.4.9. The SMO shall establish written policies for all employees (including management), and of any subcontractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section §1902(a)(68)(A) of the Social Security Act and the Louisiana Medical Assistance Program Integrity Law (MAPIL). Adherence to the False Claims Act ("FCA") which, in pertinent part, imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false in order to obtain payment from the government, or fraudulently retains government funds (31 U.S.C. §3729 through §3733); and

18.1.2.2.4.10. Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' *Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks*) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

18.1.2.2.5. A procedure for conducting explanation of benefits as outlined in Section 20.3 of this RFP;

18.1.2.2.6. A description of specific controls in place for fraud and abuse detection, including an explanation of the technology used to identify aberrant billing patterns, claims edits, post processing review of claims, and record reviews;

18.1.2.2.7. A Fraud and Abuse Unit within the organization comprised of experienced fraud and abuse reviewers. This unit shall have the primary purpose of preventing, detecting, investigating, and reporting suspected fraud and abuse that may be committed by network providers, members, employees, or other third parties with whom the SMO contracts;

18.1.2.2.8. Description of effective training and education for the Compliance Officer, the organization's employees, SMO providers and members to ensure that they know and understand the provisions of the Fraud and Abuse Compliance Plan and know about fraud and abuse and how to report it;

18.1.2.2.9. Demonstration of effective lines of communication between the Compliance Officer and the SMO's employees, providers and DHH-OBH and/or its designee;

18.1.2.2.10. A toll-free Provider Compliance Hotline phone number for members and providers to report suspected fraud and/or abuse. This hotline shall be separate from the SMO's toll-free member and provider toll-free phone number(s). The Provider Compliance Hotline may utilize an interactive voice response (IVR) system with options that are user-friendly to callers and include a decision tree illustrating IVR system and expected duration times of navigating the IVR system to reach a live person. The issues reported through the Provider Compliance Hotline, corrective actions taken, and final results must be reported annually to DHH-OBH in the Fraud and Abuse Compliance Plan, or more frequently upon request of DHH-OBH. The SMO's toll-free Provider Compliance Hotline number and accompanying explanatory statement shall be distributed to its members and providers through its Member and Provider Handbooks; and

18.1.2.2.11. Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the SMO. The SMO 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 the Louisiana Medicaid Office of Program Integrity and/or the U.S. Office of Inspector General.

18.2. SMO Prohibited Affiliations

18.2.1. As required in 42 CFR §455.104(a), the SMO shall provide DHH-OBH 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 SMO, or any subcontractor in which the SMO has 5% or more ownership interest. The SMO shall also provide such required information including, but not limited to financial statements, for each person or entity with ownership or controlling interest of five percent or greater (5%+) in the SMO and any of its subcontractors, including all entities owned or controlled by a parent organization. This information shall be provided to DHH-OBH on the DHH-OBH approved SMO Disclosure Form within thirty (30) days of DOA/OCR approval of the signed contract and whenever changes in ownership occur.

18.2.2. In accordance with 42 CFR §438.610, the SMO is prohibited from knowingly having an employment or contractual relationship with:

18.2.2.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The SMO shall comply with all applicable provisions of 42 CFR §376 (2009, as amended), pertaining to debarment and/or suspension. The SMO shall screen all employees to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal healthcare programs. To help make this determination, the SMO shall conduct screenings to comply with the requirements set forth at 42 CFR 455.436 and search at minimum the following sites:

18.2.2.1.1. Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://exclusions.oig.hhs.gov/search.aspx;

18.2.2.1.2. Louisiana Exclusion Database (LED);

18.2.2.1.3. The System of Award Management (SAM); and

18.2.2.1.4. Other applicable sites as may be determined by DHH.

18.2.2.2. The SMO shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. An attestation certifying checks are completed on a monthly basis by

the 15th of each month is required. See Section 1128A(a)(6) of the Social Security Act and 42 CFR §1003.102(a)(2).

18.2.2.3. An individual who is an affiliate of a person described in Section 18.2.2.1 which includes:

18.2.2.3.1. A director, officer, or partner of the SMO;

18.2.2.3.2. A person with beneficial ownership of five percent (5%) or more of the SMO's equity; or

18.2.2.3.3. A person with an employment, consulting or other arrangement with the SMO for the provision of items and services which are significant and material to the SMO's obligations.

18.2.2.4. The SMO shall notify DHH within three (3) days of the time it receives notice that action is being taken against the SMO or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) which could result in exclusion, debarment, or suspension of the SMO from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

18.2.3. Certification regarding debarment, suspension, ineligibility and voluntary exclusion - lower tier covered transactions

18.2.3.1. The SMO certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

18.2.3.2. Where the SMO is unable to certify to any of the statements in this certification, such SMO shall attach an explanation to this proposal.

18.3. Criminal Background Checks and Information on Persons Convicted of Crimes

18.3.1. The SMO 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. The SMO 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.

18.3.2. The SMO must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal healthcare programs. The HHS-OIG website, which can be searched by

the names of any individual, can be accessed at the following url: http://www.oig.hhs.gov/fraud/exclusions.asp.

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

18.4. Termination for Ownership Violations

18.4.1. The SMO is subject to termination, unless the SMO can demonstrate changes of ownership or control, when:

18.4.1.1. A person with a direct or indirect ownership interest in the SMO:

18.4.1.1.1. Has been convicted of a criminal offense under §1128(a), §1128(b)(1), or §1128(b)(3) of the Social Security Act, in accordance with 42 CFR §1002.203;

18.4.1.1.2. Has had civil liquidated damages or assessment imposed under §1128A of the Social Security Act; or

18.4.1.1.3. Has been excluded from participation in Medicare or any state healthcare program.

18.4.1.2. Any individual who has a direct or indirect ownership interest or any combination thereof of five percent (5%) or more, or who is an officer (if the SMO 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.

18.4.1.3. The SMO 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 five percent (5%) of the SMO’s total operating expenses, whichever is less.

18.5. Excluded Providers

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

18.5.2. The SMO shall not contract with or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 (42 U.S.C. §1320a-7) or §1156 (42 U.S.C. §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through DHH proceedings:

18.5.2.1. Revocation of the provider’s home and community-based services license;

18.5.2.2. Exclusion from the Medicaid program;

18.5.2.3. Termination from the Medicaid program;

18.5.2.4. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review (SURS) Rule (LAC 50:I.Chapter 41);

18.5.2.5. 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

18.5.2.6. The Louisiana Attorney General's Office has seized the assets of the service provider.

18.5.3. The SMO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders. The SMO shall conduct regular checks as per 42 CFR §455.436 and notify DHH-OBH of subcontracted providers found.

18.6. Reporting

18.6.1. In accordance with 42 CFR §455.1(a)(1) and §455.17, the SMO shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the Louisiana Office of Attorney General, Medicaid Fraud Control Unit (MFCU), and DHH within five (5) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the SMO shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the SMO, an SMO employee, or network providers or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any SMO which could result in exclusion, debarment, or suspension of the SMO or a SMO from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

18.6.2. The SMO shall report to DHH-OBH and the DHH Program Integrity Unit any program integrity-related (fraud, integrity, or quality) adverse action taken on a provider participating in their network. These reportable actions will include denial of credentials, enrollment, or contracts. Additionally, when the state executes permissive exclusions to terminate a provider for program integrity issues, the public will be notified as required by the regulation at 42 CFR §1002.212.

18.6.3. The SMO, through its Compliance Officer, has an affirmative duty to report all activities on a quarterly basis to DHH. If fraud, abuse, waste, neglect and overpayment issues are suspected, the SMO compliance officer shall report it to DHH immediately upon discovery. Reporting shall include, but are not limited to:

18.6.3.1. Number of complaints of fraud, abuse, waste, neglect, adverse contract terminations (any contractual termination initiated by

someone other than a participating provider), and overpayments made to the SMO that warrant preliminary investigation;

18.6.3.2. Number of complaints reported to the Compliance Officer; and

18.6.3.3. For each complaint that warrants investigation, the SMO shall provide DHH, at a minimum, the following:

18.6.3.3.1. Name and ID number;

18.6.3.3.2. Source of complaint;

18.6.3.3.3. Type of provider;

18.6.3.3.4. Nature of complaint;

18.6.3.3.5. Approximate dollars involved if applicable; and

18.6.3.3.6. Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

18.6.4. The SMO shall immediately report to DHH-OBH any suspicion or knowledge of fraud and abuse including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return, monies allowed to be paid on claims known to contain aberrant billing, improper billing, or wasteful billing.

18.6.5. The SMO shall report to DHH any cases of suspected Medicaid fraud or abuse by its members, network providers, employees, owners, or subcontractors. The SMO 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 upon discovery. In addition, the SMO shall report the following fraud and abuse information quarterly to DHH-OBH:

18.6.5.1. The number of complaints of fraud and abuse made to the SMO that warrant preliminary investigation; and

18.6.5.2. 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, and the legal and administrative disposition of the case for each case of suspected provider fraud and abuse that warrants a full investigation.

18.6.6. Within three (3) business days of when it is discovered, the SMO shall report to DHH-OBH and the DHH Program Integrity Unit (PIU) any SMO employee or network provider that has been excluded, suspended, or debarred from any state or federal healthcare benefit program, including any payment history for the individual that occurred subsequent to the effective date of the exclusion as per 42 CFR §455.17.

18.6.7. The SMO shall adhere to the policy and process for referral of cases and coordination with the DHH's Program Integrity Unit for fraud and abuse complaints regarding employees, members, and providers.

18.7. Behavioral Health Records

18.7.1. The SMO shall have a method to verify that services for which reimbursement was made, was provided to members. The SMO shall have policies and procedures to maintain, or require SMO providers and contractors to maintain, an individual behavioral health record for each member for this purpose.

18.8. Information Related to Business Transactions

18.8.1. The SMO shall furnish to DHH-OBH, 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.

18.8.2. The SMO shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about:

18.8.2.1. The ownership of any subcontractor with whom the SMO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and

18.8.2.2. Any significant business transactions between the SMO and any wholly owned supplier, or between the SMO and any subcontractor, during the five (5) year period ending on the date of this request.

18.8.3. For the purpose of this contract, “significant business transactions” means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the SMO’s total operating expenses whichever is greater.

18.8.4. Report of Transactions with Parties in Interest:

18.8.4.1. The SMO shall report to DHH-OBH 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. Federally qualified SMOs are exempt from this requirement.

18.8.4.2. Definition of Party in Interest – As defined in 42 U.S.C §300e-17(b), a party in interest is:

18.8.4.2.1. Any director, officer, partner, or employee responsible for management or administration of the SMO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the SMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the SMO; or, in the case of a SMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

18.8.4.2.2. Any organization in which a person described in subsection 18.8.4.2.1 above is director, officer, or partner; has directly or indirectly a beneficial interest of more than

5% of the equity of the SMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the SMO;

18.8.4.2.3. Any person directly or indirectly controlling, controlled by, or under common control with a SMO; or

18.8.4.2.4. Any spouse, child, or parent of an individual described in subsections 18.8.4.2.1, 18.8.4.2.2, or 18.8.4.2.3 above.

18.8.5. Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:

18.8.5.1. Any sale, exchange, or lease of any property between the SMO and a party in interest;

18.8.5.2. Any lending of money or other extension of credit between the SMO and the party in interest; and

18.8.5.3. Any furnishing for consideration of goods, services (including management services), or facilities between the SMO and the party in interest. This does not include salaries paid to employees for services in the normal course of their employment.

18.8.6. The information that must be disclosed in the transactions listed in subsection 18.8.5 above between the SMO and a party in interest includes:

18.8.6.1. The name of the party in interest for each transaction;

18.8.6.2. A description of each transaction and the quantity or units involved;

18.8.6.3. The accrued dollar value of each transaction during the fiscal year; and

18.8.6.4. Justification of the reasonableness of each transaction.

18.8.7. DHH-OBH may require that the information on business transactions be accompanied by a consolidated financial statement for the SMO and the party in interest.

18.8.8. If the SMO has operated previously in the commercial or Medicaid markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the SMO's business transactions must be reported.

18.8.9. If the contract is renewed or extended, the SMO must disclose information on business transactions which occurred during the prior contract period.

18.9. Conflict of Interest

18.9.1. Warranty of Removal of Conflict of Interest: The SMO shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The SMO shall disclose any dual relationships that pose any evident or potential conflicts of interest. The SMO shall quarterly inquire of its officers and employees concerning such conflicts, and shall inform DHH-OBH promptly of any potential conflict. The SMO shall warrant that it shall remove any conflict of interest prior to signing the contract.

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

18.10. Employee Education about False Claims Recovery

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

18.10.2. The SMO is subject to all regulations and requirements of the False Claims Act (FCA).

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19.0 SYSTEMS AND TECHNICAL REQUIREMENTS

19.1. General Requirements

19.1.1. The SMO shall have its own web-based ONC-certified Electronic Health Record (EHR) available to LBHP providers, which shall possess the following capabilities at a minimum with the ability to adapt to the SMO provider needs:

19.1.1.1. Interfacing with the state's health information exchange and other provider EHRs in the event that providers choose to opt out of using the SMO's EHR solution and want to integrate their EHR with the SMO's EHR;

19.1.1.2. The capacity to enter member/client information for both Medicaid and non-Medicaid members, edit information, and generate reports such as individual client ledger, client changes, service ticket balances, active and inactive client list, and fee assessment reports;

19.1.1.3. Decision support;

19.1.1.4. Have a mechanism for capturing services and fees, including alternate fees associated with those services;

19.1.1.5. Identify pay codes and associated adjustments, for example: write-offs, collections, pay codes and payment adjustments. The following are examples of pay codes needed: no-fee payment, self-pay, private health insurance, Medicaid, veteran's administration, CHAMPUS/TRI-CARE, Medicare, DWI, Urine co-pay, drug court, federal block grant (with the capacity to have multiple pay codes);

19.1.1.6. Generate statements, collection letters, billing history, filing claims for third party payers through a clearinghouse, including resubmissions of previously filed claims, invoices for contract payers, annual liability limits, and urine co-pays based on income and number of dependents tables;

19.1.1.7. Post-payments for multiple payers, all applicable co-payments;

19.1.1.8. Report on accounts receivable, control ledgers, balance by paycode reports, comparative reports, audit reports, ticket reports, aging report (30-60-90 day) and reconciliation reports;

19.1.1.9. Ability to collect clinical diagnosis and other information necessary to generate a billable claim; and

19.1.1.10. Ability to collect provider information necessary for the ability to generate a billable claim.

19.1.2. The SMO shall have an information system that shall support, at a minimum, the following key functions:

19.1.2.1. Twenty-four (24) hour, seven (7) days a week toll free telephone access line user and technical support.

19.1.2.2. Member services for both Medicaid and non-Medicaid members (including eligibility for all programs operated under the SMO).

19.1.2.3. Care management for both Medicaid and non-Medicaid members.

19.1.2.4. Quality management.

19.1.2.5. Grievances and appeals.

19.1.2.6. Provider network management (both Medicaid and non-Medicaid providers).

19.1.2.7. Member rights and responsibilities.

19.1.2.8. Financial reporting claims payment for capitated services, pending approval from CMS, or non-capitated if the waiver amendment for capitated children's services is denied by CMS.

19.1.2.9. Encounter tracking and submissions for capitated services, pending approval from CMS, or non-capitated if the waiver amendment for capitated children's services is denied by CMS.

19.1.2.10. Implementation planning.

19.1.2.11. Business continuity, disaster recovery and emergency preparedness.

19.1.2.12. Performance measurement and accountability.

19.1.2.13. System Helpdesk support.

19.1.2.14. EHR, EHR interoperability other EHRs, and health information exchange connectivity.

19.1.2.15. State and federal reporting requirements described below.

19.1.2.16. Secure electronic data interchange as needed to accomplish the above functions, as well as operation of the DHH-OBH data warehouse, and state access to client-level data in the SMO's data warehouse for DHH-OBH, DCFS, LDOE, and OJJ.

19.1.2.17. Secure online web-based portal that allows providers and the state agencies (DCFS, LDOE, DHH-OBH, and OJJ) to submit and receive responses to referrals and prior authorizations for services.

19.1.3. The SMO's system shall accept and process provider claims, accurately verify eligibility, collect and report encounter data and validate prior authorization and pre-certification that complies with DHH and federal reporting requirements.

19.1.4. The SMO shall ensure that its system meets the requirements of the contract, state-issued guides (e.g., SMO Systems Companion Guide) and all applicable state and federal laws, rules and regulations, including, but not limited to, the following:

19.1.4.1. Medicaid, DHH-OBH, and HIPAA Requirements in compliance with all applicable state and federal confidentiality requirements, including but not limited to state requirements under RS 46:56, and including but not limited to the requirements of federal Medicaid regulations, 42 CFR 431.300 et seq. and the federal privacy, security, and standards for electronic transactions regulations (45 CFR Parts 160-164) promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. HIPAA Security Rule (45 CFR Part 164, Subpart C) and to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III, "Security of Federal Automated Information System" and any future updates to this document, which sets forth guidelines for security plans for automated information systems in federal agencies.

19.1.4.2. Health Information Technology for Economic and Clinical Health Act (HITECH): The SMO shall comply with the Health Information Technology for Economic and Clinical Health Act, codified at 42 U.S.C. §17931. SMO will follow DHH security incident response plans regarding security breach response.

19.1.4.3. Confidentiality of Alcohol and Drug Abuse Patient Records: SMO shall agree to comply with the Drug Abuse Prevention, Treatment and Rehabilitation Act; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and applicable sections of the Public Health Service Act, codified at 42. U.S.C. 290dd-2 ("the Privacy Statute"). SMO 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. SMO shall agree to comply with the Privacy Statute and any of its current and future accompanying regulations (42 C.F.R. Part 2).

19.1.5. The SMO shall also ensure that its system interfaces with the DHH-OBH data warehouse (as per the DHH-OBH Client Level Data Standards and Procedures Manual (see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877). Reporting output and analysis of SMO's information systems is used for fulfilling state and federal reporting requirements for Medicaid, state-funded services, and grants, including the federal Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment (SAPT) Block Grant.

19.1.6. The SMO shall comply with all of DHH-BHSF's policies and procedures and shall modify their system(s) accordingly to conform with DHH-BHSF and its Fiscal Intermediary when systems interface is necessary (e.g., encounter data/claims submissions).

19.1.7. The SMO's systems shall be capable of tracking provider NVRA compliance and reporting NVRA data as outlined in Section 10 of this RFP. Including the ability to collect data from provider site coordinators including, but not limited to, the total number of applications for service or assistance, re-certifications renewals, and changes of address relating to such services or assistance received by the department, by program and site; the total number of declaration forms received by the department, by program and site; and the total number of completed voter registration applications received by the department and forwarded to the appropriate registrar of voters, by program and site.

19.1.8. The SMO's application systems foundation shall employ the relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. The SMO's application systems shall 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.

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

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

19.1.11. The SMO'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. The scope of coverage of the system will be for all programs and services provided through the SMO.

19.1.12. The SMO shall have or obtain access to additional resources, including additional corporate/national support, in the event systems modifications are beyond the resources and manpower available to the SMO. DHH-OBH reserves the right to request the SMO utilize additional resources.

19.1.13. Failure to keep systems accurate and up to date shall make the SMO subject to remediation.

19.1.14. Thirty (30) days before the go-live date of the contract, the SMO shall submit to DHH-OBH an outline of 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.

19.1.15. The SMO is responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in this RFP.

19.1.16. The SMO 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.

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

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

19.1.19. SMO 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)

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

19.1.21. All SMO-utilized computers and devices must:

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

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

19.1.21.3. Have encryption protection enabled at the Operating System level.

19.1.22. Resource Availability and Systems Changes

19.1.22.1. Resource Availability

19.1.22.1.1. The SMO shall provide Systems Help Desk services to state staff that have direct access to the data in the SMO's systems.

19.1.22.1.2. The Systems Help Desk shall:

19.1.22.1.2.1. Have an information service management system that provides an automated method to record, track, ensure follow-up, document resolution time, and report all questions, problems reported, system enhancement projects, and claims/encounter process changes to the Systems Help Desk. The system shall

be capable of receiving requests electronically and providing a means for users to track a request's progress. This information shall be accessible to DHH-OBH electronically by the go-live date of the contract.

19.1.22.1.2.2. Be available via local and toll-free telephone service, and via e-mail at least Monday through Friday , 7am to 5pm CST. After hours, the systems help desk shall provide a means for users to leave voice messages or emails in which the SMO's staff shall respond to by noon (CST) the next business day.

19.1.22.1.2.3. Answer questions regarding the SMO'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-OBH staff;

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

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

19.1.23. Information Systems Documentation Requirements

19.1.23.1. The SMO 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 SMO 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. These manuals shall be available online and in printed form.

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

19.1.23.3. The SMO shall provide to DHH-OBH a Systems Quality Assurance Plan, which shall include, but not be limited to:

19.1.23.3.1. Written system procedure and process plans;

19.1.23.3.2. Systems helpdesk process and workflows;

19.1.23.3.3. Systems access request form;

19.1.23.3.4. Procedures and measures for safeguarding against unauthorized modification to the SMO's systems;

19.1.23.3.5. An outline of how systems within the SMO'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; and

19.1.23.3.6. Data back-up policies and procedures as indicated in Section 19.13, including, but not limited to, a list of all back-up files to be stored at remote locations and the frequency with which these files are updated as well as a description of how these files shall be accessed electronically.

19.1.24. Systems Changes

19.1.24.1. The SMO's systems shall conform to future federal and/or DHH specific standards for complete and accurate encounter data exchange within one hundred twenty (120) calendar days prior to the standard's effective date or earlier, as directed by CMS or DHH. This includes CMS efforts such as the Transformed Medicaid Statistical Information System (T-MSIS).

19.1.24.2. If a system update and/or change is necessary, the SMO shall draft appropriate revisions for the documentation or manuals, and present to DHH thirty (30) days prior to implementation of system change, 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 implementation of system change.

19.1.24.3. The SMO 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:

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

19.1.24.3.1.1. Claims processing;

19.1.24.3.1.2. Eligibility and enrollment processing;

19.1.24.3.1.3. Service authorization management;

19.1.24.3.1.4. Provider enrollment and data management;

19.1.24.3.1.5. Electronic Health Record;

19.1.24.3.1.6. Conversions of core transaction management systems; and

19.1.24.3.1.7. Any system to which DHH has access (e.g., the SMO data warehouse).

19.1.24.4. The SMO shall respond to DHH-OBH notification of system problems submitted from the DHH-OBH-designated systems liaison not resulting in system unavailability according to the following timeframes:

19.1.24.4.1. Within one (1) hour of receiving notification from DHH-OBH, the SMO shall respond in writing to notices of system problems.

19.1.24.4.2. Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due to DHH-OBH.

19.1.24.4.3. The SMO shall correct the deficiency by an effective date to be determined by DHH-OBH with input from the SMO.

19.1.24.4.4. The SMO's systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

19.1.24.4.5. The SMO shall put in place procedures and measures for safeguarding against unauthorized modification to the SMO's systems that should be outlined in the Systems Quality Assurance Plan.

19.1.24.5. Unless otherwise agreed to in advance by DHH, the SMO 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. The SMO shall provide at least five (5) days' notice to DHH of any system upgrades, repairs or maintenance.

19.1.24.6. The SMO 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 Medicaid FI of the SMO's system.

19.1.25. Other Electronic Data Exchange

19.1.25.1. The SMO's system shall house indexed electronic images of documents to be used by members and providers to transact with the SMO 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 SMO 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.

19.1.25.2. The SMO shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.

19.2. Behavioral Health Records

19.2.1. The SMO shall have policies and procedures to maintain, or require SMO providers and contractors to maintain, an individual behavioral health record for each member.

19.2.2. The SMO shall ensure the behavioral health record is:

19.2.2.1. Accurate and legible;

19.2.2.2. 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

19.2.2.3. Readily available for review and provides clinical data required for Quality and Utilization Management review.

19.2.3. The SMO shall be responsible for any costs associated with the electronic submission and data layout of requested information.

19.2.4. The SMO shall ensure the behavioral health record includes, minimally, the following:

19.2.4.1. Member identifying information, including name, identification number, date of birth, gender, and legal guardianship (if applicable);

19.2.4.2. Primary language spoken by the member and any translation needs of the member;

19.2.4.3. Services provided through the SMO, date of service, service site, and name of service provider;

19.2.4.4. Behavioral health history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by a provider;

19.2.4.5. Treatment Plan and Plan of Care if required;

19.2.4.6. Documentation of freedom of choice (e.g., Freedom of Choice form), particularly with regard to choice between institutional and waiver services;

19.2.4.7. Referrals including follow-up and outcome of referrals;

19.2.4.8. Documentation of emergency and/or after-hours encounters and follow-up;

19.2.4.9. Signed and dated consent forms (as applicable);

19.2.4.10. Documentation of advance directives, as appropriate;

19.2.4.11. Documentation of each visit must include:

19.2.4.11.1. Date and begin and end times of service;

19.2.4.11.2. Chief complaint or purpose of the visit;

19.2.4.11.3. Diagnoses or medical impression;

19.2.4.11.4. Objective findings;

19.2.4.11.5. Patient assessment findings;

19.2.4.11.6. Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG);

19.2.4.11.7. Medications prescribed;

19.2.4.11.8. Health education provided;

19.2.4.11.9. Name and credentials of the provider rendering services and the signature or initials of the provider; and

19.2.4.11.10. Initials of providers must be identified with correlating signatures.

19.2.5. The SMO is required to provide one (1) free copy of any part of member's record upon member's request.

19.2.6. All documentation and/or records maintained by the SMO or any and all of its network providers shall be maintained for at least six (6) years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

19.3. Utilization Data for Members Not Enrolled

19.3.1. The SMO shall have the capacity to receive, monitor, and analyze utilization data for individuals not enrolled as members of the SMO that receive their behavioral health services from other sources (e.g., FQHC/RHC, Managed Care Organizations, LGEs).

19.3.2. All utilization data shall be transmitted in aggregate format or otherwise shall maintain strict adherence to all HIPAA regulations and requirements using an industry-standard HIPAA compliance checker approved by DHH-OBH.

19.4. Quality Management Pharmacy

19.4.1. The SMO shall have the ability to accept and analyze pharmacy data and report as requested by DHH-OBH on individual member and aggregate

pharmacy utilization data and provider prescribing practices by prescriber/provider type, as well as other similar reports on member pharmacy utilization for quality management purposes.

19.5. HIPAA Standards and Code Sets

19.5.1. 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). Data elements and file format requirements may be found in the SMO Systems Companion Guide.

19.5.2. All HIPAA-conforming exchanges of data between DHH and the SMO shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker approved by DHH-OBH. The HIPAA Business Associate Addendum (Attachment IV) shall become a part of the contract.

19.5.3. The system shall conform to the following HIPAA-compliant 5010 standards for information exchange. Batch transaction types include, but are not limited to, the following:

19.5.3.1. ASC X12N 834 Benefit Enrollment and Maintenance;

19.5.3.2. ASC X12N 835 Claims Payment Remittance Advice Transaction;

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

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

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

19.5.3.6. ASC X12N 276 Claims Status Inquiry;

19.5.3.7. ASC X12N 277 Claims Status Response;

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

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

19.5.4. The SMO shall not revise or modify the standardized forms or formats without agreement of all parties.

19.5.5. Transaction types are subject to change and the SMO shall comply with applicable federal and HIPAA standards and regulations as they occur.

19.5.6. The SMO shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are approved by DHH-OBH. These shall include, but not be limited to, HIPAA based standards, federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

19.5.7. The SMO shall require that their providers comply at all times with standardized billing paper forms and electronic formats, and all future

updates for Professional and Institutional claims. All data shall be submitted to DHH or its designee in the standard 5010 HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB transaction formats (P - Professional, and I - Institutional).

19.6. Connectivity

19.6.1. DHH-OBH is requiring that the SMO interface with DHH and the Medicaid Fiscal Intermediary (FI), LDOE, OJJ, and DCFS systems. The SMO must have capacity for near real time connectivity to all DHH-approved information systems.

19.6.2. The system shall conform and adhere to the data and document management standards of DHH and the Medicaid FI, inclusive of standard transaction code sets.

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

19.6.4. The SMO shall a secure, web-accessible electronic health record for providers on or before the go-live date of the contract. The EHR must be certified by an ONC-accredited testing body and be capable of interfacing with the state health information exchange to exchange clinical summaries.

19.6.5. The EHR must meet all stages of meaningful use standards as set by CMS and a schedule approved by DHH-OBH.

19.6.6. The SMO's EHR shall connect to the Louisiana Health Information Exchange (LaHIE) within six (6) months of EHR implementation provided readiness and required availability of resources from the LaHIE.

19.6.7. If the case arises wherein, providers may opt to implement or use their own EHR rather than using the SMO's EHR; then in such instances, the SMO shall collaborate with providers to ensure that data necessary for reporting is made available to the SMO through one or more of the following:

19.6.7.1. An interface between the SMO's EHR and the provider's EHR;

19.6.7.2. A data file of required information is securely sent from the provider to the SMO and the information contained in the data file is available for query in the Louisiana-based SMO data warehouse; or

19.6.7.3. The provider has a means of securely and directly entering the required information into the SMO's EHR system. The SMO shall work with the providers to ensure this process is as efficient and streamlined.

19.6.8. The SMO shall comply with the technical requirements of the Balancing Incentives Program (BIP) vendor for the purpose of receiving data from referrals from the Louisiana No Wrong Door Level 1 screening. In addition, the SMO must integrate BIP screening requirements into their Level II assessments and report the required Core Data Set as

necessary. The SMO shall comply with any additional BIP system requirements as directed by DHH-OBH. See Section 15.11.14 for BIP requirements. The current BIP vendor plan requires that agencies integrating with the system use web services to communicate with and obtain information from a Microsoft.net application.

19.6.8.1. The BIP program may, pending further CMS guidance, require the SMO to comply with DHH and federal efforts to coordinate its systems to meet the necessary requirements of the Health Insurance Exchange, including, but not limited to, providing means for key data fields to be shared across systems as necessary for compliance with the Affordable Care Act, Title II, Section 2202.

19.6.9. The SMO shall meet, as requested by DHH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the LBHP.

19.6.10. 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 SMO 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.

19.6.11. DHH shall require the SMO to comply with transitional requirements as necessary should DHH contract with a new Medicaid FI during the contract at no cost to DHH or its FI.

19.6.12. The SMO shall be responsible for all initial and recurring costs required for access to DHH-approved system(s), as well as DHH access to the SMO'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.

19.6.13. The SMO shall complete an Information Systems Capabilities Assessment (ISCA), which will be provided by DHH-OBH or its subcontractor. The ISCA shall be completed and returned to DHH-OBH no later than thirty (30) days from the date the signed contract is approved by The Division of Administration/Office of Contract Review (DOA/OCR).

19.7. Behavioral Health Information Management

19.7.1. Information management, analysis and reporting are essential to the effective and efficient operation of the SMO and to fulfilling state and federal reporting requirements for Medicaid, SGF, and grants, including the MHBG and SAPT federal block grants. The SMO shall provide a comprehensive, integrated, and secure internet-based behavioral health information management system (IMS) which supports: 1) the functions of the public behavioral health system as applicable; 2) DHH-OBH as the managing agency of the LBHP; 3) interface with the other child-serving agencies financing the LBHP (DCFS, LDOE, OJJ); 4) DHH-BHSF; and 5) all subcontracting providers. The IMS must be capable of interfacing with

Medicaid's FI and any other potential DHH contractors. The SMO shall work closely with DHH, DHH-OBH, DHH-BHSF and other LBHP partners on an ongoing basis to assure implementation, operation, and maintenance of this critical information resource. The system shall have the capacity for electronic data collection, analysis, transfer, and reporting of data at the client (not just aggregate) level and will provide the required data to the Medicaid Management Information System (MMIS) for Medicaid claims processing, reporting, and auditing.

19.7.2. The IMS shall support electronic and manual claims processing and administration, membership management, provider network management, including provider profiling, outcomes and quality of care information, care management, utilization management, grievances and appeals, and member services. The SMO shall utilize current state and federal standards and procedures (e.g., HL7; HIPAA; CMS; CPT; ICD-10; DSM-5) for this system and will maintain a uniform service and provider (credentials) taxonomy for billing and information management purposes. The SMO shall provide technical assistance and consultation to providers on establishing the means for effective, ongoing electronic collection and transfer of required data.

19.7.3. The scope of coverage of the IMS will be for all programs and services provided through the LBHP. Additionally, the SMO shall have a system to assist in managing the care of the LBHP members. As a result, the IMS shall be able to store and analyze claims, encounter, and eligibility information.

19.7.4. The data content will include but may not be limited to the following data sets: Client data (socio demographic and contact information; unique client ID); assessment data (including diagnoses in current DSM format; level of functioning scores, results from current and historical functional assessments including CANS and LOCUS, for example); service encounter data (e.g., date, type, duration, time of service, recipient, provider); episode data (e.g., service program; unique episode ID; date of first contact; date of admission; date of last contact; date of discharge); programmatic data (e.g., service population and eligibility; payer source; fee schedules); individual claims data; provider data (e.g., provider agency, name, unique provider ID, discipline); and care management data. The technical specifications of these data shall be in keeping with state and federal standards (e.g., SAMHSA, HIPAA, CMS) for data content.

19.7.5. The SMO shall transfer data to and from Medicaid's FI on a daily basis and to other entities at various intervals as dictated by DHH-OBH and in a format approved by DHH-OBH.

19.7.6. The SMO shall be responsible for maintaining standardized data collection process and procedures and provide training and support to all provider staff and state staff.

19.7.7. The SMO shall perform data quality management, in conjunction with DHH-OBH and the other state agencies in order to demonstrate that the

data are accurate, appropriate, complete, and timely reported across all program units.

19.7.8. The SMO shall track and report to DHH-OBH all Medicaid payments and service encounters distinguished from other payment sources. At a minimum, the Medicaid payments must be tracked by specific Medicaid Eligibility Group, as well as by individual state plan or waiver service. This data shall be reported in a format as prescribed by DHH-OBH.

19.7.9. The SMO shall have the ability to accept and analyze pharmacy data from DHH and report on individual member and aggregate pharmacy utilization data and provider prescribing practices by prescriber/provider type, as well as other similar reports on member pharmacy utilization for quality management purposes.

19.8. The SMO Louisiana Data Warehouse

19.8.1. The SMO shall maintain a data warehouse containing all systems information and data collected specific to Louisiana-based operations.

19.8.2. The SMO shall provide access to their SMO Data Warehouse to users approved by DHH-OBH which shall include, but not be limited to, client level data such as client level claims, encounters, prior authorizations and denials, eligibility, quality-related surveys, performance measures, demographics, case management, functional assessment results (e.g., CANS), and provider services.

19.8.3. The SMO shall provide a detailed electronic SMO Data Element Dictionary for the SMO Data Warehouse to DHH-OBH thirty (30) days prior to contract go-live. SMO Data Element Dictionary updates shall be supplied electronically to DHH-OBH as they occur and the document shall be dated and versioned with each update.

19.8.4. The SMO shall provide near real-time read only access to users defined by DHH-OBH for data extraction and analytics (creating reports with SAS and SQL, for example) to its operational data stores by the date the signed contract is approved by DOA/OCR.

19.8.5. The SMO's Data Warehouse shall support the ability for users to create permanent tables in the system for querying data.

19.8.6. The SMO shall provide a contact person(s) with extensive knowledge of the SMO Data Warehouse and the SMO Data Element Dictionary who can assist DHH personnel with coding and querying results, explanation of data, and troubleshooting issues. This contact person(s) shall be a part of the Systems Help Desk function as described in Section 19.1 of this RFP.

19.8.7. Training on how to use the SMO Data Warehouse and tools to access the data warehouse must be provided to DHH-OBH by the SMO thirty (30) days prior to contract go-live and upon DHH-OBH request thereafter.

19.9. The DHH-OBH Data Warehouse

19.9.1. The SMO shall provide a secure electronic data interface for the DHH-OBH behavioral health data warehouse of client-level, standardized data. Uses of this information include, but are not limited to, state and federal reporting (e.g., including, but not limited to, SAMHSA Uniform Reporting System (URS)/National Outcome Measures (NOMS), 1915(i)/1915(b)(3)/1915(c) Level of Care and Plan of Care information, Treatment Episode Data Sets (TEDS), Government Performance Reporting Act (GPRA), client-level data elements as required by the Center for Mental Health services for federal block grant reporting, and for ad hoc summarized or client-level reporting as needed by the state for service quality monitoring and performance accountability.

19.9.2. The SMO shall provide data to meet federal reporting requirements for the SAMHSA-funded MHBG and SAPT Block Grants. The client-level data will be used to verify that services were actually provided to members and for performance measurement and accountability. The SMO will work closely with DHH-OBH and its contractors and stakeholders to assure effective design, implementation, and ongoing operation of the DHH-OBH and SMO data warehouse.

19.9.2.1. The data content to be transmitted to the DHH-OBH Data Warehouse will include but may not be limited to the following data sets: Client data (demographic and contact information: unique Client ID); assessment data (including diagnosis in current DSM format: level of functioning scores, WHODAS); encounter data (e.g., date, type, duration, recipient, provider); episode data (e.g., service program; unique episode ID; date of first contact; date of admission; date of last contact; date of discharge); programmatic data (e.g., service program; unique episode ID; date of first contact; date of admission; date of last contact; date of discharge, service population and eligibility, payer source, fee schedules); individual claims data; and provider data (e.g., provider agency, name, unique provider ID, discipline). The technical specifications of these data will be in keeping with state and federal standards (e.g., SAMHSA) for data content.

19.9.3. The data set, processes, procedures, data dictionary, data structure schema, and foreign keys shall be created by the SMO within thirty (30) days from the contract go-live date and updated at least annually by contract year thereafter relative to the client-level data, which is electronically transferred to the DHH-OBH data warehouse.

19.9.4. The client-level data content, format, definitions, and the schedule and methodology of secure uploading (e.g., electronic transfer) of the client-level dataset data for the DHH-OBH data warehouse (e.g., secure FTP) will adhere to DHH-OBH and national (SAMHSA) standards as well as the DHH-OBH Client Level Data Standards and Procedures Manual (see Procurement Library at: http://new.dhh.louisiana.gov/index.cfm/page/1877).

19.9.5. The SMO shall provide an integrated behavioral health reporting store that supports the capacity for ad hoc as well as production-type reporting. The SMO shall have the capacity to provide historical, current, and accurate documented client-level data sets, as needed, by the state for its own analyses and reporting. The types of reports the SMO shall provide include but are not limited to:

19.9.5.1. Unduplicated counts of persons served by program/service and provider and provide a longitudinal history of service provision across service settings/episodes and over time, for a standard set of member/service data as outlined below:

19.9.5.1.1. Utilization/cost outliers that trigger notice for follow-up action;

19.9.5.1.2. Continuity of care and care coordination information, such as but not limited to: timely access, time between referral and first appointment, and follow up after discharge from inpatient and residential levels of care;

19.9.5.1.3. Services rendered and appropriately paid, based upon linkage of raw claims data to authorizations; and

19.9.5.1.4. Dashboard-type quality management and performance reporting, as well as standard tabular and graphical reporting.

19.9.6. The SMO shall provide an integrated behavioral health quality and outcome measurement system for collection, analysis, and reporting of client level data not collected and reported through the system described above. This includes, but may not be limited to:

19.9.6.1. All 1915(c) and 1915(b) waiver and 1915(i) SPA performance measures;

19.9.6.2. CSoC Quality Assurance Committee performance measures;

19.9.6.3. HEDIS and The Joint Commission performance measures;

19.9.6.4. Client quality-of-care surveys (e.g., the MHSIP adult and YSS-F member parent surveys required by SAMHSA and now used by the state);

19.9.6.5. Client self-assessment outcome measures (e.g., the Telesage Outcome Measurement System (TOMS);

19.9.6.6. Client Behavior Checklist (CBCL);

19.9.6.7. Clinical/functional provider assessment instruments (e.g., Addiction Severity Index (ASI);

19.9.6.8. Level of Care Utilization System (LOCUS/CALOCUS/CANS), as now utilized by the state;

19.9.6.9. The Comprehensive Adolescent Severity Inventory (CASI), which is the adolescent addiction assessment tool; and

19.9.6.10. The American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC) which is the Addiction equivalent to the LOCUS and CALOCUS.

19.9.7. In addition to the care management record, these measurement data shall be stored in client-level form in the above referenced DHH-OBH and SMO data warehouses. The data shall be available for analysis with demographics (e.g., age, race, gender, parish/region, etc.).

19.9.8. The SMO will be expected to at least bi-weekly update and transfer all DHH-OBH Data Warehouse required datasets in a format and file structure (including requisite documentation) required by DHH-OBH and the process and procedures in keeping with the changing reporting requirements of the state and federal government and local programs.

19.10. Electronic Messaging

19.10.1. The SMO 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 and any subsequent upgrades as adopted.

19.10.2. As needed, the SMO shall be able to communicate with DHH over a secure Virtual Private Network (VPN).

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

19.11. Eligibility and Enrollment Data Exchange

19.11.1. The SMO shall:

19.11.1.1. Receive, process, and update enrollment files;

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

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

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

19.11.1.5. 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.

19.11.2. The SMO shall also reconfirm eligibility on each member upon claims submission and processing.

19.12. Information Systems Availability

19.12.1. The SMO shall:

19.12.1.1. Allow DHH staff or other individuals authorized by DHH-OBH and, upon request, CMS direct access to its data for the purpose of data mining and review;

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

19.12.1.3. 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;

19.12.1.4. Ensure that the systems and processes within its span of control associated with its data exchanges with DHH's FI and its contractors are available and operational 24/7;

19.12.1.5. Ensure that in the event of a declared major failure or disaster, the SMO'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;

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

19.12.1.6.1. Upon discovery of a problem within or outside the SMO'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 SMO and DHH or its Medicaid FI; and

19.12.1.6.2. 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.

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

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

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

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

19.12.1.8.3. Within five (5) business days of the occurrence of a problem with system availability, the SMO shall provide DHH with full written documentation that includes a corrective action plan describing how the SMO will prevent the problem from reoccurring.

19.13. Contingency Plan

19.13.1. The SMO, 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.

19.13.2. 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, alternate sites, and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.

19.13.3. The SMO shall have a Contingency Plan that must be submitted to DHH-OBH for approval no later than thirty (30) days from the date the signed contract is approved by DOA/OCR.

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

19.13.4.1. Alternate site options for continuous operations;

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

19.13.4.3. 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;

19.13.4.4. System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system; and,

19.13.4.5. 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.

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

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

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

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

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

19.14.2. The data back-up policy and procedures shall include, but not be limited to:

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

19.14.2.2. Documented back-up procedures;

19.14.2.3. Provisions for DHH-access to retrieve backed-up data;

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

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

19.14.2.6. Any change in back-up procedures in relation to the SMO's technology changes.

19.14.3. DHH shall be provided with a list of all back-up files to be stored at remote locations and the frequency with which these files are updated as well as electronic access to all files as part of the Systems Quality Assurance Plan.

19.15. Records Retention

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

19.15.2. The historical encounter data submission shall be retained for a period of not less than six (6) years, following generally accepted retention guidelines.

19.15.3. 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 seventy-two (72) hour turnaround or less on request for access to information in machine readable form, that is between six (6) to ten (10) years old.

19.16. Information Security and Access Management

19.16.1. The SMO's system shall:

19.16.1.1. Provide user-defined access to all SMO systems to DHH employees as determined by DHH-OBH and with the use of an established access request and denial form;

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

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

19.16.1.2.2. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall

be restricted to specified staff jointly agreed to by DHH and the SMO;

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

19.16.1.2.4. 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;

19.16.1.2.5. 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 SMO and approved by DHH;

19.16.1.2.6. 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:

19.16.1.2.6.1. 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;

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

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

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

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

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

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

19.16.1.2.8. 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;

19.16.1.2.9. 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;

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

19.16.1.2.11. 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 thirty (30) calendar days after the date the signed contract is approved by DOA/OCR.

19.16.1.2.12. Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the SMO shall conduct a security risk assessment and communicate the results in an information security plan provided no later than thirty (30) calendar days after the date the signed contract is approved by DOA/OCR. The risk assessment shall also be made available to appropriate federal agencies.

19.17. Audit Requirements

19.17.1. The SMO shall ensure that their systems facilitate the auditing of individual claims. Adequate audit trails shall be provided throughout the systems. To facilitate claims auditing, the SMO shall ensure that the systems follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) *Audit and Account Guide, The Auditor's Study and Evaluation of Internal Control in Electronic Data Processing (EDP) Systems*.

19.17.2. An EDP audit is an analysis of an organization's computer and information systems in order to evaluate the integrity of its production systems as well as potential security gaps.

19.17.3. The SMO shall maintain and adhere to an internal EDP Policy and Procedures manual available for DHH-OBH review upon request, which at a minimum shall contain and assure all accessible screens used throughout the system adhere to the same Graphical User Interface (GUI) standards, and that all programmers shall adhere to the highest industry standards for coding, testing, executing and documenting all system activities. The manual is subject to yearly audit, by both state and independent auditors.

19.18. State Audits

19.18.1. The SMO shall provide, through DHH-OBH, to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The SMO shall provide information necessary to assist the state auditor in processing or utilizing the files.

19.18.2. If the auditor's findings point to discrepancies or errors, the SMO shall provide a written corrective action plan to DHH-OBH within ten (10) business days of receipt of the final audit report.

19.18.3. At the conclusion of the audit, an exit interview may be conducted and a yearly written report of all findings and recommendations may be provided by the state auditors. These findings shall be reviewed by DHH-OBH and integrated into the SMO's materials or plans, if applicable.

19.19. Independent Audit

19.19.1. The SMO shall be required to contract with an independent firm, subject to the written approval of DHH-OBH, which has experience in conducting EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the contract's systems application. These requirements are also applicable to any subcontractor or vendor delegated the responsibility of adjudicating claims. The independent firm shall:

19.19.1.1. Perform limited scope EDP audits on an ongoing and annual basis for contract compliance at the conclusion of the first twelve (12) month operation period and each twelve (12) month period thereafter, while the contract is in force with DHH and at the conclusion of the contract; and

19.19.1.2. Perform a comprehensive audit on an annual basis, for controls placed in operation and operation effectiveness, to determine the SMO's compliance with the obligations specified in the contract and the SMO Systems Companion Guide.

19.19.2. The auditing firm shall deliver to the SMO and to DHH-OBH a report of findings and recommendations within thirty (30) calendar days of the close of each audit. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews and become part of the SMO's EDP manual upon request by DHH-OBH.

19.19.3. DHH-OBH shall use the findings and recommendations of each report as part of its monitoring process.

19.19.4. The SMO shall deliver to DHH-OBH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the final audit report.

19.19.5. Audits shall include a scope necessary to fully comply with the AICPA Statement on Standards for Attestation Engagements as it relates to the internal controls of a Service Organization (SSAE-16 Report).

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20.0 CLAIMS MANAGEMENT

20.1. Electronic Claims Management (ECM) Functionality

20.1.1. The SMO shall comply with DHH's Electronic Claims Data Interchange policies for certification of electronically submitted claims.

20.1.2. To the extent that the SMO compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the SMO shall process the provider's claims for covered services provided to members, consistent with applicable state policies and procedures and the terms of the contract and the SMO Systems Companion Guide, including, but not limited to, timely filing, and compliance with all applicable state and federal laws, rules and regulations.

20.1.2.1. The SMO shall maintain an electronic claims management system accessible to DHH-OBH, that will:

20.1.2.1.1. Provide a payment system for Medicaid and all other funding sources providing services within the LBHP;

20.1.2.1.2. Have the capability to perform eligibility, billing, accounts receivables, accounts payable, remittance advices, prior authorization, fiscal management, provider enrollment, and other requirements as determined by DHH;

20.1.2.1.3. Uniquely identify the attending and billing provider of each service;

20.1.2.1.4. Identify the date of receipt of the claim (the date the SMO receives the claim and encounter information);

20.1.2.1.5. Store claims and encounters to the claims line level (accessible through SMO data warehouse for data analysis);

20.1.2.1.6. Identify real-time complete and accurate claims and encounters history with dates of adjudication status of each claim such as paid (including multiple paid amounts such as TPL, Medicare, what the SMO paid, and billed amount), denied, rejected, pended, appealed, etc., and follow up information on appeals;

20.1.2.1.7. Provide a means of electronically submitting, tracking, and reconciling claims and encounters (including those where a third-party is the primary payer);

20.1.2.1.8. Identify the date of payment, the date & number of the check or other form of payment such as electronic funds transfer (EFT);

20.1.2.1.9. Identify all data elements as required by DHH for complete and accurate encounter data submission as stipulated in

this section of the RFP and the SMO Systems Companion Guide;

20.1.2.1.10. Allow submission of non-electronic and electronic claims by contracted providers;

20.1.2.1.11. Receive LEA claims and submit them to the Medicaid FI for claims adjudication.

20.1.3. The SMO shall ensure that an electronic claims management (ECM) capability that accepts and processes claims submitted electronically is implemented and user-friendly.

20.1.4. The SMO shall ensure the ECM system shall function in accordance with information exchange and data management requirements as specified in this section of the RFP and the SMO Systems Companion Guide.

20.1.5. The SMO shall ensure the system is capable of processing a certain percentage (as determined by DHH-OBH) of claims electronically (without manual intervention).

20.1.6. The SMO shall ensure that as part of the ECM function it can provide on-line and phone-based capabilities to obtain processing status information.

20.1.7. The SMO shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

20.1.8. The SMO shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the SMO 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.

20.1.9. The SMO shall require that their providers comply at all times with standardized billing forms and formats, and all future updates for Professional claims (CMS 1500) and Institutional claims (UB 04).

20.1.10. The SMO must comply with requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010, regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

20.1.11. The SMO agrees that at such time that DHH-OBH presents recommendations concerning SMO system changes that are consistent with industry norms, the SMO shall comply with said recommendations within ninety (90) calendar days from notice by DHH-OBH.

20.1.12. The SMO shall have procedures thirty (30) days prior to contract go-live available to providers, in written and web format, for the acceptance of claim submissions. The SMO shall revisit and update these procedures at least annually. These procedures must be approved by DHH-OBH and include the following:

20.1.12.1. The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims;

20.1.12.2. The process for reviewing claims for accuracy and acceptability;

20.1.12.3. The process for prevention of loss of such claims; and

20.1.12.4. The process for reviewing claims for determination as to whether claims are accepted as clean claims.

20.1.13. The SMO shall have a procedure approved by DHH-OBH available to providers in written and web form for notifying providers of batch rejections to the individual claim line level 30 days prior to contract go-live. The report, at a minimum, should contain the following information:

20.1.13.1. Date batch was received by the SMO;

20.1.13.2. Date of rejection report;

20.1.13.3. Claim line level rejection detail;

20.1.13.4. Name or identification number the SMO issuing batch rejection report;

20.1.13.5. Batch submitters name or identification number; and

20.1.13.6. Reason batch is rejected.

20.1.14. Acceptance of claims submission and/or batch denial notification procedures must be revised annually. The SMO shall submit the revised procedures to DHH-OBH for approval. Upon approval, the procedures must be made available to providers in written and web format within ten business days of DHH-OBH approval.

20.1.15. The SMO shall assume all costs associated with claim and encounter processing, including the cost of reprocessing/resubmission, due to processing errors caused by the SMO or to the design of systems within the SMO's span of control.

20.1.16. The SMO shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from DHH.

20.1.17. For purposes of network management, the SMO shall notify all contracted providers to file claims associated with covered services directly with the SMO, or its contractors, on behalf of LBHP members.

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

20.1.19. The SMO must process as either a claim or encounter all patients who receive state-funded behavioral health services.

20.2. Claims Processing Methodology Requirements

20.2.1. The SMO shall perform system edits, including, but not limited to:

20.2.1.1. Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by DHH or any other state entity that applies to the period during which the charges were incurred;

20.2.1.2. A review of the entire claim within five (5) working days of receipt of an electronic claim, to determine that the claim is not a clean claim and issue an exception report to the provider indicating all defects or reasons known at that time that the claim is not a clean claim. The exception report shall contain at a minimum the following information:

20.2.1.2.1. Member name;

20.2.1.2.2. Provider claim number, patient account number, and/or unique member identification number;

20.2.1.2.3. Procedure, revenue, and diagnostic codes;

20.2.1.2.4. Date of service;

20.2.1.2.5. Total billed charges;

20.2.1.2.6. Provider name/identification number; and

20.2.1.2.7. The date the report was generated.

20.2.1.3. Medical necessity – The system shall validate that medical necessity was determined;

20.2.1.4. Prior Approval – The system shall determine whether a covered service required prior approval and if so, whether the SMO granted such approval;

20.2.1.5. Duplicate Claims – The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed (duplicate logic shall follow DHH policy). The SMO's system shall have sufficient mechanisms in place to capture service begin and end time, service type, billing provider, servicing provider, and recipient details in order to detect duplicate claims;

20.2.1.6. Covered Services - Ensure that the system verifies that a service is a covered service and is eligible for payment according to the provider type and modifier (as applicable);

20.2.1.7. Third-party Liability (TPL) – Ensure the system can edit claims up front for other insurance;

20.2.1.8. 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;

20.2.1.9. Quantity of Service - Ensure that the system shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied;

20.2.1.10. 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; and

20.2.1.11. Have claims processing staff qualified in accordance with Section 6.2 of this RFP.

20.2.2. The SMO shall provide their claims processing systems guide thirty (30) days prior to the contract go-live date, inclusive of all edits used to manage utilization, eligibility, appropriate payment, and appropriateness of provider billing.

20.3. Explanation of Benefits (EOBs)

20.3.1. On a monthly basis, the SMO shall provide individual explanation of benefits (EOB) notices to a sample group of the members who received services in a manner that complies with 42 CFR §455.20 and §433.116(e). The required notice must specify:

20.3.1.1. The service furnished;

20.3.1.2. The name of the provider furnishing the service;

20.3.1.3. The date on which the service was furnished; and

20.3.1.4. The amount of the payment made for the service.

20.3.2. The SMO shall stratify the paid claims sample to ensure that all provider types are represented in the same pool. The paid claims sample should be a minimum of one hundred (100) claims per month to be reported on a quarterly basis.

20.3.3. Surveys shall be performed within forty-five (45) days after a claim has been paid. This sampling may be performed by mail, telephonically, or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.

20.3.4. The SMO shall over sample particular provider groups upon request by DHH-OBH.

20.3.5. The SMO shall track any feedback received from members. The SMO shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

20.3.6. Within three (3) business days, results indicating that paid services may not have been received shall be referred to the SMO's fraud and abuse

department for review, to DHH-OBH, and to DHH through the following URL: http://new.dhh.louisiana.gov/index.cfm/page/219.

20.3.7. The SMO shall provide a quarterly report to DHH-OBH regarding the EOB results from sample group notices in a format to be approved by DHH-OBH. This report shall include attestations certifying EOBs were developed and sent to beneficiaries, and that the beneficiaries were provided sixty (60) days for comment and suggestion. The attestation form will be provided by DHH-PIU. DHH-OBH reserves the right to conduct monitoring reviews of all EOBs.

20.4. Remittance Advices

20.4.1. In conjunction with its payment cycles, the SMO shall provide remittance advices.

20.4.2. Each remittance advice generated by the SMO to a provider shall clearly identify the following information for each claim:

20.4.2.1. The name of the member;

20.4.2.2. Unique provider identification number (TIN, Group NPI, and NPI, for example, upon request of the provider);

20.4.2.3. Member claim number or patient account number;

20.4.2.4. Date of service;

20.4.2.5. Total provider charges;

20.4.2.6. Member liability, specifying any co-insurance, deductible, co-payment, or non-covered amount;

20.4.2.7. Amount paid by the SMO;

20.4.2.8. Amount denied and the reason for denial; and

20.4.2.9. 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.”

20.5. Adherence to Key Claims Management Standards

20.5.1. Prompt Payment to Providers

20.5.1.1. The SMO shall process and pay within thirty (30) calendar days of receipt of claim, ninety-five percent (95%) of all clean claims (as defined in Glossary) to providers for covered services delivered to a member.

20.5.1.2. The SMO shall process and pay within forty-five (45) calendar days of receipt of claim, ninety-nine percent (99%) of all clean

claims (as defined in Glossary) to providers for covered services delivered to a member.

20.5.1.3. If a claim is denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

20.5.1.4. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the timeframe for claims processing.

20.5.1.5. To the extent that the provider contract requires compensation of a provider 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:

20.5.1.5.1. The time period specified in the provider contract between the provider and the SMO, or if a time period is not specified in the contract:

20.5.1.5.1.1. The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or

20.5.1.5.1.2. Within five (5) calendar days after receipt of the capitated payment and supporting member roster information from DHH when the SMO is required to compensate the provider directly.

20.5.1.6. The SMO shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. The provider should bill the third party insurance first. If after sixty (60) days payment has not been received then the provider can bill the SMO. Providers must maintain the 12 month timely filing.

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

20.6. National Provider Identifier (NPI)

20.6.1. The HIPAA Standard Unique Health Identifier regulations (45 CFR Part 162, Subparts A & D) require that all covered entities (healthcare clearinghouses and those healthcare providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

20.7. Claims Dispute Management

20.7.1. The SMO shall develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The

claims dispute process must be submitted to DHH-OBH for approval within thirty (30) days of DOA/OCR approval of the signed contract.

20.7.2. 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 SMO 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) calendar days of being selected, unless the SMO 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.

20.7.3. The SMO shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.

20.7.4. The SMO shall adjudicate all appealed claims to a paid or denied status within thirty (30) business days of receipt of the appealed claim.

20.7.5. The SMO shall adjudicate all claims, including appealed claims, within twenty-four (24) months from the date of service.

20.7.6. The SMO must deny any claim not initially submitted to the SMO by the three hundred and sixty-fifth (365) calendar day from the date of service, unless the SMO or its subcontractors created the error. If a provider files erroneously with the Medicaid FI, but produces documentation verifying that the initial filing of the claim occurred timely within the three hundred and sixty-five (365) calendar day period, the SMO shall process the provider's claim and not deny for failure to meet timely filing guidelines.

20.8. Claims Payment Accuracy Report

20.8.1. On a monthly basis, the SMO shall submit a claims payment accuracy percentage report to DHH-OBH. The report shall be based on an audit conducted by the SMO. 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 2% of daily claims per month, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

20.8.2. The minimum attributes to be tested for each claim selected shall include:

20.8.2.1. Claim data correctly entered into the claims processing system with assigned transaction number;

20.8.2.2. Claim is associated with the correct provider;

20.8.2.3. Proper authorization was obtained for the service;

20.8.2.4. Authorization limits have not been exceeded;

20.8.2.5. Member eligibility at processing date correctly applied;

20.8.2.6. Allowed payment amount agrees with contracted rate;

20.8.2.7. Duplicate payment of the same claim has not occurred;

20.8.2.8. Denial reason applied appropriately;

20.8.2.9. Co-payment application considered and applied, if applicable;

20.8.2.10. Effect of modifier codes correctly applied;

20.8.2.11. Proper coding consistent with provider credentials;

20.8.2.12. Adjustments to claims are properly made with supporting documentation; and

20.8.2.13. Payment is coordinated properly when other insurance is applicable.

20.8.3. The results of testing at a minimum should be documented to include:

20.8.3.1. Results for each attribute tested for each claim selected;

20.8.3.2. Amount of overpayment or underpayment for each claim processed, adjusted, or paid in error;

20.8.3.3. Explanation of the erroneous processing for each claim processed, adjusted, or paid in error;

20.8.3.4. 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

20.8.3.5. Claims processed, adjusted, or paid in error have been corrected.

20.8.4. If the SMO contracted for the provision of any covered services, and the SMO's contractor is responsible for processing claims, then the SMO shall submit a claims payment accuracy percentage report for the claims processed by the contractor.

20.9. Claims Summary Report

20.9.1. The SMO must submit weekly Claims Summary Reports to DHH-OBH by claim type in a format approved by DHH-OBH.

20.10. Encounter Data

20.10.1. The SMO's system shall be able to transmit complete and accurate encounter data to the Medicaid FI's system per the requirements set forth by DHH for the appropriate submission of encounter data.

20.10.2. The SMO shall report third-party liability (TPL) information in encounter data at the direction of DHH.

20.10.3. Prior to the contract go-live date, the SMO's system shall be ready to submit complete and accurate encounter data to the FI in a HIPAA-compliant provider-to-payer COB format. The SMO must incur all costs associated with certifying HIPAA transactions readiness through a third-party prior to submitting complete and accurate encounter data to the FI. Data elements and reporting requirements are provided in the SMO Systems Companion Guide*.*

20.10.3.1. All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

20.10.4. The SMO shall provide the FI with complete and accurate encounter data for all levels of behavioral health services provided.

20.10.4.1. All inpatient and outpatient encounters must include ancillary charges and the appropriate revenue codes.

20.10.5. The SMO shall have the ability to update CPT/HCPCS, ICD-9, ICD-10, DSM-V, and other codes based on HIPAA standards and move to future versions as required.

20.10.6. In addition to CPT, ICD-9, ICD-10, DSM-V, and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the SMO and DHH to evaluate performance measures.

20.10.7. The SMO shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to DHH's FI.

20.10.8. The FI encounter process utilizes 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 SMO. 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 SMO for immediate correction. The SMO shall make themselves familiar with these DHH edits and program their system accordingly.

20.10.9. DHH-OBH, DHH-BHSF, and the Medicaid FI shall determine which claims processing edits are appropriate for encounters and shall set encounter edits to "pay" or "deny". Encounter denial codes shall be deemed "repairable" or "non-repairable". An example of a repairable encounter is "provider invalid for date of service". An example of a non-repairable encounter is "exact duplicate". The SMO is required to be familiar with the FI exception codes and dispositions for the purpose of repairing denied encounters.

20.10.10. The SMO shall provide to DHH-OBH any and all required denied claims information.

20.10.11. The SMO shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The SMO shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with DHH and the Medicaid FI's billing requirements.

20.10.12. Due to the need for timely data and to maintain integrity of processing sequence, the SMO 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-OBH. Failure to research and address reported errors may result in remediation as per Section 22 of this RFP.

20.10.13. For complete and accurate encounter data submissions, the SMO shall submit all encounter data at least weekly, and no later than the week following the week in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00). The SMO CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

20.10.14. If the SMO fails to submit complete encounter data, 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 SMO may be subject to remediation as outlined in Section 22 of the RFP.

20.10.15. The SMO shall ensure that all encounter data from a contractor is incorporated into the appropriate number of files as defined in the SMO Systems Companion Guide and in accordance with any required isolation of various claim types such as professional and institutional.

20.10.16. The SMO shall ensure that files contain settled claims and claim adjustments or voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the SMO has a capitation arrangement.

20.10.17. The SMO shall ensure the level of detail associated with encounters from providers shall be equivalent to the level of detail associated with encounters for which the SMO received and settled a fee-for-service claim, if applicable, pending CMS approval on Medicaid State Plan and waiver amendments.

20.10.18. The SMO shall adhere to federal and/or department payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the encounter data submissions and will be treated similarly by DHH.

20.10.19. Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be

ascertained in accordance with the SMOs applicable reimbursement methodology for that service.

20.10.20. Encounter Adjustment Resubmission Guidelines

20.10.20.1. The SMO shall resubmit encounter adjustments any day of the week, but will not exceed the daily and weekly limits as set by the Medicaid FI.

20.10.20.2. The SMO shall resubmit encounter adjustments before 6:00 p.m. CST on Monday, Tuesday, Wednesday, and before noon CT on Thursday. Encounter adjustments submitted after 6:00 p.m. CT on Monday, Tuesday and Wednesday will run the following day.

20.10.20.3. The weekly cut off is at noon CT on Thursdays. Encounter adjustments submitted after noon CT on Thursday will run in the following week's cycle.

20.10.21. The SMO shall comply with the required encounter data format provided by DHH. Encounter data includes claims paid by the SMO for services delivered to members through the SMO 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. Data must include the appropriate level of detail as required for the calculation of actual costs and cost settlements for inpatient services to be conducted by a third party independent of DHH-BHSF.

20.10.22. Encounter data is subject to external audits which may require encounter adjustments and/or voids of previously submitted encounters. All adjustments to historical claims data shall be reflected with the period that the adjustment occurs. The SMO shall ensure that adjustments are not posted to historical claims data, altering prior data regarding payment retrospectively (i.e., once the date is passed, payments cannot be modified for that period).

20.10.23. DHH may change the Encounter Data Transaction requirements with thirty (30) calendar days' written notice from DHH-OBH to the SMO. The SMO shall, upon notice from DHH, provide notice of changes to subcontractors.

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21.0 CONTRACT COMPLIANCE & MONITORING

21.1. Contact Personnel

21.1.1. DHH-OBH will be responsible for the primary oversight of the contract, including contract interpretation. DHH-BHSF will be ultimately responsible for Medicaid policy decisions. As appropriate, DHH-OBH will provide clarification of SMO requirements and DHH-BHSF shall be the ultimate authority and interpreter of Medicaid policy, regulations, and procedures. DHH's Office of Behavioral Health, Division of Health Plan Management will be the SMO's point of contact and shall receive all inquiries and requests for interpretation or information regarding the contract and all required reports unless otherwise specified in the contract. The SMO shall also designate a member of its senior management who shall act as a liaison between the SMO'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.

21.1.3. Contract Monitor

21.1.3.1. All work performed by the SMO will be monitored by the Contract Monitor:

Karen Stubbs
Department of Health and Hospitals
Office of Behavioral Health
Division of Health Plan Management
628 North 4th Street
Baton Rouge, LA 70821
Phone: 225.342.7601
E-mail: Karen.Stubbs@la.gov

21.2. Notification to SMO of Policies and Procedures

21.2.1. DHH-OBH will provide the SMO with updates to appendices and LBHP policies, procedures and guidelines affecting the provision of services under this contract.

21.2.2. DHH-BHSF will provide the SMO with interpretation of pertinent federal and state Medicaid regulations upon request by the SMO.

21.2.3. The SMO will submit written requests to DHH for additional clarification, interpretation or other information. Provision of such information does not relieve the SMO of its obligation to keep informed of applicable federal and state laws related to its obligations under this contract.

21.3. SMO Contract and Information Changes

21.3.1. The SMO shall immediately notify DHH-OBH of any of the following in writing:

21.3.1.1. Change in business address/location, telephone number, facsimile number, and e-mail address;

21.3.1.2. Change in corporate status or nature, corporate structure, solvency, and incorporation status;

21.3.1.3. Change in corporate officers and executive employees;

21.3.1.4. Change in ownership, including but not limited to the new owner's legal name, business address, telephone number, facsimile number, and e-mail address;

21.3.1.5. Change in federal employee identification number or federal tax identification number; or

21.3.1.6. Change in SMO litigation history, current litigation, audits and other government investigations both in Louisiana and in other states.

21.4. Required Submissions

21.4.1. The SMO shall submit documents as specified in this RFP. DHH-OBH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the SMO's responsibilities under the terms of the contract.

21.5. Ongoing Contract Monitoring

21.5.1. DHH will monitor the SMO's performance to assure the SMO is in compliance with the contract provisions. However this does not relieve the SMO of its responsibility to continuously monitor its providers' performance in compliance with the contract provisions.

21.5.2. DHH or its designee will, at a minimum annually, monitor the operation of the SMO for compliance with the provisions of this contract, and applicable federal and state laws and regulations. Inspection may include the SMO'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, 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.

21.5.3. If not specified in this contract, DHH or its designee shall coordinate with the SMO to establish the scope of review relevant time frames for obtaining information, and the criteria for review.

21.5.4. The SMO shall provide access to documentation, medical records, premises, and staff as deemed necessary by DHH.

21.5.5. The SMO 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 SMO must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement as directed by DHH-OBH may result in monetary penalties, sanctions and/or enrollment restrictions.

21.6. Readiness Review Prior to Operations Start Date

21.6.1. DHH-OBH will assess the performance of the selected SMO prior to and after the anticipated go-live date for operations. DHH-OBH or its designee will complete a readiness review of the SMO prior to contract go-live. This includes evaluation of all of the SMO's program components including IT, administrative services, and care management. Each readiness review will be performed on-site at the SMO's Louisiana administrative offices.

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

21.6.2.1. Clinical operations;

21.6.2.2. Information systems;

21.6.2.3. Claims monitoring; and

21.6.2.4. Financial monitoring and reporting.

21.7. Monitoring Reports

21.7.1. DHH-OBH will require SMOs to submit monthly, quarterly, annual, and ad hoc reports that will allow DHH-OBH to assess the SMO's performance.

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22.0 REMEDIATION

22.1. Sanctions Generally

22.1.1. A sanction is a punitive action assessed or applied for a violation in one or more areas of contractual responsibility. The imposition of a sanction indicates that the SMO has negligently or purposefully violated the contract, failed to comply with lesser remediation, or is out of compliance with applicable state and federal laws.

22.1.2. For failure to comply with any requirement contained within this RFP or contract documents allows DHH-OBH to impose remediation.

22.1.3. DHH-OBH may use the provisions of 42 CFR §438.700 *et seq.* as guidance for the imposition of sanctions.

22.1.4. DHH-OBH may impose a system of graduated remediation which includes, but is not limited to:

22.1.4.1. Administrative Action

22.1.4.2. Corrective Action Plan (CAP)

22.1.4.3. Monetary Penalties

22.1.4.4. Sanctions

22.1.4.5. Termination

22.1.5. DHH-OBH reserves the right to impose monetary penalties or any other remediation outside the parameters as outlined in sections 22.2 through 22.7 of this RFP. DHH-OBH will determine the appropriate option based on the nature of the deficiency or non-compliance with the requirements of this contract.

22.1.6. The SMO shall bear the expense of compliance with any finding of noncompliance under this contract.

22.2. Administrative Actions

22.2.1. Administrative actions exclude monetary penalties, sanctions, and termination and include, but are not limited to:

22.2.1.1. A warning through written notice or consultation;

22.2.1.1.1. DHH-OBH may notify the SMO through a written Notice to Cure when it is determined the SMO is deficient or non-compliant with requirements of the contract.

22.2.1.1.2. The Notice to Cure will specify the period of time during which the SMO must bring its performance back into compliance with contract requirements;

22.2.1.2. Education requirement regarding program policies and procedures. The SMO may be required by DHH-OBH to conduct

a staff or provider education program as a condition of continued participation;

22.2.1.3. Review of SMO policy and processes;

22.2.1.4. Referral to the Louisiana Department of Insurance for investigation;

22.2.1.5. Referral for review by appropriate professional organizations; and

22.2.1.6. Referral to DHH Program Integrity Unit or to the Office of the Attorney General for investigation.

22.3. Corrective Action Plans

22.3.1. To correct or resolve any deficiency, DHH-OBH may require the SMO to develop a Corrective Action Plan (CAP).

22.3.2. The CAP must provide:

22.3.2.1. A detailed explanation of the reasons for the cited deficiency;

22.3.2.2. The SMO's assessment of the cause;

22.3.2.3. A specific proposal to remedy or resolve the deficiency;

22.3.2.4. Detailed timelines and deliverables; and

22.3.2.5. An SMO lead or contact person for the CAP.

22.3.3. The CAP must be submitted by the deadline set forth in DHH-OBH request for a CAP. The CAP must be approved by DHH-OBH in writing.

22.3.4. DHH-OBH will notify the SMO in writing of DHH-OBH's final disposition of concerns.

22.3.5. The CAP shall be monitored by DHH-OBH to bring activities of the SMO into compliance with state and federal regulations. DHH-OBH may monitor the effectiveness of the plan via required reporting on a specified basis, through onsite evaluations and/or any other source.

22.4. Monetary Penalties

22.4.1. The purpose of establishing and imposing monetary penalties is to provide a means for DHH-OBH to obtain the services and level of performance required for successful operation of the contract. DHH-OBH'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-OBH to assess additional monetary penalties or actual damages or sanctions.

22.4.2. In accordance with 42 CFR §438.704, the limit on or the maximum civil money penalty DHH-OBH may impose varies depending on the nature of the SMO's action or failure to act.

22.4.3. A maximum of $25,000 may be imposed upon the SMO for each determination of any of the following:

22.4.3.1. Failure to provide services;

22.4.3.2. Misrepresentation or false statements to members, potential members, or healthcare providers; and

22.4.3.3. Failure to comply with physician incentive plan requirements.

22.4.4. A maximum of $100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or false statements to CMS or DHH-OBH;

22.4.5. A maximum of $15,000 for each member or recipient DHH-OBH determines was not enrolled because of discrimination due to the member's health status or need for services (subject to the $100,000 limit above);

22.4.6. A maximum of $25,000 or double the amount of the excess charges (whichever is greater), is the penalty for charging premiums or charges in excess of the amounts permitted under the LBHP, DHH-OBH shall return the amount of overcharge to the affected member(s).

22.4.7. DHH-OBH may impose monetary penalties when the SMO is out of compliance with the provisions of this RFP and other contract documents, including, but not limited to, the following:

22.4.7.1. Incorrect encounter data/claims submissions may subject the SMO to penalties of between $500 and $250,000 depending upon the volume and severity of incorrect submissions as determined by DHH-OBH;

22.4.7.2. Failure to fill vacant key staff positions required by this RFP within ninety (90) days - $250 per working day from the 91st day of vacancy until filled or from the 121st day - $500 per working day from 121st day of vacancy until filled with an employee approved by DHH-OBH;

22.4.7.3. Deliverables required in this contract, including but not limited to *Appendix C: Deliverables Submissions Table* (see Procurement Library at http://new.dhh.louisiana.gov/index.cfm/page/1877), and any other ad hoc deliverables requested by DHH-OBH that are late, inaccurate, or submitted in a format not prior approved by DHH-OBH - $2,500 per calendar day per deliverable;

22.4.7.4. Failure to meet any scope of work requirements as outlined in this RFP may subject the SMO to penalties of between $500 and $25,000 based on the severity as determined by DHH-OBH; and

22.4.7.5. Late, incomplete or inaccurate submissions to DHH-OBH as per Section §26.10.1.5 of this RFP regarding actual and potential HIPAA noncompliance may subject the SMO up to $2,500 in monetary penalties per day per violation until confirmation from DHH-OBH that the deliverable is satisfied.

22.4.8. DHH-OBH reserves the right to collect monetary penalties using one of the following options:

22.4.8.1. Withholding payment from the SMO;

22.4.8.2. Billing the SMO for the appropriate monetary penalty amount; or

22.4.8.3. Retainage.

22.4.9. Monetary Penalties for HIPAA Violations

22.4.9.1. In accordance, with Section 13410(d) of the HITECH Act and section 1176(a) of the Social Security Act, penalties for a covered entity or business associate violating HITECH range from $100 per violation to $1.5 million for all violations in a calendar year. Criminal penalties for the deliberate mistreatment of PHI or failure of timely breach reporting may apply directly to any SMO employee responsible for the offense. Penalties for individuals cannot exceed $250,000 and/or imprisonment not more than ten years.

22.4.9.2. If the SMO fails to comply with all applicable HIPAA requirements, the SMO shall pay all fines or penalties imposed by the U.S. Department of Health and Human Services (HHS) under 45 CFR §160.404.

22.4.9.3. The state may assess additional penalties for HIPAA noncompliance, failure to systemically correct HIPAA noncompliance, or failure to notify required parities (i.e., providers and/or members).

22.5. Sanctions

22.5.1. DHH-OBH may impose sanctions against the SMO if it makes any determinations of the following non-exclusive actions/occurrences:

22.5.1.1. The SMO has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH-OBH;

22.5.1.2. The SMO has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142 (Medicare-Medicaid anti-fraud and abuse amendments);

22.5.1.3. The SMO 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 SMO's member;

22.5.1.4. The SMO 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;

22.5.1.5. The SMO 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;

22.5.1.6. The SMO has rebated or accepted a fee or portion of fee or charge for a patient referral;

22.5.1.7. The SMO has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

22.5.1.8. The SMO has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

22.5.1.9. The SMO has failed to furnish any information requested by DHH regarding payments for providing goods or services; and

22.5.1.10. The SMO 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.

22.6. Termination of Contract

22.6.1. DHH may terminate the contract when DHH determines the SMO and/or SMO subcontractor(s) have failed to perform, or have violated, substantive terms of the contract and have failed to meet federal or state requirements.

22.6.2. In accordance with 42 CFR §438.708, DHH-OBH has the authority and may terminate the SMO's contract and enroll that entity's members in another SMO or provide their Medicaid benefits through other options, if DHH-OBH determines that the SMO failed to do either of the following:

22.6.2.1. Carry out substantive terms of its contract; or

22.6.2.2. Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

22.6.3. If DHH chooses to terminate the SMO contract, the termination will be effective no less than thirty (30) calendar days from the date of the Notice of Intent to Terminate. The SMO may, at the discretion of DHH-OBH, be allowed to correct the deficiencies within the thirty (30) calendar day notice period or prior to the issuance of a Notice of Termination.

22.6.4. After DHH-OBH notifies the SMO that it intends to terminate the contract, DHH-OBH will notify members of the SMO in writing the notice of the termination and information, consistent with 42 CFR §438.10 and §438.722, on their options for receiving Medicaid services following the effective date of termination.

22.7. Termination Due to Serious Threat to Health of Members

22.7.1. DHH-OBH may terminate the contract immediately if it is determined that actions by the SMO or its subcontractor(s) pose a serious threat to the health of members.

22.8. Termination for SMO Insolvency, Bankruptcy, Instability of Funds

22.8.1. The SMO's insolvency or the filing of a petition in bankruptcy by or against the SMO shall constitute grounds for termination for cause. If DHH determines the SMO has become financially unstable, DHH will immediately terminate this contract upon written notice to the SMO effective the close of business on the date specified.

22.8.2. The SMO shall cover continuation of services to members for the duration of any period for which payment has been made, as well as for inpatient admissions up until discharge. Subject to provisions in 42 CFR §438.106 and pursuant to Section 1932(b)(6) of the Social Security Act (as enacted by section 4704 of the Balanced Budget Act of 1997), if the SMO becomes insolvent, the SMO shall not hold members liable and members shall not be held liable for the following:

22.8.2.1. The SMO's debts in the event of insolvency.

22.8.2.2. Covered services provided to the member, for which the state does not pay the SMO.

22.8.2.3. Covered services provided to the member, for which DHH or the SMO does not pay the individual or healthcare provider that furnishes the services under a contractual referral or other arrangement.

Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the SMO provided the services directly.

22.9. Provider Sanctions

22.9.1. Nothing contained herein shall prohibit DHH-OBH from imposing sanctions, monetary penalties, license revocation, and Medicaid termination, upon a healthcare provider for its violations of federal or state law, rule or regulations.

22.10. Non-Waiver of Breach

22.10.1. The failure of DHH at any time to require performance by the SMO of any provision of this contract, or the continued payment of the SMO 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.

22.10.2. 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. 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.

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23.0 PROPOSAL

23.1. General Information

23.1.1. This section outlines the provisions that govern determination of compliance of each proposer's response to the RFP.

23.1.2. DHH shall determine, at its sole discretion, whether or not the requirements have been reasonably met.

23.1.3. Omissions of required information shall be grounds for rejection of the proposal by DHH.

23.1.4. Proposals should respond to the responsibilities as outlined in this RFP and its attachments and appendices.

23.2. Blackout Period

23.2.1. 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.

23.2.2. 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.

23.2.3. 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.

23.2.4. Any costs associated with cancellation or termination will be the responsibility of the proposer or bidder.

23.2.5. Notwithstanding the foregoing, the Blackout Period shall not apply to:

23.2.5.1. A protest to a solicitation submitted pursuant to La. R.S. 39:1671 or LAC 34:V.145.A.8;

23.2.5.2. Duly noticed site visits and/or conferences for bidders or proposers;

23.2.5.3. Oral presentations during the evaluation process; and

23.2.5.4. 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.

23.3. Code of Ethics

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

23.3.2. 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 that can officially rule on ethics issues.

23.3.3. Any potential conflict of interest that is known or should reasonably be known by a proposer as it relates to this RFP should be immediately reported to the RFP Coordinator by the proposer.

23.4. Rejection and Cancellation

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

23.4.1.1. Reject all proposals received in response to this solicitation;

23.4.1.2. Cancel this RFP; or

23.4.1.3. Cancel or decline to enter into a contract with the successful proposer at any time after the award is made and before the contract receives final approval from DOA/OCR.

23.4.1.4. In accordance with the provisions of La.R.S. 39:2192, in awarding contracts after August 15, 2010, any public entity is authorized to reject a proposal or bid from, or not award the contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the following provisions of the Louisiana Revised Statutes of 1950 governing

public contracts: Title 38, Chapter 10 (public contracts); Title 39, Chapter 16 (professional, personal, consulting, and social services procurement); or Title 39, Chapter 17 (Louisiana Procurement Code).

23.5. Contract Award and Execution

23.5.1. The Secretary of DHH reserves the right to:

23.5.1.1. Make an award without presentations by proposers or further discussion of proposals received.

23.5.1.2. Enter into a contract without further discussion of the proposal submitted based on the initial offers received.

23.5.1.3. Contract for all or a partial list of services offered in the proposal.

23.5.2. The RFP and proposal of the selected proposer shall become part of any contract initiated by the state.

23.5.3. The selected proposer shall be expected to enter into a contract that is substantially the same as the sample contract included in Attachment III. In no event shall a proposer submit its own standard contract terms and conditions as a response to this RFP. The proposer should submit with its proposal any exceptions or exact contract deviations that its firm wishes to negotiate. Negotiations may begin with the announcement of the selected proposer.

23.5.4. If the contract negotiation period exceeds 15 days or if the selected proposer fails to sign the final contract within 15 days of delivery, the state may elect to cancel the award and award the contract to the next-highest-ranked proposer.

23.6. Assignments

23.6.1. 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.

23.6.2. Information as to the experience and qualifications of proposed subcontractors or joint ventures should be included in the proposal. In addition, written commitments from any subcontractors or joint ventures should be included as part of the proposal.

23.6.3. All assignments must be approved by DHH.

23.7. Determination of Responsibility

23.7.1. Determination of the proposer's responsibility relating to this RFP shall be made according to the standards set forth in Louisiana Administrative Code (LAC) 34:V.136. The state must find that the selected proposer:

23.7.1.1. Has adequate financial resources for performance, or has the ability to obtain such resources as required during performance;

23.7.1.2. Has the necessary experience, organization, technical qualifications, skills, and facilities, or has the ability to obtain them;

23.7.1.3. Is able to comply with the proposed or required time of delivery or performance schedule;

23.7.1.4. Has a satisfactory record of integrity, judgment, and performance; and

23.7.1.5. Is otherwise qualified and eligible to receive an award under applicable laws and regulations.

23.7.2. Proposers should ensure that their proposals contain sufficient information for the state to make its determination by presenting acceptable evidence of the above mentioned items to perform the contracted services.

23.8. Proposal and Contract Preparation Costs

23.8.1. The proposer assumes sole responsibility for any and all costs associated with the preparation and reproduction of any proposal submitted in response to this RFP.

23.8.2. 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.

23.8.3. 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 DHH.

23.9. Ownership of Proposal

23.9.1. 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.

23.10. Errors and Omissions

23.10.1. DHH reserves the right to make corrections due to minor errors of proposer identified in proposals by DHH or the proposer. DHH, at its option, has the right to request clarification or additional information from proposer, and may request such clarification as it deems necessary at any point in the proposal review process.

23.10.2. DHH reserves the right to seek clarification to resolve inadequate proposal content or contradictory statements in a proposer's proposal.

23.11. Resources Available To Proposer

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

http://new.dhh.louisiana.gov/index.cfm/page/1877

23.12. Proposal Submission

23.12.1. 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.

23.12.2. The proposer shall submit:

23.12.2.1. One (1) original hard copy (the Certification Statement must have original signature signed in ink);

23.12.2.2. Five (5) electronic copies in PDF format (CD or flash drive); and

23.12.2.3. Five (5) hard copies of each proposal.

23.12.3. Proposer shall provide one electronic copy of the redacted proposal submission (CD or flash drive).

23.12.4. No facsimile or emailed proposals will be accepted.

23.12.5. The financial statements shall be submitted separately from the technical proposal; however, for mailing purposes, all packages may be shipped in one container.

23.12.6. As there is no negotiated cost associated with this contract, there is no cost proposal to be submitted with the technical/general proposal.

23.12.7. 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

23.13. Proprietary and/or Confidential Information

23.13.1. The designation of certain information as trade secrets and/or privileged or confidential proprietary information is applicable to this proposal. Only information which is in the nature of legitimate trade secrets or non-published financial data may be deemed proprietary or confidential. Any proposal marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

23.13.2. Any material within a proposal identified as such must be clearly marked in the proposal and will be handled in accordance with the Louisiana Public Records Act, R.S. 44:1-44 and applicable rules and regulations. 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.

23.13.3. 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:

23.13.3.1. "The information contained in pages _____ of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such information 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 shall have the right to use or disclose the data therein to the extent provided in the contract and as required by law. This restriction does not limit the state's right to use or disclose data obtained from other sources without restrictions."

23.13.3.2. Further, to protect such data, each page containing such data shall be specifically identified and marked **"CONFIDENTIAL".**

23.13.4. 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.

23.13.5. 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 sections or information have been removed."

23.13.6. Any proposal marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

23.13.7. 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.

23.14. Proposal Format

23.14.1. 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.

23.14.1.1. An item-by-item response to the RFP is requested and should be organized according to the proposal content outlined below.

23.14.1.2. Page limits will be included in the Evaluation Criteria and Assigned Weights table in Section 24.2 outlined below. Any proposal content beyond the identified page limits will not be evaluated. Emphasis should be on simple, straightforward and concise statements of the proposer's ability to satisfy the requirements of the RFP.

23.15. Requested Proposal Outline

23.15.1. Corporate and Administrative Background Requirements

23.15.1.1. Introduction/Administrative Data

23.15.1.2. Relevant Corporate Experience

23.15.1.3. Personnel Qualifications

23.15.2. Corporate Financial Condition

23.15.3. Work Plan/Project Execution

23.15.3.1. Technical/Fiscal Requirements

23.15.3.2. Quality Management

23.15.3.3. Member Interface and Benefits

23.15.3.4. Infrastructure

23.15.3.5. Pharmacy

23.16. Proposal Content

23.16.1. Quality And Timeliness

23.16.1.1. Proposals should include information that will assist the Department in determining the level of quality and timeliness that may be expected. DHH shall determine, at its sole discretion, whether or not the RFP provisions have been reasonably met.

23.16.1.2. The proposal should describe the background and capabilities of the proposer, give details on how the services will be provided. Work samples may be included as part of the proposal, but not supplemental materials.

23.16.2. Assume Complete Responsibility

23.16.2.1. 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.

23.16.3. Approach

23.16.3.1. Proposals should define proposer's functional approach in meeting each requirement and identify the tasks necessary to meet each of the requirements as outlined in the RFP.

23.16.3.2. Additional/supplemental materials outside of the proposal in response to the required proposal content outlined below will not be considered during the proposal evaluation process.

23.16.4. Corporate and Administrative Background Requirements Proposal

23.16.4.1. The proposal for corporate and administrative background requirements shall include the following elements with answers to the questions detailed below:

23.16.4.1.1. Introduction/Administrative Data (including response to the Veteran and Hudson Initiatives);

23.16.4.1.2. Relevant Corporate Experience; and

23.16.4.1.3. Personnel Qualifications

23.16.4.2. Introduction/Administrative Data

23.16.4.2.1. The purpose of the introductory section is for summary information about the proposer's organization.

23.16.4.2.2. Specifically, the proposal response should include answers to the following queries weighted as indicated in the table below. Any response beyond the page limit given below will be disregarded.

Introduction/Administrative Data Proposal Content			
Question Number	**Proposal Request**	**Point Value**	**Page Limit**
23.16.4.2.1	Describe how proposer will facilitate coordination and collaboration between the public partners as outlined in Section 1 of the RFP**.**	3 points	3 pages
23.16.4.2.2	Briefly describe the proposer's organization's ability to adhere to the draft schedule of events as outlined in Section 2 of the RFP	3 points	3 pages
23.16.4.2.3	Please include a description of how the proposer's organizational components communicate and work together in both an administrative and functional capacity from the top down. Please provide an organizational chart of the proposer's corporate and Louisiana based organization.	3 points	3 pages
23.16.4.2.4	Please describe how the organization's corporate resources will be utilized to support this contract during implementation and throughout the term of this contract.	3 points	3 pages
23.16.4.2.5	Proposer should demonstrate participation in Veteran Initiative and Hudson Initiative Small Entrepreneurships or explanation if not applicable. (See Attachment I and Section 24.1.6 of the RFP for additional information).	40 points	Unlimited

23.16.4.2.3. The proposer shall additionally submit the following information for consideration of a complete proposal:

23.16.4.2.3.1. Location of Administrative Office with Full Time Personnel, include all office locations (address) with full time personnel.

23.16.4.2.3.2. Name and address of principal officer;

23.16.4.2.3.3. Name and address for purpose of issuing checks and/or drafts;

23.16.4.2.3.4. For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation.

23.16.4.2.3.5. If out-of-state proposer, give name and address of local representative, if none, so state;

23.16.4.2.3.6. If any of the proposer's personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number;

23.16.4.2.3.7. If the proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state;

23.16.4.2.3.8. Proposer's state and federal tax identification numbers; and

23.16.4.2.3.9. Veteran/Hudson Initiative Submission (Attachment I).

23.16.4.2.4. The Certification Statement ***must*** be included in the proposal. The proposer must sign and submit an original Certification Statement (See Attachment II).

23.16.4.3. Relevant Corporate Experience

23.16.4.3.1. The purpose of this proposal section is to indicate the proposer has a record of prior successful experience in the implementation of the services sought through this RFP. All experience under this section should be in sufficient detail to allow an adequate evaluation by DHH.

23.16.4.3.2. The proposer should have, within the last 24 months implemented a similar type project. Proposers should give at least two customer references for projects implemented in at least the last 24 months. References shall include the name, email address and telephone number of each contact person.

23.16.4.3.3. The proposal response should include answers to the following queries weighted as indicated in the table below. Any response beyond the page limit given below will be disregarded.

Relevant Corporate Experience Proposal Content			
Question Number	**Proposal Request**	**Point Value**	**Page Limit**
23.16.4.3.1	Please describe the proposer's knowledge and corporate experience in dealing with multiple public sector entities (state or local); specifically, the juvenile justice and child welfare involved populations.	3 points	3 pages
23.16.4.3.2	Please describe the proposer's experience in managing care for substance use disorder populations.	3 points	3 pages
23.16.4.3.3	Please describe the proposer's experience in managing care for the Medicaid and non-Medicaid populations.	3 points	3 pages
23.16.4.3.4	Explain the proposer's strategy for ensuring compliance with all applicable state and federal laws and regulations, including changes in law and how these changes will be implemented (e.g., CMS requirements).	3 points	3 pages
23.16.4.3.5	Please outline the proposer's emergency management plan and provide workflows.	3 points	3 pages
23.16.4.3.6	Please describe the proposer's corporate experience and actions taken to safeguard against potential HIPAA violations. Additionally, provide examples of corrective measures proposer intends to take in response to a range of potential HIPAA	3 points	3 pages

	violations by degree, and list examples of the proposer's intended proactive measures for consistent and active monitoring of potential violations.		

23.16.4.4. Personnel Qualifications

23.16.4.4.1. The purpose of this section is to evaluate the relevant experience, resources, and qualifications of the proposed staff to be assigned to this project. The experience of proposer's personnel in implementing similar services to those to be provided under this RFP will be evaluated. The adequacy of personnel for the proposed project team will be evaluated on the basis of project tasks assigned, allocation of staff, professional skill mix, and level of involvement of personnel.

23.16.4.4.2. The proposal response should include answers to the following queries weighted as indicated below. Any response beyond the page limit given below will be disregarded.

Personnel Qualifications Proposal Content			
Question Number	**Proposal Request**	**Point Value**	**Page Limit**
23.16.4.4.1	Describe the proposer's general approach and ability to fulfill the requirements of the scope of work relative to Staff Requirements and Support Services. Please provide specific staffing configurations (including job responsibilities, workload and lines of supervision) and an organization chart that includes position titles, number of positions, qualifications and reporting relationships, as well as, associated workflows that illustrate how the proposer's organization will fulfill the obligations of this contract. Share relevant examples from the proposer's other public sector contracts which proposer believes demonstrate the proposer's ability to deliver on this scope of work and demonstrate five years or more of behavioral health managed care experience.	3 points	5 pages
23.16.4.4.2	Please describe the proposer's recruitment strategy for qualified personnel to support the requirements of this contract.	3 points	3 pages
23.16.4.4.3	Please provide resumes for any identified staff or if no one has been identified, outline qualifications for key personnel. Resumes should include experience with proposer; previous experience in projects of similar scope and size; and educational background, certifications, licenses, special skills, etc. If subcontractor personnel will be used, the proposer should clearly identify these persons, if known, and provide the same information requested for the proposer's personnel.	3 points	Unlimited

23.16.5. Corporate Financial Condition Proposal

23.16.5.1. The proposer's financial solvency will be evaluated. The proposer's ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be considered.

23.16.5.2. Proposers are required to achieve 12 of 15 points in this section. Scoring less than 12 points will disqualify proposer from consideration.

23.16.5.3. The proposal response should include answers to the following queries weighted as indicated in the table below. Any response beyond the page limit given below will be disregarded.

Corporate Financial Condition Proposal Content			
Question Number	**Proposal Request**	**Point Value**	**Page Limit**
23.16.5.1	**Publically Traded Information** If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report. If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. *Note: Proposer must include your organization's parent organization, affiliates, and subsidiaries in this response. If your organization is not publicly traded, you must state "organization is not publicly traded" in your*	3 points	Unlimited

	response to this item.		
23.16.5.2	**Evaluation of Financial Solvency** The proposer shall demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be considered. Provide the following as documentation of the Proposer's and parent corporation's sufficient financial strength and resources to provide the scope of services as required (Proposer shall include the Proposer's parent organization in all submissions): • Provide your last three (3) statements containing your Risk Based Capital Ratio as prepared in accordance with instructions published by the National Association of Insurance Commissioners (NAIC). Include for both the proposing entity and the parent organization if applicable. • The three most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be: o Prepared with all monetary amounts detailed in U.S. currency; o Prepared under U.S. generally accepted accounting principles; and o Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements. • The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows. • Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable. Provide the following information (in Excel format) based on each of the financial statements submitted: (1)	3 points	Unlimited

	Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.		

23.16.5.3	**Financial Responsibility and Stability**
	Please provide the following:
	• a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing;
	• two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a credit rating determined by an accredited credit bureau within the last 6 months;
	• a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate. Proposal should include for each of the last three (3) years, copies of financial statements, preferably audited, including at least a balance sheet and profit and loss statement, or other appropriate documentation which would demonstrate to the Department the proposer's financial resources sufficient to conduct the project;
	• your organization's credit rating and bond rating. Include your organization's parent organization, affiliates, and subsidiaries in this response; and
	• as applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:
	  • AM Best Company (financial strengths ratings);
	  • TheStreet.com, Inc. (safety ratings); and
	  • Standard & Poor's (long-term insurer financial strength). Group with financial questions
	
	If your organization is not publicly traded provide a credit rating that would substitute.
		3 points	Unlimited

23.16.5.4	**Insolvency, Federal Financial Participation, and Access to Records, Books and Documents** Provide a statement of whether or not, in the last ten (10) years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to	3 points	5 pages

	emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries in this response. Describe the Proposer's general ledger and accounting system and how the system tracks and records revenue and expenses from separate funding streams, including location of system and records. Describe the Proposer's experience with audits from governmental agencies. Provide two examples of actual audit reports and the resulting corrective action plan.		
23.16.5.5	**Financial Guarantees for Performance** Performance bond/retainage. Describe how the Proposer will meet the performance bonding/retainage requirement outlined in the RFP. For purposes of this response, assume that the initial performance bonding/retainage requirement is approximately 10% of the total annual contract. Monetary penalties. Describe the Proposer's experience in performing contracts with monetary penalties provisions, and acknowledge the Proposer's acceptance of the remediation provisions of this RFP. Describe any sanctions issued against the proposer including reason, amount of sanction and corrective actions to resolve the issue.	3 points	3 pages

23.16.6. Work Plan/Project Execution

23.16.6.1. Technical/Fiscal Requirements Proposal

23.16.6.1.1. The Technical/Fiscal proposal response will be scored by a separate PRC and should be clearly marked identifying it from other proposal response sections. The response must include answers to the following queries weighted as indicated in the table below.

23.16.6.1.2. Any response beyond the page limit given below will be disregarded.

Technical/Fiscal Requirements Proposal Content			
Question Number	**Proposal Request**	**Point Value**	**Page Limit**
23.16.6.1.1	Describe the proposer's general approach and ability to fulfill the requirements of the scope of work relative to each of the following sections. For each of these sections, please provide specific staffing configurations and an organization chart that	3 points	5 pages

	includes position titles, number of positions, qualifications and reporting relationships, as well as, associated workflows that illustrate how the proposer's organization will fulfill the obligations of this contract. Share relevant examples from the proposer's other public sector contracts which proposer believes demonstrate the proposer's ability to deliver on this scope of work: • SMO Reimbursement • Provider Payments • Systems and Technical Requirements		
23.16.6.1.2	Describe how proposer will configure its system to address the billing complications associated with mixed service protocols.	3 points	3 pages
23.16.6.1.3	Describe the Proposer's third party liability and coordination of benefits process for identifying other health insurance. Include the capture and storing of other health insurance information. Include any system edits invoked during claims processing.	3 points	3 pages
23.16.6.1.4	Describe the Proposer's telephone system capabilities, call center software and operating systems.	3 points	3 pages
23.16.6.1.5	Describe how Information Technology (IT) and claims management functions will be organized, including staff that will be Louisiana-based and staff available from the Proposer's corporate operations. Provide an organizational chart for IT and claims management that includes position titles, numbers of positions, reporting relationships, and location. Describe the qualifications of staff.	3 points	3 pages
23.16.6.1.6	Describe training on the Proposer's systems including, but not limited to, EHR, claims systems, website, training portals, and other provider-based systems, etc. for the following entities: • Providers • IT and claims staff • State agency staff • Other personnel that interact with the proposer's systems	3 points	3 pages
23.16.6.1.7	Describe the Proposer's software systems and hardware for managed care and claims payment functions. Include any ancillary modules or systems in use for other related functions (e.g., provider, eligibility, authorizations, data store) and how the systems are interfaced. Please provide a workflow diagram of the process.	3 points	3 pages
23.16.6.1.8	Describe how the BH MIS will electronically and securely interface with the Department of Health and Hospitals (DHH) Medicaid Medical Information System (MMIS) system, the DHH-Office of Behavioral Health (OBH) data warehouse, including the capability of interagency electronic transfer to and from the participating State agencies (DHH, DHH-OBH, the Department of Child and Family Services, the Department of Education (LDOE) and the Office of Juvenile Justice) as needed to support operations.	3 points	3 pages
23.16.6.1.9	Describe the information system proposer has to support the operations and practice of the Wraparound Agencies (WAAs) in	3 points	3 pages

	accordance with the fidelity standards of the National Wraparound Initiative.		
23.16.6.1.10	Proposer provided documentation of their experience in developing data exchange protocols with state agencies and providers for the transfer of detailed client-level data to support state and federal reporting and quality monitoring, including success/consistency in transfer of data with other states.	3 points	3 pages
23.16.6.1.11	Describe the Proposer's use of internet website for providers, including any interface with the claims system, eligibility and provider data. Include provider capabilities to use the website to submit authorization requests, claims or inquiries.	3 points	3 pages
23.16.6.1.12	Describe the Proposer's experience and capabilities in using, creating and sharing data and maintaining electronic health records. Explain the proposer's strategy for connecting and transmitting data between the proposer's EHR and other provider electronic health record systems for full functionality.	3 points	3 pages
23.16.6.1.13	Describe the Proposer's system's ability to send and receive data from other agencies, consistent with the collaboration requirement in the Scope of Work.	3 points	3 pages
23.16.6.1.14	Describe the Proposer's reporting capabilities. Include the reporting functionality, where the reporting is performed (e.g., online or separate database) with how current data is for reporting. Describe ad hoc reporting capabilities and anticipated turnaround time.	3 points	3 pages
23.16.6.1.15	Describe the Proposer's technical support or "help desk" services available to front-end users of the proposer's information systems and the proposer's approach for resolution including response times.	3 points	3 pages
23.16.6.1.16	Describe the Proposer's experience with the HIPAA 835 and electronic funds transfer (EFT).	3 points	3 pages
23.16.6.1.17	Describe the Proposer's internal claims audit including percent of claims audited. Provide a sample of the reports used in this process.	3 points	3 pages
23.16.6.1.18	Describe the proposer's approach to prioritizing system changes including self-identified modifications and requests by state agencies, providers, and the contractor. How will proposer manage a large volume of competing demands for project completion?	3 points	3 pages
23.16.6.1.19	Describe the Proposer's coordination of benefits experience for determining payment.	3 points	3 pages
23.16.6.1.20	*Additional Information:* In addition to required systems reports, provide a list and explanation of system reports and their frequency that proposer feels would provide value in managing the program	3 points	3 pages

23.16.6.2. Quality Management Proposal

23.16.6.2.1. The Quality Management proposal response will be scored by a separate PRC and should be clearly marked identifying it from other proposal response sections. The response must include answers to the following queries weighted as indicated in the table below.

23.16.6.2.2. Any response beyond the page limit given below will be disregarded.

Quality Management Proposal Content			
Question Number	**Proposal Request**	**Point Value**	**Page Limit**
23.16.6.2.1	Describe the proposer's general approach and ability to fulfill the requirements of the scope of work relative to each of the following sections. For each of these sections, please provide specific staffing configurations and an organization chart that includes position titles, number of positions, qualifications and reporting relationships, as well as, associated workflows that illustrate how the proposer's organization will fulfill the obligations of this contract. Share relevant examples from the proposer's other public sector contracts which proposer believes demonstrate the proposer's ability to deliver on this scope of work. • Grievance and Appeal Procedures • Quality Management • Program Integrity	3 points	10 pages
23.16.6.2.2	Outline the proposer's approach and provide the proposer's associated workflows for grievance and appeals including the process for logging, tracking and trending grievances (reference Section 16).	3 points	3 pages
23.16.6.2.3	Describe the proposer's strategy for ensuring compliance with prevention and detection of Medicaid fraud, waste and abuse components of this RFP (reference Section 18).	3 points	3 pages
23.16.6.2.4	Describe how the proposer's utilization and care management, grievance and appeals, and network functions inform the proposer's quality program and strategies.	3 points	3 pages
23.16.6.2.5	Describe how QM functions will be organized, including staff that will be Louisiana-based and staff available from the Proposer's corporate operations. Provide an organizational chart for QM that includes position titles, numbers of positions, qualifications and reporting relationships.	3 points	3 pages
23.16.6.2.6	Describe how members, families/caretakers, providers, advocates, and stakeholders will be involved in the design, implementation and evaluation of QM	3 points	3 pages

	information.		
23.16.6.2.7	Describe how the proposer will resolve QOC concerns and how information related to the concerns will be used to improve the QOC provided to members.	3 points	3 pages
23.16.6.2.8	Provide the following information regarding the two most recent member satisfaction surveys with members of government/public sector managed behavioral health care programs: • Time period • Overall response rate to satisfaction survey • Percent of respondents satisfied overall • Lowest rated item and percent satisfied	3 points	3 pages
23.16.6.2.9	Please describe how proposer would work to develop meaningful reports for each agency and ensure timely submission of the initial and subsequent required deliverable packages.	3 points	3 pages
23.16.6.2.10	Describe how proposer will establish meaningful benchmarks for performance measures.	3 points	3 pages
23.16.6.2.11	*Additional Information:* Does the proposer have NCQA accreditation (No, yes, or in progress)? Verification of the accreditation or work in progress is required in order to receive associated point values.	0 = No 1 = In Progress 2 = Yes	3 pages

23.16.6.3. Member Interface and Benefits Proposal

23.16.6.3.1. The Member Interface and Benefits proposal response will be scored by a separate PRC and should be clearly marked identifying it from other proposal response sections. The response must include answers to the following queries weighted as indicated in the table below.

23.16.6.3.2. Any response beyond the page limit given below will be disregarded.

Member Interface and Benefits Proposal Content			
Question Number	**Proposal Request**	**Point Value**	**Page Limit**
23.16.6.3.1	Describe the proposer's general approach and ability to fulfill the requirements of the scope of work relative to each of the following sections. For each of these sections, please provide specific staffing configurations and an organization chart that includes position titles, number of positions, qualifications and reporting relationships, as well as, associated workflows that illustrate how the proposer's organization will fulfill the obligations of this contract. Share relevant examples from the proposer's other public sector contracts which proposer believes demonstrate the	3 points	15 pages

	proposer's ability to deliver on this scope of work. • Eligibility • Covered Benefits and Services • Care and Utilization Management • Member Education and Communications		
23.16.6.3.2	Describe the proposer's experience with implementing other public sector programs for various populations of focus with differing eligibility requirements. Provides examples of associated challenges that arose and how these were addressed.	3 points	3 pages
23.16.6.3.3	Describe the proposer's approach and provide workflows that illustrate the proposer's process for assessing and developing treatment plans that include services that are appropriate in amount, duration and scope for both Medicaid and non-Medicaid populations.	3 points	3 pages
23.16.6.3.4	Please address how proposer will track the benefit package and funding source of each eligible member and ensure that the member is offered all eligible benefits and that the appropriate funding source reimburses for the covered benefits.	3 points	3 pages
23.16.6.3.5	Please describe how proposer will address the identified service gaps listed in the Non-State Plan Services section of the RFP (p. 106-107), and share examples of strategies utilized with other public sector entities to address similar gaps in services and network.	3 points	3 pages
23.16.6.3.6	Please provide examples of the proposer's experience in managing housing programs and facilitating coordination amongst multiple entities for the purpose of eligibility determinations, placement in housing, and linkage appropriate services.	3 points	3 pages
23.16.6.3.7	Describe how proposer still structure the interface between the proposer's Care Managers and the Wraparound Agencies Child and Family Teams to determine an authorized, appropriate plan of care.	3 points	3 pages
23.16.6.3.8	Describe how the proposer will conduct Care Management (CM) and Utilization Management (UM) of behavioral health (BH) services. Describe how CM and UM will be integrated and organized for all covered populations, including workflow.	3 points	3 pages
23.16.6.3.9	Describe and provide rationale for the organization of the CM/UM program including associated organizational charts.	3 points	3 pages
23.16.6.3.10	Describe the ongoing monitoring protocols for CM/UM staff including the nature and frequency of supervision, documentation of audits, call monitoring, and any other oversight activities.	3 points	3 pages
23.16.6.3.11	Describe how the Proposer will provide an outreach program to ensure that priority populations understand the benefits and services available to them. Include how the Proposer defines and identifies priority population members. Provide	3 points	3 pages

	an example of a successful outreach program.		
23.16.6.3.12	Describe how member services will be organized. Provide an organizational chart that includes position titles, numbers of positions, and reporting relationships. Describe the qualifications of member services staff and supervisors. Please include the ongoing monitoring protocols for member services staff, including the nature and frequency of supervision, documentation of audits, call monitoring, quality review, and any other oversight activities**.**	3 points	3 pages
23.16.6.3.13	Please explain how proposer will ensure appropriate care coordination with the member's primary care providers and provide associated timeframes. Give examples of how proposer achieve this in the proposer's other programs.	3 points	3 pages
23.16.6.3.14	Describe the UM workflow and processes for denial of care and referral to alternative services.	3 points	3 pages
23.16.6.3.15	Describe the authorization process and how it will differ between different levels of care and populations.	3 points	3 pages
23.16.6.3.16	Describe how the Proposer will address the high utilization of inpatient services and emergency room in Louisiana through the CM and UM process. Discuss strategies the Proposer has used successfully in other programs to divert children and adults from inpatient and residential care, decrease their length of stay in inpatient and residential settings and prevent readmissions.	3 points	3 pages
23.16.6.3.17	Describe how the proposer will review and monitor data for utilization, trends and other QM purposes for non-Medicaid populations.	3 points	3 pages
23.16.6.3.18	Describe how the required toll-free twenty-four (24) hour, seven (7) days a week call line will be staffed. Distinguish between Baton Rouge area staff and those located outside of Baton Rouge and Louisiana within the continental United States. Also describe the system back-up plan to cover calls to the toll-free line and how proposer will address hold time requirements in the RFP.	3 points	3 pages
23.16.6.3.19	Describe the proposer's mechanism for live call monitoring the telephone system and other relevant features and explain how this information is used to support staff development and improve the quality of the member's call experience.	3 points	3 pages
23.16.6.3.20	Describe the Proposer's plan to ensure that all callers to a common single point of contact are provided accurate information that fully addresses their need, including call transfer and tracking of calls requiring follow up.	3 points	3 pages
23.16.6.3.21	Describe the Proposer's plan to manage and respond to grievances including call resolution or transfer, staff training, and follow-up with the member or originator of the grievance.	3 points	3 pages
23.16.6.3.22	*Additional information*: What infrastructure do proposer have in place for utilization of peer support for the member's	3 points	3 pages

	benefit?		
23.16.6.3.23	*Additional information:* What is the proposer's system for referrals to informal/natural supports and/or non-LBHP services?	3 points	3 pages

23.16.6.4. Infrastructure Proposal

23.16.6.4.1. The Infrastructure proposal response will be scored by a separate PRC and should be clearly marked identifying it from other proposal response sections. The response must include answers to the following queries weighted as indicated in the table below.

23.16.6.4.2. Any response beyond the page limit given below will be disregarded.

Infrastructure Proposal Content			
Question Number	**Proposal Request**	**Point Value**	**Page Limit**
23.16.6.4.1	Describe the proposer's general approach and ability to fulfill the requirements of the scope of work relative to each of the following sections. For each of these sections, please provide specific staffing configurations and an organization chart that includes position titles, number of positions, qualifications and reporting relationships, as well as, associated workflows that illustrate how the proposer's organization will fulfill the obligations of this contract. Share relevant examples from the proposer's other public sector contracts which proposer believes demonstrate the proposer's ability to deliver on this scope of work. • Health Care Integration • Provider Network Requirements • Provider Services • Transition Requirements	3 points	10 pages
23.16.6.4.2	Discuss how provider relations, network development and network monitoring will be addressed.	3 points	3 pages
23.16.6.4.3	Address the proposer's experience with contracting for services typically provided by child welfare and juvenile justice agencies that are funded through state general funds, federal funds, or grants (i.e., not Medicaid-reimbursable services).	3 points	3 pages
23.16.6.4.4	Provide an example of how the Proposer has developed, organized or implemented another public sector mental health and substance use provider network to successfully achieve system goals similar to those outlined in the RFP.	3 points	3 pages
23.16.6.4.5	Describe how the Proposer will secure sufficient numbers of providers to ensure service access by contract start date. What barriers are anticipated with having sufficient	3 points	3 pages

	access by contract start date? What strategies would the Proposer employ to address these barriers? Identify any staff or subcontractors who will facilitate the transition and discuss their qualifications.		
23.16.6.4.6	Describe the resources for providers to obtain information about covered services, billing requirements, payments and training or other resources.	3 points	3 pages
23.16.6.4.7	Describe how the proposer will develop service alternatives to unnecessary inpatient utilization for children and adults, including those with substance use disorders.	3 points	3 pages
23.16.6.4.8	Discuss strategies the proposer has used and plans to use to develop network capacity that includes these components: • Establishment of priorities for network development • Assessment of current provider capabilities • Collaboration with DHH-OBH in plan development • Input from Proposer's CM/UM staff • Input from individuals, families, and system partners	3 points	3 pages
23.16.6.4.9	Describe the strategies the Proposer will use to facilitate BH provider, primary care physician, DCFS, OJJ, LDOE and OBH collaboration other than at the individual case level. Describe the Proposer's experience in at least one (1) example of collaboration, including the actions and strategies taken and results.	3 points	3 pages
23.16.6.4.10	Describe the proposer's plan to mandate subcontractors' acceptance of all contract requirements and monitoring protocol to ensure that subcontractor (i.e., treatment provider) requirements are continuously met.	3 points	3 pages
23.16.6.4.11	Describe the proposer's plan for implementing a statewide network of crisis response providers, out of home treatment providers, and required waiver service providers. Provide an example of the Proposer's success in responding to gaps in the provider network.	3 points	3 pages
23.16.6.4.12	Describe the proposer's approach to transition planning, particularly in relation to ensuring that member services are not interrupted. Provide a client reference to verify this experience.	3 points	3 pages
23.16.6.4.13	Describe any contract awarded to the proposer which was cancelled or terminated by the contractor, and state the cause and circumstances surrounding the cancellation or termination.	3 points	3 pages
23.16.6.4.14	Provide an implementation plan that addresses the requirements of this request for proposal (RFP), including, but not limited to, establishing a Baton Rouge site, recruitment, hiring and training personnel, network development and information technology (IT). The implementation plan should include tasks, milestones, due dates and parties responsible. The implementation plan	3 points	Unlimited

	shall include: • Schedules and timetables for implementation • Communication plan that includes a plan to communicate with Members, providers and stakeholders • Website development plan • Network development • Clinical transition and service continuation • A staffing plan identifying hiring expectations and staff associated with each task of the implementation period • Training plan for Contractor staff, State Agency staff, Members, providers, and stakeholders • Fiscal requirements and cost avoidance plans • Quality Management • Utilization Management • Grievances and appeals • Overall MIS • Business Continuity, Disaster Recovery, and Risk Management • Contract compliance • Program integrity • A designated full time Project Manager (PM) by the proposer		
23.16.6.4.15	Describe the proposer's business continuity, disaster recovery and emergency preparedness plans. Address how the proposer will participate in disaster recovery when a disaster occurs and a state of emergency is declared by the state.	3 points	3 pages

23.16.6.5. Pharmacy Proposal

23.16.6.5.1. The Pharmacy proposal response will be scored by a separate PRC and should be clearly marked identifying it from other proposal response sections. The response must include answers to the following queries weighted as indicated in the table below.

23.16.6.5.2. Any response beyond the page limit given below will be disregarded.

Pharmacy Benefit Management Proposal Content			
Question Number	**Proposal Request**	**Point Value**	**Page Limit**
23.16.6.5.1	Describe the proposer's general approach and ability to fulfill the requirements of the scope of work relative to Pharmacy Benefit Management. Please provide specific staffing configurations and an organization chart that includes position titles, number of positions, qualifications and reporting relationships, as well as, associated workflows that illustrate how the proposer's organization	3 points	5 pages

	will fulfill the obligations of this contract.		
23.16.6.5.2	Share relevant examples from the proposer's other public sector contracts which proposer believes demonstrates its ability to deliver on this scope of work relative to PBM.	3 points	3 pages
23.16.6.5.3	Describe how the SMO will develop and maintain a Pharmacy and Therapeutics Committee or similar entity for the development, including proposed membership, primary functions and responsibilities.	3 points	3 pages
23.16.6.5.4	Describe how the SMO's PBM activities will provide value in terms of outcomes, savings, and administrative efficiency.	3 points	3 pages
23.16.6.5.5	Describe capabilities and experience in managing, monitoring, and adjudicating behavioral health pharmacy benefits for the Medicaid adult and youth population.	3 points	3 pages
23.16.6.5.6	Describe how the SMO anticipates maintaining an adequate prescriber and dispenser/pharmacy network and plans for toll-free call center for prescribers.	3 points	3 pages
23.16.6.5.7	Provide the SMO's plans for prescriber education, training, and outreach.	3 points	3 pages
23.16.6.5.8	Describe how the SMO would propose managing all behavioral health medications prescribed by authorized behavior health specialists, and describe capabilities to support such a model. Include proposed processes related to prior authorization requests, approvals, denials/non-authorizations, routine and expedited appeals, peer-to-peer reviews, and maximum time frames for each.	3 points	3 pages
23.16.6.5.9	Describe how the SMO plans to develop pharmacy benefit management policy and procedure manual and make it accessible to both prescribers and members. Include samples of proposed behavioral health pharmacy prior authorization forms for use.	3 points	3 pages
23.16.6.5.10	Describe how the SMO will develop and maintain a behavioral health pharmacy formulary and Preferred Drug List (PDL) and benefit management plan, including, but not limited to any/all prior authorization, fail first, step therapy and refill too-soon requirements.	3 points	3 pages
23.16.6.5.11	Describe how the Proposer will review, monitor and analyze pharmacy data for medication side effects, adverse drug interactions and member adherence.	3 points	3 pages
23.16.6.5.12	Describe strategies to detect under- and over-utilization and potential inappropriate utilization of medications by members and by providers.	3 points	3 pages
23.16.6.5.13	Describe proposed processes for override of restrictions related to step therapy and/or fail first protocols.	3 points	3 pages
23.16.6.5.14	Describe the SMO's processes which assure continuity of care and medication access when recipients are discharged from residential facilities on prescribed medications.	3 points	3 pages
23.16.6.5.15	Describe processes for submission of automated	3 points	3 pages

	authorization requests and for communicating authorization decisions to prescribers and members with 24 hours.		
23.16.6.5.16	Describe how the SMO plans to utilize encounter, beneficiary, and prescription data to manage and monitor prescribing practices compared to recognized guidelines.	3 points	3 pages
23.16.6.5.17	Describe how the SMO plans to manage prescribers that deviate from the guidelines and/or standard practice including any drugs administered in a physician's office, hospital, or other professional care setting, which the SMO cannot manage.	3 points	3 pages
23.16.6.5.18	Describe the SMO's management program and approach: for Medication Assisted Treatment (MAT) used for treatment of substance use disorders; to stimulant prescribing; to antipsychotic prescribing in youth; and for injectable antipsychotics.	3 points	3 pages
23.16.6.5.19	Include how the SMO intends to address prescription drug coverage such as changes in therapy tapering from one antipsychotic to a different agent, necessity of use of two agents in the same "global" therapeutic class, and the necessity of adding an injectable agent to an oral regimen.	3 points	3 pages
23.16.6.5.20	Describe how the SMO would employ efficacy and side effect profiles of each class and the number of drugs in the class to determine how many products will be covered without a prior authorization requirement.	3 points	3 pages
23.16.6.5.21	Describe any guarantees the SMO proposes with respect to specialty drug patient outcomes, relative effectiveness, and compliance	3 points	3 pages
23.16.6.5.22	Describe any drugs the SMO would recommend for coverage only under the specialty behavioral health benefit, only under the physical health benefit, and those recommended for coverage under both benefits.	3 points	3 pages
23.16.6.5.23	Describe standard, routine and ad hoc pharmacy benefit management and drug utilization reporting capabilities.	3 points	3 pages
23.16.6.5.24	Describe how pharmacy claims will operate within the SMO's system.	3 points	3 pages
23.16.6.5.25	Describe the SMO's plan for utilization of a Prescription Drug Monitoring Program (PDMP).	3 points	3 pages

23.16.7. All information included in a proposal should be relevant to a specific requirement detailed in proposal content outlined above. For each response, the proposer should include both the section and number of the requirement and the text of the requirement from the RFP Sections 23.16.4 through §23.16.5.

23.16.8. A proposal will be scored according to how well the requirements for each section of the proposal content requirements is addressed. Proposal submissions must specifically address and answer with the required information in its designated section or the response will not be considered.

23.16.9. Attachments/supplemental materials should only be provided as requested in proposal content requirements and should be clearly labeled, including the section and number from Sections 23.16.4 through §23.16.5. Specifically, attachments as mentioned in the proposal content requirements include:

23.16.9.1. Organizational charts

23.16.9.2. Workflow diagrams

23.16.9.3. Sample reports

23.16.9.4. Personnel resumes

23.16.10. These attachments shall **not** be counted against the page limit requirements of the proposal given above. Any information not meeting the proposal content and attachment requirements will be deemed extraneous and will not be considered in the evaluation process.

23.17. Waiver of Administrative Formalities

23.17.1. The Department of Health and Hospitals reserves the right, at its sole discretion, to waive minor administrative informalities contained in any proposal.

23.18. Withdrawal of Proposal

23.18.1. 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.

23.19. Interpretive Conventions

23.19.1. Whenever the terms “shall,” “ensure,” “will,” “must,” or “is required” are used in this RFP in conjunction with a specification or performance requirement, the specification or requirement is mandatory.

23.19.2. 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.

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24.0 EVALUATION AND SELECTION

24.1. Evaluation Criteria

The following procedures will be used to evaluate proposals:

24.1.1. Evaluations will be conducted and scored for each section outlined in Section 23.16 above by a Proposal Review Committee (PRC).

24.1.2. Proposal Review Committee 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.

24.1.3. Evaluations of the financial statements will be conducted by a member of the DHH Office of the Secretary Division of Fiscal Management and/or the Office of Statewide Reporting and Accounting Policy (OSRAP) as applicable.

24.1.4. Each PRC shall evaluate each proposal against the evaluation criteria in this RFP, rather than against other proposals, and scoring will be done by consensus of the PRC members assigned to each proposal section. The scores of all the PRC evaluated sections will be added together for an aggregate score for the entire proposal.

24.1.5. Scoring will be based on a possible total of **400** points and the proposal with the highest total score will be recommended for award.

24.1.6. Hudson/Veteran Small Entrepreneurship Program

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

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

24.1.6.2.1. Proposer is a certified small entrepreneurship: Full amount of the reserved points (40 points).

24.1.6.2.2. 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:

24.1.6.2.2.1. The number of certified small entrepreneurships to be utilized;

24.1.6.2.2.2. The experience and qualifications of the certified small entrepreneurship(s); and

24.1.6.2.2.3. The anticipated earnings to accrue to the certified small entrepreneurship(s).

24.1.7. Evaluation Criteria and Assigned Weights

24.1.7.1. Proposals that pass the preliminary screening and mandatory requirements review will be evaluated based on information provided in the proposal. The evaluation will be conducted according to the following.

Question Number	Category	Assigned Weight	Suggested RFP Sections
23.16.4	**Corporate and Administrative Background Requirements**	**79**	
1	Intro/Administrative Data	12	1 & 2
1.5	Veteran and Hudson Initiatives	40	24.1.6
2	Relevant Corporate Experience	18	6 & 26
3	Personnel Qualifications	9	6
23.16.5	**Corporate Financial Condition**	**15**	**3.2 & 26.17**
23.16.6	**Work Plan/Project Execution**	**281**	
1	Technical/Fiscal	60	7, 12, 14, 19, & 20
2	Quality	32	16, 17, & 18
3	Member Interface and Benefits	69	5, 8, 11, & 15
4	Infrastructure (network, integration, transition)	45	4, 10, 13, & 25
5	Pharmacy	75	9
24.2	**On Site Presentation**	**25**	
TOTAL		**400**	

24.2. On Site Presentations

24.2.1. After the initial evaluation period, DHH-OBH may select the highest scoring proposers that are reasonably susceptible of receiving an award, to conduct an on-site presentation for additional points to be added to the proposers' final scores when making the final determination of contract award. On-site presentations will allow the selected proposers to demonstrate their unique capability to provide the services requested in this RFP.

24.2.2. Proposers selected for on-site presentations should:

24.2.2.1. Provide a strategic overview of services to be provided;

24.2.2.2. Summarize major strengths and additional benefits that the particular proposer can bring to the LBHP and the implementation of this contract;

24.2.2.3. Demonstrate flexibility and adaptability to handle both anticipated and unanticipated changes;

24.2.2.4. Provide proposed solutions to identified gaps in the service/provider array identified in this RFP; and

24.2.2.5. If possible, have the project manager in attendance to provide their view of the partnership envisioned with DHH.

24.2.3. Presentations will be assessed by the PRC for a possible 25 additional points in the scoring process depending on content and responsiveness to the RFP.

24.3. Evaluation Team

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

24.4. Administrative and Mandatory Screening

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

24.5. Clarification of Proposals

24.5.1. 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.

24.6. Announcement of Award

24.6.1. Subject to Section 23.4 above, DHH-OBH will compile the scores and make a recommendation to the head of the agency on the basis of the responsive and responsible proposer with the highest score and deemed to be in the best interest of the state.

24.6.2. The state will notify the successful proposer by carriers that require signature upon receipt, by fax with voice confirmation, or by email with reply confirmation and proceed to negotiate terms for final contract. Unsuccessful proposers will be notified in writing accordingly.

24.6.3. The following shall be made available, upon request, to all interested parties after the "Notice of Intent to Award" letter has been issued:

24.6.3.1. Proposals received *(except for that information appropriately designated as confidential in accordance with R.S. 44.1 et seq);*

24.6.3.2. Selection memorandum along with list of criteria used along with the weight assigned each criteria;

24.6.3.3. Scores of each proposal considered along with overall scores of each proposal considered; and

24.6.3.4. A narrative justifying selection.

24.6.4. 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.

24.6.5. 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.

24.6.6. Mandatory requirements established by DHH are not subject to negotiation.

24.6.7. The award of a contract is subject to the approval of the Division of Administration, Office of Contractual Review.

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25.0 TRANSITION REQUIREMENTS

25.1. Introduction

25.1.1. Transition is defined as those activities that the SMO is required to perform upon implementation or expiration of the contract, termination of the contract, or upon the development of new managed care system under the oversight of DHH in which the SMO must transition contract operations to DHH, a subsequent SMO, or a third party. The transition requirements in this section are applicable upon any termination/change in scope of the contract 1) initiated by DHH-OBH or 2) at the expiration of the contract period and any extensions. This section discusses the SMO fulfilling the following responsibilities:

25.1.1.1. Develop an implementation plan

25.1.1.2. Develop a transition plan

25.1.1.3. Provide transition services

25.1.1.4. Provide transfer of data

25.1.1.5. Provide post-transition services

25.2. Implementation

25.2.1. The transition requirements in this section apply to an incoming SMO.

25.2.2. The purpose of the transition time period is to demonstrate the ability to provide core benefits and services to all assigned members upon completion of the SMO implementation plan.

25.2.3. DHH-OBH may require the SMO to update information submitted in their proposal.

25.2.4. The SMO shall fully cooperate with the previous SMO and DHH-OBH to assure a smooth and timely transition.

25.2.5. Failure to timely or correctly implement transition requirements, implementation plan activities or meet readiness timelines shall subject the SMO to penalties or sanctions identified in the remediation chapter of this RFP.

25.3. Implementation Plan

25.3.1. Upon notification of award, the SMO is required to create a written implementation plan due to DHH-OBH thirty (30) days after contract award. The implementation plan shall present the scope of work for the activities that must occur between the contract award and the go-live date.

25.3.2. The SMO agrees to provide all materials required to complete the implementation plan by the dates established by DHH-OBH, as agreed to in the implementation plan and/or required by a Readiness Review contractor.

25.3.3. The implementation plan shall include all elements required in section 23.16.6.4.14 as well as requirements listed in this section.

25.3.4. The implementation plan shall address:

25.3.4.1. Communication plan with the previous SMO, transition of responsibilities and a timeline;

25.3.4.2. Communication plans with the Medicaid FI;

25.3.4.3. DCFS, OJJ and LDOE communication plan;

25.3.4.4. Member outreach;

25.3.4.5. Provider transition;

25.3.4.6. Member telephone number transfer;

25.3.4.7. Claims system operations readiness for March 1, 2015;

25.3.4.8. SMO staff and provider training plan and curricula; and

25.3.4.9. Information systems readiness prior to March 1, 2015, and training of SMO staff and DHH-OBH staff.

25.3.5. This implementation plan in no way replaces the requirement of a readiness review prior to go-live.

25.3.6. Implementation deadlines may be amended upon agreement of DHH-OBH.

25.4. Transfer of Data, Compatibility of Systems and Testing

25.4.1. The SMO must have hardware, software, network and communications systems with the capability and capacity to handle and operate all systems and subsystems required by this RFP.

25.4.2. Upon notification of award, the new SMO must work with DHH-OBH and the previous SMO to ensure connectivity of all information technology systems and to make adjustments to any of the new SMO's business operations necessary to implement the services described in this RFP.

25.4.3. Prior to go live, the SMO will accept into its system any and all necessary data files and information available from DHH, its contractors, or the previous SMO.

25.4.4. The SMO shall have capabilities to receive all necessary data from the previous SMO and convert all data elements with a 100% match rate at no additional cost to the state.

25.4.5. The SMO will produce data extracts and receive data transfers and transmissions. The SMO must be able to demonstrate the ability to produce and send complete and accurate encounter files.

25.4.6. The SMO will install and test all hardware, software, and telecommunications required to support the contract. The SMO will define and test modifications to the SMO's system(s) required to support the business functions of the contract.

25.4.7. If any errors or deficiencies are evident, the SMO will develop resolution procedures to address the problem identified. The SMO will provide DHH, or designated contractor, with test data files for systems and interface testing for all external interfaces. This includes testing of the required telephone lines for providers and members and any necessary connections to the Medicaid FI, OBH data warehouse and External Quality Review Organization.

25.4.8. The SMO will demonstrate its system capabilities and adherence to contract specifications during readiness review.

25.5. General Transition Requirements

25.5.1. In the event the contract expires or is terminated for any reason, the SMO shall:

25.5.1.1. 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;

25.5.1.2. Promptly supply all information necessary for the reimbursement of any outstanding claims;

25.5.1.3. Comply with direction provided by DHH-OBH to assist in the orderly transition of equipment, services, software, leases, etc. to DHH-OBH or a third party designated by DHH-OBH; and

25.5.1.4. The SMO shall participate in a transition planning team as established by DHH-OBH. The SMO's transition planning team shall include program evaluation staff and program monitoring staff, as well as staff that supports all automated and computerized systems and databases.

25.5.2. In the event the contract or any portion thereof is terminated for any reason, or expires, the SMO shall assist DHH-OBH in the notification to and transition of its members to another SMO at the SMO's own expense.

25.5.3. The SMO's staff shall be utilized during the hand-off of duties. There shall be clear lines of responsibility between the SMO, the replacement SMO, and/or DHH-OBH.

25.5.4. The SMO shall cooperate with the replacement SMO and/or DHH-OBH to assure a smooth and timely transition.

25.6. Transition Plan

25.6.1. In the event of written notification of termination of the contract by DHH-OBH, the SMO shall submit a Transition Plan within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the SMO and DHH-OBH. The

Plan shall address the transition of records and information maintained by the SMO relative to core benefits and services provided to LBHP members. The Transition Plan must be approved by DHH-OBH.

25.6.2. The transition plan must comprehensively detail:

25.6.2.1.1. Proposed approach to transition

25.6.2.1.2. Proposed schedule for transition

25.6.2.1.3. Tasks and timelines for transition

25.6.2.1.4. Transition activities

25.6.2.1.5. All information systems production data, program libraries, and documentation including documentation update procedures during transition

25.6.2.1.6. Resource requirements associated with transition tasks

25.6.3. The detailed plan for transition shall ensure an orderly transfer of responsibility and/or the continuity of those services required under the terms of the contract to a new SMO or DHH-OBH and shall include the following:

25.6.3.1. A realistic schedule and timeline to hand-off responsibilities to the replacement SMO or DHH-OBH.

25.6.3.2. The SMO shall develop a plan on how to best inform and keep SMO employees during the transition.

25.6.3.3. The names of staff that shall be utilized during the hand-off of duties and their responsibilities such that there shall be clear lines of responsibility between the SMO, the replacement SMO and/or DHH-OBH.

25.6.3.4. The actions that shall be taken by the SMO to cooperate with the replacement SMO and/or DHH-OBH to assure a smooth and timely transition.

25.6.3.5. A matrix listing each transition task, the functional unit and the person, agency or SMO responsible for the task, the start and deadline dates to complete the planned task, and a place to record completion of the task.

25.6.3.6. All information necessary for reimbursement of outstanding claims.

25.6.3.7. A plan to transition records and information maintained by the SMO to either DHH, a subsequent SMO, or a third party designated by DHH-OBH.

25.6.4. If the contract is not terminated by written notification as provided above, the SMO shall propose a Transition Plan six (6) months prior to the end of the contract period, including any extensions to such period. The Plan shall address all the requirements listed above.

25.6.5. As part of the Transition Plan, the SMO must provide DHH-OBH with copies of all relevant member and core benefits and services data, documentation, or other pertinent information necessary, as determined by DHH-OBH, for DHH-OBH or a subsequent SMO to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan will describe the SMO'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-OBH and according to the schedule approved by DHH-OBH.

25.6.6. The SMO shall report, in writing, to the State Contract Monitor and within 48 hours of identification of any problems and corrective actions taken regarding the plan for transition.

25.7. Transition Services

25.7.1. The SMO shall complete all work in progress and all tasks called for by transition plan prior to final payment to the SMO. If it is not possible to resolve all issues during the end-of-contract transition period, the SMO shall list all unidentified or held items that could not be resolved, including reasons why they could not be resolved, prior to the end of the contract and provide an inventory of open items along with all supporting documentation. To the extent there are unresolved items, the cost to complete these items will be deducted from the final payment or withheld from retainage or the performance bond as applicable. The SMO shall specify a process to brief the DHH-OBH or replacement SMO on issues before the hand-off of responsibilities.

25.7.2. Fiscal Transition Services

25.7.2.1. Upon contract expiration or termination, DHH-OBH reserves the right to purchase materials or to complete the required work. DHH-OBH may recover any reasonable excess costs resulting from contract cancellation or termination from the SMO by:

25.7.2.1.1. Deduction from an unpaid balance;

25.7.2.1.2. Collection from retainage or performance bond as applicable; or

25.7.2.1.3. Any combination of the above or any other remedies as provided by law.

25.7.2.2. The SMO shall return to DHH-OBH within thirty (30) days of termination or expiration of the contract any funds advanced to the SMO for coverage of members for periods after the date of termination to DHH-OBH within thirty (30) days of termination of the contract.

25.7.2.3. The SMO shall supply all information necessary for reimbursement of outstanding claims.

25.7.3. Member Services Transition Services

25.7.3.1. The SMO shall cooperate with DHH-OBH during the planning and transition of contract responsibilities from the SMO to a replacement SMO or DHH-OBH. The SMO shall ensure that member services are not interrupted or delayed during the remainder of the contract and the transition planning by all parties shall be cognizant of this obligation. The SMO shall:

25.7.3.1.1. Make provisions for continuing all management and administrative services and the provision of services to members until the transition of all members is completed and all other requirements of this contract are satisfied.

25.7.3.1.2. Designate a transition coordinator who is intimately familiar with the daily operations and requirements of services and benefits. The transition coordinator shall interact closely with DHH-OBH and the staff from the new SMO to ensure a safe and orderly transition and shall participate in all transition meetings.

25.7.3.1.3. Upon DHH-OBH request, submit for approval an additional detailed plan for the transition of its members.

25.7.3.1.4. Provide all reports set forth in this contract and necessary for the transition process.

25.7.3.1.5. Notify providers, subcontracts and members of the contract expiration or termination, as directed by DHH-OBH, including transfer of provider network participation to DHH-OBH or its designee.

25.7.3.1.6. Complete payment of all outstanding obligations for covered services rendered to members. The SMO shall cover continuation of services to members for the duration of the period for which payment has been made as well as for inpatient admissions up until discharge.

25.7.3.1.7. Transfer the toll-free call center line telephone numbers to DHH-OBH or subsequent SMO to allow for the continuous use of the number for member services and provider services numbers.

25.7.3.2. In the event of contract termination, the SMO shall stop all work as of the effective date contained in the Notice of Termination and shall immediately notify all management subcontracts, in writing, to stop all work as of the effective date of the Notice of Termination. Upon receipt of the Notice of Termination, and until the effective date of the Notice of Termination, the SMO shall perform work consistent with the requirements of this contract and in accordance with a written plan approved by DHH-OBH for the orderly transition of members to another SMO. Unless otherwise directed by DHH-OBH, the SMO shall direct

subcontracted providers to continue to provide services consistent with the member's treatment plan or plan of care.

25.8. Transfer of Data

25.8.1. The SMO shall transfer all data regarding the provision of member core benefits, member core services, and all data and information necessary to transition operations to DHH-OBH, subsequent SMO, or a third party, at the sole discretion of and as directed by DHH-OBH. Data, information, and services necessary and sufficient to enable DHH-OBH to map all SMO program data from the SMO's system(s) to the replacement system(s) of DHH-OBH or subsequent SMO, including comprehensive data dictionary. All transfers of data must be compliant with HIPAA.

25.8.2. The SMO must transfer information necessary to transition operations including: data and reference tables; data entry software; third-party software and modifications; documentation relating to software and interfaces; functional business flows; and operation information including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operation information regarding subcontractors. For purposes of this provision, "documentation" means all operations, technical or user manuals used in conjunction with software, services, and deliverables, that DHH-OBH determines are necessary to view and extract application data in a proper format. The SMO must provide the documentation in the formats in which the documentation exists at the expiration or termination of the contract.

25.8.3. All relevant data must be received and verified by DHH-OBH or the subsequent SMO. If DHH-OBH determines that not all of the data regarding the provision of member core benefits and services to members was transferred to DHH-OBH or the subsequent SMO, as required, or the data is not HIPAA compliant, DHH-OBH reserves the right to hire an independent contractor to assist DHH-OBH 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 SMO transitioning out.

25.8.4. The SMO shall cooperate fully with a subsequent SMO and DHH-OBH during Transition Period including, at a minimum, sharing and transferring behavioral health member information and records, as required by DHH-OBH.

25.8.5. The new SMO shall fully cooperate with the previous SMO and DHH-OBH during the Transition Period, including receiving all necessary data from the previous SMO and conversion of all data elements with a 100% match rate at no additional cost to the state.

25.8.6. Upon the request of DHH-OBH and for a period of up to twenty-four (24) months following the termination of this contract, the SMO shall make available to DHH-OBH and to other agencies of the state and to providers participating in the state Medicaid program continued access and support to the SMO EHR for the continuation of business operations necessary to ensure the continuation of service delivery. Such availability of the SMO EHR shall be made either by the SMO continuing to host and operate the

EHR on the SMO's hardware or by delivering to DHH-OBH the EHR and all necessary user documentation to enable DHH-OBH to operate the system, as determined by DHH-OBH. Such support shall be made available directly by the SMO or through an arrangement with the SMO's third-party vendor, as determined by mutual agreement of the parties. For purposes of this paragraph, support shall include all maintenance necessary to ensure that all functionality of the EHR required by this RFP and available during the term of this RFP is available during the EHR Continuation Period. Nothing in this paragraph is intended to limit the ability of DHH-OBH, any other agency of the state, or any provider from purchasing the vendor services directly from the third-party EHR vendor.

25.9. Post-Transition Services

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

25.9.2. If the SMO does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for DHH-OBH or the subsequent SMO to assume the operational activities successfully, the SMO agrees to reimburse DHH-OBH 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.

25.9.3. The SMO must pay any and all additional costs incurred by DHH-OBH that are the result of the SMO's failure to provide the requested records, data or documentation within the time frames agreed to in the Transition Plan.

25.9.4. The SMO 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 SMO agrees to repay any valid, undisputed audit exceptions, penalties, or findings imposed on or taken by DHH in any audit of the contract.

25.9.5. The expiration or termination or suspension shall not affect the obligation of the SMO to indemnify DHH-OBH for any claim by any third party against the state or DHH-OBH arising from the SMO's performance of this contract and for which the SMO would otherwise by liable under this contract.

25.10. Transition to Managed Care Contract for Long-Term Supports and Services

25.10.1. It is the state's intent to enter into a managed care contract which shall offer holistic healthcare to its members requiring long-term care, including behavioral health services.

25.10.2. The SMO 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.

25.10.3. This transition will result in the loss of Per Member Per Month (PMPM) payments to the SMO for members transitioning out of the LBHP 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.

25.10.4. The SMO shall adhere to all transition requirements provided by DHH upon implementation of the new managed care contract.

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26.0 TERMS AND CONDITIONS

26.1. General Requirements

26.1.1. The SMO shall successfully complete a readiness review as specified in Section 21.6 of this RFP prior to the effective date in the time frame specified by DHH. If the SMO does not pass the readiness review the contract shall be terminated by DHH.

26.1.2. In the event the state exercises such right, all terms and conditions, requirements and specifications of the contract shall remain the same and apply during the renewal period, pursuant to the following:

26.1.2.1. DHH will contract with an actuarial firm to calculate actuarially sound capitation rate ranges for each year of the contract.

26.1.2.2. If the state elects to renew the contract, the SMO shall accept the amount of rate adjustment(s) developed by DHH-OBH. The contracted rates will be within the actuarially sound rate range developed by DHH's actuary.

26.1.2.3. DHH, at its discretion, may adjust the rate to reflect trends occurring in the healthcare market that fall within the actuarial sound rate range, subject to available funds.

26.1.3. The SMO agrees to comply with all state and federal laws, regulations, and policies as they exist or as subsequently amended that are or may be applicable to this contract, not specifically mentioned in this section, including those in the DHH pro forma contract. 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 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 SMO may request DHH to make policy determinations required for proper performance of the services under this contract.

26.2. Amendments

26.2.1. The contract may be amended at any time as provided in this paragraph. The contract may be amended whenever appropriate to comply with state and federal requirements or state budget reductions, provided however, that rates must be certified as actuarially sound. No modification or change of any provision of the contract shall be made or construed to have been made unless such modification is mutually agreed to in writing by the SMO 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.

26.2.2. 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 LBHP. Such clarifications shall be implemented by the SMO and will not require an amendment to the contract.

26.3. Applicable Laws and Regulations

26.3.1. The SMO agrees to comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

26.3.1.1. Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);

26.3.1.2. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 U.S.C. §7401, et seq.) and 20 USC §6082(2) of the Pro-Children Act of 1994 (P.L. 103-227);

26.3.1.3. 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 SMO 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;

26.3.1.4. Title VII of the Civil Rights Act of 1964 (42 U.S.C. §2000e) in regard to employees or applicants for employment;

26.3.1.5. 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;

26.3.1.6. 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;

26.3.1.7. 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;

26.3.1.8. The Balanced Budget Act of 1997, P.L. 105-33, and the Balanced Budget Refinement Act of 1999, P.L. 106-113;

26.3.1.9. The Americans with Disabilities Act, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;

26.3.1.10. Sections 1128 and 1156 of the Social Security Act, relating to exclusion of the SMO for fraudulent or abusive activities involving the Medicare and/or Medicaid programs;

26.3.1.11. The federal Drug Free Workplace Act of 1988, P.L. 100-690, as implemented in 45 CFR Part 82;

26.3.1.12. Title IX of the Education Amendments of 1972 regarding education programs and activities; and

26.3.1.13. The Mental Health Parity and Addiction Equity Act (MHPAEA), P.L. 110-343. The SMO shall follow CMS guidance regarding the Patient Protection and Affordable Care Act (PPACA) expansion of the MHPAEA as it relates to PIHPs.

26.4. Assessment of Fees

26.4.1. The SMO and DHH agree that DHH may elect to deduct any assessed fees, fines, penalties, or sanctions from payments due or owing to the SMO or direct the SMO to make payment directly to DHH for any and all assessed fees, fines, penalties, or sanctions. In the alternative, DHH may elect to withhold assessed fees, fines, penalties, or sanctions from the retainage funds reserved as per Section 26.7. The choice is solely and strictly at DHH's discretion.

26.5. Attorney's Fees

26.5.1. In the event DHH should prevail in any legal action arising out of the performance or non-performance of the contract, the SMO shall pay, in addition to any monetary fines, damages, penalties, or sanctions, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

26.6. Insurance Requirements

26.6.1. General Insurance Information

26.6.1.1. The SMO 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-OBH for approval before work commences. The SMO shall be named as the insured on the policy.

26.6.1.2. Said insurance 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.

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

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

26.6.1.5. Subcontract's Insurance. The SMO shall require that any and all subcontracts, which are not protected under the SMO's own

insurance policies, take and maintain insurance of the same nature and in the same amounts as required of the SMO.

26.6.1.6. The SMO and its subcontracts shall procure and maintain, until all of their obligations have been discharged, including until any warranty periods under this contract are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the SMO, his agents, representatives, employees, or subcontracts. The insurance requirements herein are minimum requirements for this contract and in no way limit the indemnity covenants contained in this contract. The state in no way warrants that the minimum limits contained herein are sufficient to protect the SMO from liabilities that might arise out of the performance of the work under this contract by the SMO, its agents, representatives, employees, or subcontracts, and SMO is free to purchase additional insurance.

26.6.1.7. Insurance Covering Special Hazards. Special hazards as determined by DHH shall be covered by rider or riders in the Commercial General Liability Insurance Policy or policies herein elsewhere required to be furnished by the SMO, or by separate policies of insurance in the amounts as defined in any Special Conditions of the contract included therewith.

26.6.1.8. Licensed and Non-Licensed Motor Vehicles. The SMO shall maintain during the life of the contract, Automobile Liability Insurance in an amount not less than combined single limits of $1,000,000 per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the contract on the site of the work to be performed there under, unless such coverage is included in insurance elsewhere specified.

26.6.2. Workers' Compensation Insurance

26.6.2.1. Before any work is commenced on the contract, the SMO shall obtain and maintain during the life of the contract, Workers' Compensation Insurance for all of the SMO's employees that provide services under the contract.

26.6.2.2. The SMO shall require that any subcontractor and/or contract providers obtain all similar insurance prior to commencing work unless such employees are covered by the protection afforded by the SMO.

26.6.2.3. In case any class of employees engaged in work under the contract at the site of the project is not protected under the Workers' Compensation Statute, the SMO shall provide for any such employees, and shall further provide or cause any and all subcontracts to provide Employer's Liability Insurance for the protection of such employees not protected by the Workers' Compensation Statute.

26.6.2.4. The SMO 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.

26.6.2.5. 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 SMO, subcontractor and/or provider obtaining such insurance.

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

26.6.3. Commercial General Liability Insurance

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

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

26.6.3.3. 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 combined single limits of one (1) million dollars ($1,000,000).

26.6.4. Reinsurance

26.6.4.1. The SMO shall hold a certificate of authority from the Department of Insurance (DOI) and file all contracts of reinsurance, or a summary of the plan of self-insurance with DOI and DHH.

26.6.4.2. 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.

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

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

26.6.4.5. Errors and Omissions Insurance

26.6.4.5.1. The SMO 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 (1) million dollars ($1,000,000), per occurrence.

26.6.4.5.2. 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.

26.7. Bond Requirements

26.7.1. Performance Bond

26.7.1.1. The SMO may be required to establish and maintain a performance bond of ten (10) million dollars ($10,000,000) for as long as the SMO 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 SMO's obligations to DHH and (2) performance by the SMO of its obligations under this contract [42 CFR §438.116].

26.7.1.2. Upon receipt of a written directive by DHH, the bond must be obtained from an agent appearing on the United States Department of Treasury's list of approved sureties. The performance bond must be made payable to the state. The contract and dates of performance must be specified in the performance bond. The original performance bond must be submitted to DHH. The original performance bond will have the raised engraved seal on the bond and on the Power of Attorney page. The SMO must retain a photocopy of the performance bond.

26.7.1.3. The performance bond must be rated at least A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The SMO shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The SMO shall be in material breach of this contract if it fails to maintain or renew the performance bond as required by DHH.

26.7.1.4. In the event that DHH exercises an option to renew the contract for an additional period, the SMO shall be required to maintain the validity and enforcement of any required bond for the

specified period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal.

26.7.1.5. In the event of a default by the SMO, DHH may, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the purposes of the following:

26.7.1.5.1. Paying any damages because of a breach of the SMO's obligations under this contract;

26.7.1.5.2. Reimbursing DHH for any payments made by DHH on behalf of the SMO; and

26.7.1.5.3. Reimbursing DHH for administrative expenses incurred by reason of a breach of the SMO's obligations under this contract, including, but not limited to, expenses incurred after termination of this contract for reasons other than the convenience of the state by DHH.

26.7.1.6. The SMO agrees that if it is declared to be in default of any material term of this contract, the SMO shall:

26.7.1.6.1. Make any payments or expenditures deemed necessary to DHH-OBH, in its sole discretion, incurred by DHH-OBH in the direct operation of the contract pursuant to the terms of this contract and to reimburse DHH-OBH for any extraordinary administrative expenses incurred in connection with the direct operation of the SMO.

26.7.1.6.2. Reimburse DHH-OBH for expenses exceeding the performance bond amount.

26.7.2. Fidelity Bond

26.7.2.1. The SMO shall secure and maintain during the life of the contract a blanket fidelity bond on all personnel in its employment.

26.7.2.2. 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 SMO and its subcontractors.

26.7.2.3. The SMO must submit to DHH a photocopy of the fidelity bond at least thirty (30) days prior to the go-live date of the contract is mandated unless this time requirement is reduced by mutual agreement of the parties.

26.8. Retainage

26.8.1. At the discretion of DHH, DHH may secure a retainage of ten percent (10%) from all capitation payments under the contract as surety for performance in addition to the performance bond or in lieu of the bond. On successful completion of contract deliverables, the retainage amount may be released on an annual basis.

26.8.2. In the event of a default by the SMO, DHH may, in addition to any other remedies it may have under this contract, keep any collected retainage funds for the purposes of the following:

26.8.2.1. Paying any damages because of a breach of the SMO's obligations under this contract;

26.8.2.2. Reimbursing DHH for any payments made by DHH on behalf of the SMO; and

26.8.2.3. Reimbursing DHH for administrative expenses incurred by reason of a breach of the SMO's obligations under this contract, including, but not limited to, expenses incurred after termination of this contract for reasons other than the convenience of the state by DHH.

26.8.3. During the transition to a new contractor, in lieu of the customary 10% retainage for the last month of the contract, DHH may withhold seventy-five percent (75%) of the final payment to the SMO for a maximum of ninety (90) days from the due date of such amount to ensure that the outgoing SMO 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.

26.8.4. The SMO agrees that if it is declared to be in default of any material term of this contract, the SMO shall reimburse DHH-OBH for expenses exceeding the retainage amount.

26.9. Safeguarding Information

26.9.1. The SMO 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 SMO's written safeguards shall:

26.9.1.1. Be comparable to those imposed upon DHH by 42 CFR Part 431, Subpart F and La.R.S. 46:56;

26.9.1.2. State that the SMO 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;

26.9.1.3. 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;

26.9.1.4. Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

26.9.1.5. Specify appropriate personnel actions to sanction violators.

26.10. Board Resolution/Signature Authority

26.10.1. The SMO, if a corporation, shall secure and attach to the contract a formal Board Resolution, dated within three (3) years, indicating the signatory to the contract is a corporate representative and authorized to sign said contract.

26.11. Confidentiality of Information

26.11.1.1. The SMO shall assure that medical records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through the SMO'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 and other state and federal laws, DHH policies or this contract. The SMO 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.

26.11.1.2. All information as to personal facts and circumstances concerning members or potential members obtained by the SMO 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 HIPAA 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.

26.11.1.3. Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 as agreed upon in the HIPAA Business Associate Agreement.

26.11.1.4. The SMO 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 SMO 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.

26.11.1.5. The SMO is required to submit an incident report to DHH-OBH with a corrective action plan and timelines for implementation of correction for approval by DHH-OBH within three (3) days of SMO discovery of any HIPAA violation, breach or use or disclosure of PHI as defined in 45 CFR §164.402, or potential

violation, breach, or disclosure within three (3) days of DHH-OBH notifying the SMO of a HIPAA violation, breach, use, or disclosure of PHI as defined in 45 CFR §164.402 or potential violation, breach, or disclosure. The incident report shall include, at a minimum:

26.11.1.5.1. Date of discovery;

26.11.1.5.2. Date or date range of violation/potential violation;

26.11.1.5.3. Cause of the incident including sequence and mechanisms;

26.11.1.5.4. Number of unauthorized individuals who viewed PHI;

26.11.1.5.5. Number of affected individuals whose PHI was compromised;

26.11.1.5.6. Steps taken to correct this incident to date, and planned steps to correct incident;

26.11.1.5.7. Steps taken to prevent reoccurrence from happening in the future;

26.11.1.5.8. Steps taken to mitigate any harmful effects caused by the unauthorized disclosure;

26.11.1.5.9. Any training or other corrective action targeted to SMO staff or providers subsequent to this incident;

26.11.1.5.10. Plans for notification of CMS/HHS; and,

26.11.1.5.11. Notification plan to individuals.

26.11.1.5.12. A risk assessment which includes the following:

26.11.1.5.12.1. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

26.11.1.5.12.2. The unauthorized person who used the PHI or to whom the disclosure was made;

26.11.1.5.12.3. Whether the PHI was actually acquired or viewed; and

26.11.1.5.12.4. The extent to which the risk to the PHI has been mitigated.

26.12. Effect of Termination on SMO's HIPAA Privacy Requirements

26.12.1. Upon termination of this contract for any reason, the SMO shall return or destroy all Protected Health Information received from DHH, or created or received by the SMO on behalf of DHH. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of the SMO. The SMO shall not retain any copies of the Protected Health Information.

26.12.2. In the event that the SMO determines that returning or destroying the Protected Health Information is not feasible, the SMO 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 SMO 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 SMO maintains such Protected Health Information.

26.13. Contract Language Interpretation

26.13.1. The SMO 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.

26.14. Governing Law and Place of Suit

26.14.1. 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 provision both as to 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 as the exclusive venue for same, and any federal suit shall be filed in the U.S. District Court for the Middle District of Louisiana as the exclusive venue for same. This section shall not be construed as providing a right / cause of action to the SMO in any of the aforementioned Courts.

26.15. Severability

26.15.1. If any provision of this contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both DHH and SMO 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 SMO will be discharged from further obligations created under the terms of the contract.

26.16. Cooperation with Other Contractors

26.16.1. 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 SMO agrees to cooperate fully with such other contractors. The SMO shall not commit any act that will interfere with the performance of work by any other contractor.

26.16.2. The SMO's failure to cooperate and comply with this provision, shall be sufficient grounds for DHH to halt all payments due or owing to the SMO

until it becomes compliant with this or any other contract provision. DHH-OBH's determination on the matter shall be conclusive and not subject to Appeal.

26.17. Copyrights

26.17.1. 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.

26.18. Corporation Requirements

26.18.1. If the SMO is a corporation, the following requirement must be met prior to execution of the contract:

26.18.1.1. If a for-profit corporation whose stock is not publicly traded, the SMO must file a Disclosure of Ownership form with the Louisiana Secretary of State.

26.18.1.2. If the SMO is a corporation not incorporated under the laws of the state, the SMO must obtain a Certificate of Authority pursuant to La.R.S. 12:301-302 from the Louisiana Secretary of State.

26.18.1.3. The SMO must provide written assurance to DHH from the SMO's legal counsel that the SMO 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.

26.19. Employment of Personnel

26.19.1. In all hiring or employment made possible by or resulting from this contract, the SMO agrees that:

26.19.1.1. There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin; and

26.19.1.2. 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.

26.19.2. 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 SMO 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 SMO concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the SMO

concerning employment made possible as a result of this contract shall conform to federal, state, and local regulations.

26.20. Non-Discrimination

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

26.21. Emergency Management Plan

26.21.1. The SMO shall submit an emergency management plan within forty-five (45) days from the date the signed contract is approved by DOA/OCR to DHH-OBH for approval. The emergency management plan shall specify actions the SMO shall conduct to ensure the ongoing provision of health services in an epidemic, natural disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, state-required shelter in place orders, and technological and/or attack-related emergencies. Revisions to the DHH-OBH approved emergency plan shall be submitted to DHH-OBH for approval no less than thirty (30) days prior to implementation of requested changes. The SMO shall submit an annual certification (from the date of the most recently approved plan) to DHH-OBH certifying that the emergency plan is unchanged from the previously approved plan.

26.21.2. At a minimum, the plan should include the following:

26.21.2.1. How the SMO will educate its members and providers regarding hurricane preparedness and evacuation planning (must include plan for accessing services at alternate locations if evacuated);

26.21.2.2. Examples of the SMO outreach campaign information for both members and providers. Information should include references, contact information and websites for local and state resources including, but not limited to, DHH-OPH, Red Cross, GOHSEP, FEMA, Louisiana State Police, and National Weather Services Offices;

26.21.2.3. An SMO contact list (phone and email) for members/providers to contact to determine where healthcare services may be accessed/rendered;

26.21.2.4. How the SMO will identify members with special healthcare needs who require evacuation assistance and informing local officials of those identified;

26.21.2.5. Information regarding other types of emergencies (epidemics, man-made disasters);

26.21.2.6. Information regarding the business continuity plan and internal disaster training of the SMO;

26.21.2.7. MOUs with healthcare providers (especially hospitals and dialysis providers) in parishes outside of the disaster area for provision of services to evacuated members;

26.21.2.8. MOUs with healthcare facilities in parishes outside of the disaster area that would allow evacuated providers to render services within their facilities;

26.21.2.9. Registry of healthcare providers (LMHPs, etc.) who are willing to volunteer in state operated special needs shelters, and work with DHH-OBH and the local governing entity for specific trainings required;

26.21.2.10. Use of EHR to provide healthcare providers access to member's health history and receive information of care provided during evacuation (will members be able to access their medical records through EHR or other means when there is an evacuation, closure of provider's office, for example);

26.21.2.11. Information regarding how members and providers will interact with their call center prior to, during, and after an event. The SMO shall provide examples to DHH-OBH regarding the scripts that will be released to members during the aforementioned times;

26.21.2.12. Plan to disseminate information to members regarding the availability status of their providers (ex: closed permanently or temporarily) and any alternate providers that may be available in the event of a disaster;

26.21.2.13. Emergency contracting with out-of-state healthcare providers to provide healthcare services to evacuated members;

26.21.2.14. Provide a plan to ensure access to emergency psychiatric acute beds for adults in need of inpatient treatment during and after an emergency event;

26.21.2.15. Plan to ensure appropriate members have access to EPSDT services currently not in the Service Definitions Manual but medically necessary from out-of-network or out-of-state providers in a timely manner; and

26.21.2.16. Plan for the continuation of SMO operations, including but not limited to, member verification, claims processing, provider/member complaints handling, and prior authorization.

26.21.3. The SMO shall participate in any appropriate disaster/emergency trainings meetings that are provided by DHH and/or its partners

(including, but not limited to, GOHSEP, DCFS, FEMA, Red Cross, Local/Parish Governing Authorities).

26.22. Political Activity

26.22.1. 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."

26.22.2. The SMO shall not use funds paid to the SMO by DHH-OBH, or interest earned, for the purpose of influencing or attempting to influence any officer or employee of any state or federal agency; or any member of, or employee of a member of, the United States Congress or the Louisiana State Legislature:

26.22.2.1. In which it asserts authority to represent DHH-OBH or advocate the official position of DHH-OBH in any matter before a state or federal agency; or any member of, or employee of a member of, the United States Congress or the Louisiana State Legislature.

26.22.2.2. In connection with awarding of any federal or state contract, the making of any federal or state grant, the making of any federal or state loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal or state contract, grant, loan, or cooperative agreement.

26.22.3. Proposers shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier up to the recipient (45 CFR Part 3).

26.22.4. By signing this contract, the SMO signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the state, 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.

26.23. Entire Contract

26.23.1. This contract, together with the RFP and addenda issued thereto by DHH, the proposal submitted by the SMO 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.

26.23.2. The SMO shall comply with all provisions of the contract and with the performance of the provisions of said contract. The SMO shall be bound by all applicable Department issued guides. The SMO 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 SMO shall comply with all applicable DHH policies and procedures in effect throughout the duration of the contract period. The SMO shall comply with all applicable DHH provider manuals, rules and regulations and guides.

26.23.3. DHH, at its discretion, will issue correspondence to inform the SMO of changes in Medicaid policies and procedures which may affect the contract. Unless otherwise specified in the Medicaid correspondence the SMO will be given sixty (60) calendar days to implement such changes.

26.24. Incorporation of Attachments & Appendices

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

26.24.2. All appendices referred to in this RFP or attached hereto, are provided to offer clarity on specific obligations under this contract, and as such, are considered required elements of this contract. Appendices can be found in the Procurement Library at this link:

http://new.dhh.louisiana.gov/index.cfm/page/1877

26.25. Independent Assurances

26.25.1. DHH-OBH will also require the SMO and/or subcontractors, if performing a key internal control, to submit to an independent SSAE 16 SOC 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by the state the contractor shall be required to 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.

26.25.2. These audits will require the SMO 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 DHH-OBH and/or the SMO 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.

26.25.3. The SMO shall supply DHH-OBH with an exact copy of the report within thirty (30) calendar days of completion. The SMO shall agree to implement recommendations as suggested by the audits within three months of report issuance at no cost to the state. Cost of the audit is to be borne by the SMO.

26.26. Integration

26.26.1. This contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The SMO 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.

26.27. Order of Precedence

26.27.1. 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:

26.27.1.1. The body of the contract with exhibits and attachments excluding the RFP and the SMO's proposal;

26.27.1.2. This RFP and any addenda or attachments or appendices;

26.27.1.3. SMO Systems Companion Guide; and

26.27.1.4. The proposal submitted by the SMO in response to this RFP.

26.28. Indemnification and Limitation of Liability

26.28.1. Neither party shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. The parties shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under contract.

26.28.2. The SMO shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and hold harmless the state and its authorized users from suits, actions, damages and costs of every name and description relating to personal injury and damage to real or personal tangible property caused by the SMO, its agents, employees, partners or subcontractors, without limitation; provided, however, that the SMO shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the state. If applicable, the SMO will indemnify, defend and hold the state and its authorized users harmless, without limitation, from and against any and all damages, expenses (including reasonable attorneys' fees), claims, judgments, liabilities and costs which may be finally assessed against the state in any action for infringement of a United States Letter Patent with respect to the products furnished, or of any copyright, trademark, trade secret or intellectual property right, provided that the state shall give the SMO:

26.28.2.1. Prompt written notice of any action, claim or threat of infringement suit, or other suit;

26.28.2.2. The opportunity to take over, settle or defend such action, claim or suit at Contractor's sole expense; and

26.28.2.3. Assistance in the defense of any such action at the expense of the SMO.

26.28.3. Where a dispute or claim arises relative to a real or anticipated infringement, the state or its authorized users may require the SMO, at its sole expense, to submit such information and documentation, including formal patent attorney opinions, as the Commissioner of Administration shall require.

26.28.4. The SMO shall not be obligated to indemnify that portion of a claim or dispute based upon:

26.28.4.1. Authorized user's unauthorized modification or alteration of a product, material or service;

26.28.4.2. Authorized user's use of the product in combination with other products not furnished by the SMO;

26.28.4.3. Authorized user's use in other than the specified operating conditions and environment.

26.28.5. In addition to the foregoing, if the use of any item(s) or part(s) thereof shall be enjoined for any reason or if the SMO believes that it may be enjoined, the SMO shall have the right, at its own expense and sole discretion as the authorized user's exclusive remedy to take action in the following order of precedence:

26.28.5.1. To procure for the state the right to continue using such item(s) or part(s) thereof, as applicable;

26.28.5.2. To modify the component so that it becomes non-infringing equipment of at least equal quality and performance; or

26.28.5.3. To replace said item(s) or part(s) thereof, as applicable, with non-infringing components of at least equal quality and performance, or

26.28.5.4. If none of the foregoing is commercially reasonable, then provide monetary compensation to the state up to the dollar amount of the contract.

26.28.6. For all other claims against the SMO where liability is not otherwise set forth in the contract as being "without limitation," and regardless of the basis on which the claim is made, the SMO’s liability for direct damages, shall be the greater of $100,000, the dollar amount of the contract, or two (2) times the charges rendered by the SMO under the contract. Unless otherwise specifically enumerated herein or in the work order mutually agreed between the parties, neither party shall be liable to the other for special, indirect or consequential damages, even if the party has been advised of the possibility of such damages. Neither party shall be liable for lost profits, lost revenue or lost institutional operating savings.

26.28.7. The state and its authorized user may, in addition to other remedies available to them at law or equity and upon notice to the SMO, retain such monies from amounts due the SMO via the withheld retainage, or may proceed against the performance and payment bond, if any, as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against them.

26.28.8. In the event of circumstances not reasonably within the control of the SMO or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the SMO, 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 SMO shall be liable for the core benefits and services required to be provided or arranged for in accordance with this contract.

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

26.29. Hold Harmless as to the SMO Members

26.29.1. The SMO 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, SMO members, or persons acting on their behalf, for healthcare services which are rendered to such members by the SMO and its subcontractors.

26.29.2. The SMO further agrees that the SMO member shall not be held liable for payment for LBHP 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 SMO provided the service directly. The SMO agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by SMO and insolvency of the SMO.

26.29.3. The SMO further agrees that the SMO 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 SMO or does not obtain timely approval or required prior-authorization.

26.29.4. The SMO further agrees that this provision shall be construed to be for the benefit of SMO members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the SMO and such members, or persons acting on their behalf.

26.30. Safety Precautions

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

26.31. Homeland Security Considerations

26.31.1. The SMO shall perform the services to be provided under this contract entirely within the boundaries of the United States. In addition, the SMO 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.

26.31.2. If the SMO performs services, or uses services, in violation of the foregoing paragraph, the SMO 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 SMO shall be required to hold harmless and indemnify DHH pursuant to the indemnification provisions of this contract.

26.31.3. The prohibitions in this section shall also apply to any and all agents and subcontractors used by the SMO to perform any services under this contract.

26.32. Independent Provider

26.32.1. It is expressly agreed that the SMO and any subcontractors and agents, officers, and employees of the SMO 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. It is further expressly agreed that this contract shall not be construed as a partnership or joint venture between the SMO or any subcontractor and DHH and the state.

26.33. Interest

26.33.1. Interest generated through investments made by the SMO under this contract shall be the property of the SMO and shall be used at the SMO’s discretion.

26.34. Loss of Federal Financial Participation (FFP)

26.34.1. The SMO may be liable for any loss of FFP suffered by DHH due to the SMO's, or its subcontractors', failure to perform the services as required under this contract. Payments provided for under this contract may be denied for new members as determined by DHH when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR §438.730.

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

26.35.1. No person or SMO 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 "Office of Behavioral Health," 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.

26.36. Moral and Religious Objections

26.36.1. If the SMO objects to a service on moral or religious grounds, it is not required to provide, reimburse for, or provide coverage of that service, though it would otherwise be required to do so.

26.36.2. If the SMO 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 SMO must furnish information about the services it does not cover in accordance with 1932(b)(3)(B)(ii) of the Social Security Act and 42 CFR §438.102(b)(1) by notifying:

26.36.2.1. DHH-OBH with its proposal, or whenever it adopts the policy during the term of the contract;

26.36.2.2. Members within ninety (90) days after adopting the policy with respect to any particular service; and

26.36.2.3. Members through the inclusion of the information in the member's information manual/handbook.

26.36.3. If the SMO elects not to provide, reimburse for, or provide coverage of a core benefit or service because of an objection on moral or religious grounds, the monthly capitation payment for the SMO will be recalculated.

26.37. Non-Allowable Costs

26.37.1. DHH-OBH follows the federal guidelines for allowable and non-allowable costs as outlined in OMB Circular A-87. This applies to any charitable contribution, donation or support from the SMO to an organization or entity in the form of cash, property or services rendered from SMO funds. In addition, the SMO:

26.37.1.1. Shall not make charitable donations or contributions from SMO program funds.

26.37.1.2. Is allowed to make charitable contributions or donations from its general revenue, earned income funds, or other corporate income funds without DHH-OBH approval, as long as the SMO

does not report such charitable contributions or donations as an Allowable Expense.

26.38. Physician Incentive Plans

26.38.1. The SMO 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.

26.38.2. The SMO will provide assurance satisfactory to DHH that the requirements of 42 CFR §422.208 are met.

26.39. Rate Adjustments

26.39.1. The SMO and DHH both agree that the monthly capitation rates identified in this RFP shall be in effect during the period identified on the SMO Rate Schedule that will be posted on DHH's website. At the sole discretion of DHH, rates may be adjusted during the contract period based on DHH and actuarial analysis, subject to CMS review and approval, and availability of funds.

26.39.2. The SMO 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 SMO refuse to accept the revised monthly capitation rate, the provisions of the RFP for contract termination and transition shall apply.

26.40. Record Retention for Awards to Recipients

26.40.1. Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of six (6) years from the date of submission of the final expenditure report, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

26.40.1.1. 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;

26.40.1.2. Records for real property and equipment acquired with federal funds shall be retained for six (6) years after final disposition;

26.40.1.3. When records are transferred to or maintained by DHH, the six (6) year retention requirement is not applicable to the recipient; and

26.40.1.4. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR §74.53 (g).

26.41. Release of Records

26.41.1. The SMO shall release medical records upon request by members or authorized representatives, as may be directed by authorized personnel

of DHH, appropriate agencies of the state, 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 SMO shall not charge DHH-OBH or their designated agent for any copies of records requested.

26.42. Termination for Convenience

26.42.1. DHH may terminate this contract for convenience and without cause upon thirty (30) calendar days written notice. DHH shall not be responsible to the SMO or any other party for any costs, expenses, or damages occasioned by said termination, i.e., this termination is without penalty. In no case, shall the contract continue beyond the specified termination date.

26.43. Termination for Non-Appropriation of Funds

26.43.1. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act of Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds have not been appropriated.

26.43.2. In the event that federal and/or state funds to finance this contract become unavailable after the effective date of this contract and in the middle of a state fiscal year, or prior to the anticipated contract expiration date, DHH may terminate the contract without penalty. Availability of funds shall be determined solely by DHH. Notification will be made with thirty (30) days written notice when possible.

26.43.3. 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 owed documents.

26.44. Time is of the Essence

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

26.45. Titles

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

26.46. Transfer of Ownership

26.46.1. The SMO shall not sell or transfer any rights or interest relative to its ownership interest as the statewide management organization serving the State of Louisiana through the LBHP during the life of the contract without prior written approval of DHH.

26.46.2. Any action by the SMO in contradiction of this section may subject the SMO to legal action and/or remediation.

26.47. Use of Data

26.47.1. DHH-OBH shall have at least user-defined access to all SMO data systems as needed for verification 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 SMO resulting from this contract.

26.48. Conflict of Interest Provisions

26.48.1. The SMO shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The SMO shall quarterly inquire of its officers and employees concerning such conflicts, and shall inform DHH promptly of any potential conflict. The SMO shall warrant that it shall remove any conflict of interest prior to signing the contract.

26.48.2. 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.

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

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

The State of Louisiana Veteran and Hudson Initiatives are designed to provide additional opportunities for Louisiana-based small entrepreneurships (sometimes referred to as LaVet's and SE's respectively) to participate in contracting and procurement with the state. A certified Veteran-Owned and Service-Connected Disabled Veteran-Owned small entrepreneurship (LaVet) and a Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) small entrepreneurship are businesses that have been certified by the Louisiana Department of Economic Development. All eligible vendors are encouraged to become certified. Qualification requirements and online certification are available at https://smallbiz.louisianaforward.com/index_2.asp.

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

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

Proposer Status and Reserved Points

- Proposer is a certified small entrepreneurship: Full amount of the reserved points
- Proposer is not a certified small entrepreneurship but has engaged one or more certified small 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)

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

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

The statutes (R.S 39:2171 et*. seq.)* concerning the Veteran Initiative may be viewed at http://legis.la.gov/lss/lss.asp?doc=671504 and the statutes (R.S 39:2001 *et. seq.)* concerning the Hudson Initiative may be viewed at: http://legis.la.gov/lss/lss.asp?doc=96265 The rules for the Veteran Initiative (LAC 19:IX.Chapters 11 and 13) and for the Hudson Initiative (LAC 19:VIII.Chapters 11 and 13) may be viewed at http://www.doa.louisiana.gov/osp/se/se.htm

A current list of certified Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurships may be obtained from the Louisiana Economic Development Certification System at https://smallbiz.louisianaforward.com/index_2.asp. Additionally, a list of Hudson and Veteran Initiative small entrepreneurships, which have been certified by the Louisiana Department of Economic Development and who have opted to register in the State of Louisiana LaGov Supplier Portal https://lagoverpvendor.doa.louisiana.gov/irj/portal/anonymous?guest_user=self_reg may be accessed from the State of Louisiana Procurement and Contract (LaPAC) Network http://wwwprd1.doa.louisiana.gov/osp/lapac/vendor/srchven.cfm. When using this site, determine the search criteria (e.g., alphabetized list of all certified vendors, by commodities, etc.) and select SmallE, VSE, or DVSE.

CERTIFICATION STATEMENT

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

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

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

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

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

1. The information contained in its response to this RFP is accurate;
2. Proposer complies with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein;.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's technical and cost proposals are valid for at least 90 days from the date of proposer's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have ***30*** calendar days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov).

Authorized Signature:

Original Signature Only: Electronic or Photocopy Signature are NOT Allowed

Print Name:

Title:

DHH – CF – 1
Revised 2011-06

CONTRACT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

CFMS:
DHH:
Agency #:

AND

FOR

Personal Services ☐ Professional Services ☐ Consulting Services ☐ Social Services

1) **Contractor (Legal Name if Corporation)**	5) **Federal Employer Tax ID# or Social Security # (Must be 11 Digits)**
2) **Street Address**	6) **Parish(es) Served**
City **State** **Zip Code**	7) **License or Certification #**
3) **Telephone Number**	8) **Contractor Status**
4) **Mailing Address (if different)**	**Subrecipient:** ☐ Yes ☐ No **Corporation:** ☐ Yes ☐ No **For Profit:** ☐ Yes ☐ No **Publicly Traded:** ☐ Yes ☐ No
City **State** **Zip Code**	8a) **CFDA#**(Federal Grant #)

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

10) **Effective Date** 11) **Termination Date**

12) This contract may be terminated by either party upon giving thirty (30) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.

13) **Maximum Contract Amount**

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

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

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**First Name**	**Last Name**
	Title	**Phone Number**

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

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

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.
2. Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)
3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.
   Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating DHH Office**.
4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.
5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.
6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.
7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.
8. In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.
9. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.
10. Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.
11. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.
12. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 42:1113 as amended in the 2008 Regular Session of the Louisiana Legislature.
13. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

14. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502..
15. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.
16. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if contract exceeds $20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.
17. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.
18. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.
19. Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.
20. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.
21. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.
22. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

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

SIGNATURE **DATE**	**SIGNATURE** **DATE**
NAME	**NAME**
TITLE	**TITLE**
SIGNATURE **DATE**	**SIGNATURE** **DATE**
NAME	**NAME**
TITLE	**TITLE**

Rev 09/2013

HIPAA Business Associate Addendum

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

1. The Louisiana Department of Health and Hospitals ("DHH") is a Covered Entity, as that term is defined herein, because it functions as a health plan and as a health care provider that transmits health information in electronic form.
2. Contractor is a Business Associate of DHH, as that term is defined herein, because contractor either: (a) creates, receives, maintains, or transmits PHI for or on behalf of DHH; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for DHH involving the disclosure of PHI.
3. Definitions: As used in this addendum –

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

   B. The terms "Business Associate", "Covered Entity", "disclosure", "electronic protected health information" ("electronic PHI"), "health care provider", "health information", "health plan", "protected health information" ("PHI"), "subcontractor", and "use" have the same meaning as set forth in 45 C.F.R. § 160.103.

   C. The term "security incident" has the same meaning as set forth in 45 C.F.R. § 164.304.

   D. The terms "breach" and "unsecured protected health information" ("unsecured PHI") have the same meaning as set forth in 45 C.F.R. § 164.402.
4. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this contract and addendum as required by the HIPAA Rules and by this contract and addendum.
5. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule or regulation (including the HIPAA Rules) or as otherwise required or permitted by this contract and addendum.
6. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this contract and addendum, including administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH.
7. In accordance with 45 C.F.R. § 164.502(e)(1)(ii) and (if applicable) § 164.308(b)(2), contractor shall ensure that any agents, employees, subcontractors or others that create, receive, maintain, or transmit PHI on behalf of contractor agree to the same restrictions, conditions and requirements that apply to contractor with respect to such information, and it shall ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees' or subcontractors' actions or omissions do not cause contractor to violate this contract and addendum.
8. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1. Disclosures which must be reported by contractor include, but are not limited to, any security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La.R.S. 51:3071 *et seq*. At the option of DHH, any harm or damage resulting from any use or disclosure which violates this contract and addendum shall be mitigated, to the extent practicable, either: (a) by contractor at its own expense; or (b) by DHH, in which case contractor shall reimburse DHH for all expenses that DHH is required to incur in undertaking such mitigation activities.
9. To the extent that contractor is to carry out one or more of DHH's obligations under 45 C.F.R. Part 164, Subpart E, contractor shall comply with the requirements of Subpart E that apply to DHH in the performance of such obligation(s).
10. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR § 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR § 164.528 for at least six (6) years after the date of the last such disclosure.

11. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR § 164.524.
12. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
13. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of DHH available to the Secretary of the U. S. DHHS for purposes of determining DHH's compliance with the HIPAA Rules.
14. Contractor shall indemnify and hold DHH harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this addendum by contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. The parties agree that the legal relationship between DHH and contractor is strictly an independent contractor relationship. Nothing in this contract and addendum shall be deemed to create a joint venture, agency, partnership, or employer-employee relationship between DHH and contractor.
16. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any provision of the HIPAA Rules or any material term of this addendum.
17. At the termination of the contract, or upon request of DHH, whichever occurs first, contractor shall return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor shall extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.