

REQUEST FOR PROPOSALS

STATEWIDE MANAGEMENT ORGANIZATION
FOR
THE LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF BEHAVIORAL HEALTH

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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 438.214(c).

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

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.

Aged/Blind/Disabled – A unique eligibility category within the Medicaid Program that defines specific conditions for which a person may be determined eligible to receive Medicaid health care services. This category includes individuals who are eligible for Medicaid due to age, blindness, or disability.

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 a SMO, which results in the denial, reduction, suspension, termination, or delay of health care benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

ARAMIS – The Accounts Receivables and Management Information System is the main portal for data entered into the Office of Behavioral Health's statewide information management system. It emulates the management reporting functions for public mental health center programs and also provides for automated accounts receivable functions. It operates on a LAN. ARAMIS is a DOS-based system. Data from ARAMIS is now uploaded to OMH-IIS in ever decreasing time frames until real-time data transfer is achieved.

BC/DRP – Business Continuity and Disaster Recovery Plans.

BHSF/DHH – Bureau of Health Services Financing, Department of Health and Hospitals.

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.

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 marshalling 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).

CFT– Child and Family Team.

CHIP – **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 twenty-one, 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 addictive disorders. Clients said to have COD have one or more addictive disorders, as well as one or more mental disorders.

CommunityCARE – Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program, which links Medicaid/CHIP eligibles to a primary care provider for their medical home.

CommunityCARE Program – System of comprehensive health care based on a primary care case management (PCCM) model operated as a State plan option in Louisiana. Primary care physicians receive a monthly management fee, in addition to the fee-for-service payment, to coordinate their Member's health care.

Community Mental Health Clinic (CMHC) – Facilities providing outpatient behavioral health services throughout the Office of Behavioral Health's geographic regions and service districts. Services include screening and assessment, emergency crisis care, individual evaluation and treatment, medication administration and management, clinical casework services, specialized services for children and adolescents, specialized services for individuals in the criminal justice system, specialized services for the elderly, and pharmacy services.

Coordinated Care Network (CCN) – An entity designed to improve performance and health outcomes through the creation of a cost-effective integrated health care delivery system, which provides a continuum of evidence-based, quality-driven health care services for Medicaid/CHIP eligibles.

Coordinated Care Network–Prepaid (CCN-P) – A prepaid entity that participates in the Louisiana Medicaid Program. The entity is regulated by the Louisiana Department of Insurance, with respect to licensure and financial solvency, pursuant to Title 22 of the Louisiana Revised Statutes. With respect to its products and services offered, pursuant to the Louisiana Medicaid Program, it is regulated by the Louisiana Department of Health and Hospitals.

Coordinated Care Program – The program within the Louisiana Medicaid Program that provides statewide leadership to promote the health and well-being (through effective utilization of resources) of Louisianans in DHH's CommunityCARE, Shared Savings Coordinated Care Network and Prepaid Coordinated Care Network programs.

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 health care 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.

Cost-Based Reimbursement – A method of payment for medical care, by third parties, for services delivered to patients. The amount of payment is based on the allowable costs of the provider for delivering the service.

Cost Neutral – The mechanism used to smooth data, share risk, or adjust for risk that will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

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

CSoC – Coordinated System of Care.

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

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

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.

DOE – Department of Education.

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

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

EBD – Emotional Behavioral Disorders.

EBP – Evidenced-Based Practices.

Electronic Health Records (I) – A computer-based record containing health care information. This technology, when fully developed, meets provider needs for real-time data access and

evaluation in medical care. Implementation of EMR increases the potential for more efficient care, speedier communication among providers, and management of SMOs.

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

ELMHS – Eastern Louisiana Mental Health System.

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) and that are needed to screen, evaluate, and stabilize an emergency medical condition. Services are defined under Section 1867 (e) of the Social Security Act (“anti-dumping provisions”). If an emergency medical condition exists, the SMO is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the “prudent layperson” standard shall apply to both in-plan and out-of-plan coverage.

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 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 the SMO has any financial liability to a provider.

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.

Essential Community Providers – LA R.S. 40.22.41 A. For the purposes of this Part, “essential community providers” mean health care providers who have historically served medically needy or indigent patients, including each of the following:

1. Federally qualified health centers.
2. Rural health clinics.
3. Hospitals owned or operated by the state.
4. Community health centers.
5. Small rural and service district hospitals.
6. Physicians who have historically served Medicaid and indigent patients.
7. Children's hospital as defined by 42 CFR Section 412.23(d).

- Essential community providers shall include only those providers who are licensed, certified, and enrolled as available to participate in the Medicaid program.
- Essential community providers shall not include any health care providers who have been convicted of fraud against the Medicaid program.
- Essential community providers shall meet all quality assurance standards required by the Louisiana Department of Health and Hospitals and the United States Department of Health and Human Services for participation in the Medicaid program and any waiver program approved for the Medicaid program.

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

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 State's with Medicaid managed care programs.

Experimental Procedure/Service – A procedure or service that requires additional research to determine its safety, effectiveness, and benefit compared to standard practices. The available clinical scientific data 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.

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 health care 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.

FICA – Federal Insurance Contribution Act.

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.

Grievance – An expression of Member/Provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Health Care Professional – A physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

Health Care Provider – A health care professional or entity that provides health care services or goods.

Healthcare Effectiveness Data and Information Set (HEDIS) – A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (e.g., SMO) performance.

HIPAA – Health Insurance Portability and Accountability Act.

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 Health Care, 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. SMOs shall move to ICD-10-CM as it becomes effective.

ICM – Intensive case management services.

IEP Services – These are therapies included in a student's Individualized Education Plan (IEP); included are physical therapy, occupational therapy, speech/language therapy, audiology, and some psychological therapy. The enrolled provider must be a public school system and the provider certifies the State match via CPE. The school board 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.

Immediate – In an urgent manner, instantly, or without delay.

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

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.

Individualized Plan of Care (IPoC) – The IPoC or Plan of Care (POC) 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.

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

Institutionalized – A patient in a nursing facility or an inpatient in a medical institution or institution for mental disease.

Investigational Procedure/Service – See “Experimental Procedure/Service”.

IST/ISP – Incompetent to Stand Trial/Proceed.

IT – Information Technology.

JLCB – Joint Legislative Committee on the Budget.

JPHSA – Jefferson Parish Human Services Authority.

KIDMED – Louisiana’s screening component of the EPSDT program provided for Medicaid/CHIP eligible children under the age of 21. This program is required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).

LaCHIP – Refers to Louisiana’s Medicaid expansion CHIP (Title XXI) Program that provides health coverage to uninsured children under age 19, whose families have net income up to 200 percent of the federal poverty level (FPL) but greater than the Medicaid limit. Phase 1 includes children ages 6-18 years, with family income from 100% up to and including 133% FPL; Phase II includes children with income from 134% up to and including 150% FPL; Phase 3 includes children with income from 151% FPL up to and including 200% FPL.

LaCHIP Prenatal Program (Phase IV) – Louisiana’s separate CHIP (Title XXI) program, which provides prenatal coverage through the Medicaid delivery system for children whose uninsured mothers are ineligible for Medicaid and have net family income at or below 200% FPL.

LaCHIP Affordable Plan (Phase V) – Louisiana’s separate CHIP (Title XXI) program that provides health coverage to uninsured children in families with income from 201% up to and including 250% FPL. The program is administered by the Louisiana Office of Group Benefits.

LaMOMS – The Medicaid program for pregnant women with income up to and including 133% FPL and optional coverage for pregnant women with income from 134% up to and including 185% FPL. With a 15% income disregard, the income limit is actually 200% FPL. The program provides pregnancy-related services, delivery, and post-partum care for 60 days after the pregnancy ends for women whose sole basis of eligibility is pregnancy.

LMHP – A Licensed Mental Health Practitioner (LMHP) is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse 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)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by DHH, in addition to their scope of practice license. LMFTs and LACs are not permitted to diagnose under their scope of practice under state law. LPCs are limited by scope of practice under state law to diagnosing conditions or disorders requiring mental health counseling and may not use appraisal instruments, devices or procedures for the purpose of treatment planning, diagnosis, classification or description of mental and emotional disorders and disabilities, or of disorders of personality or behavior, which are outside the scope of personal problems, social concerns, educational progress and occupations and careers. Per the State's practice act and consistent with State Medicaid Regulation, Medical and Licensed Psychologists may supervise up to two Clinical Psychologists.

LAN – Local Area Network.

LEA – Local Education Agency.

LGE – Local Governing Entities.

LMMIS – Louisiana Medicaid Management Information System.

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 a special target population of children eligible for the Coordinated System of Care (CSoc); adults with serious mental illness (SMI); and the SMO child/adult population (e.g., the rest of the non-institutionalized Medicaid population). The benefit package for this third population includes inpatient psychiatric care, emergency room care, substance abuse services and care by psychiatrists for all adults and children. It also includes all EPSDT behavioral health care services for all Medicaid children. This population could be referred to as a traditional behavioral health “carve-out” program. The Louisiana Behavioral Health Partnership managed by DHH-OBH oversees the Behavioral Statewide Management Organization (SMO), the prepaid inpatient health plan (PIHP) that implements the 1) 1915(b) waiver; 2) the 1915(i) Adult Mental Health Rehabilitation services for the Severely Mentally Ill; and 3) the CSoc – 1915(c) SED Children's waiver. The mental health and substance abuse PIHP is at-risk for adult services including adults with limited mental health and substance abuse benefits and is paid on a non-risk basis for children's services and any individual with retroactive eligibility and spend-down beneficiaries in the month they meet their spend-down. Adults are eligible under the PIHP for State Plan services including care by psychiatrists, inpatient psychiatric care, emergency rooms, and substance abuse rehabilitation services. Children are eligible under the PIHP for those State Plan services as well as all medically necessary EPSDT services. The SMO will also manage behavioral health services for Non-Medicaid eligible populations served by OBH, DCFS, and OJJ, and funded through state general funds and block grants, including services for individuals with co-occurring mental health and addictive conditions.

Louisiana Children's Health Insurance Program (LaCHIP) – Louisiana's Children's Health Insurance Program created by Title XXI of the Social Security Act in 1997. The program provides health care coverage for uninsured children up to age 19 through a Medicaid expansion for children at or below 200% FPL and a separate State CHIP program for children with income from 200% up to and including 250% FPL; a separate unborn prenatal option is also provided.

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.

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 health care 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, SMO's complaint and grievance procedures; health care delivery systems, services, or expanded services; benefits; geographic service areas; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that required DHH approval prior to implementation; and the SMO's capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material.

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 health care providers for serving eligible individuals.

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/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 FFS Provider – An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, been approved by DHH, and accepts payment in full for providing benefits to Medicaid eligibles. The amounts paid are described in approved Medicaid reimbursement provisions, regulations, and schedules.

Medical Home – Systems of care led by a team of primary care providers who partner with the patient, the patient's family, and the community to coordinate care in all settings, from specialists and hospitals, to pharmacies, nursing homes and home health agencies. Primary care providers are inclusive of physician-led and nurse-practitioner-led primary care practices.

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.

Medical Loss Ratio – The percentage of Per-Member-Per-Month (PMPM) payments received by SMOs from DHH used to pay Medicaid Members' medical claims.

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 health care 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.

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

Medically Necessary Services – Health care services that are in accordance with generally accepted evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate, or prevent the worsening of a condition or conditions that endanger life; cause suffering or pain; or have resulted or will result in a handicap, physical deformity, or malfunction; and 2) not 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 Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.

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

Member – Persons enrolled in the SMO.

Member Bill of Rights – 42 CFR §438.100.

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

MH/BH – Mental Health/Behavioral Health.

MHBG – Mental Health Block Grant.

MHRSIS – Mental Health Rehabilitation Services Information System.

MHSD – Metropolitan Human Services District.

MITA – Medicaid Information Technology Architecture.

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

Must – Denotes a mandatory requirement.

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

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.

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

Network Adequacy – Refers to the network of behavioral health care providers for a 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.

OAD – Office for Addictive Disorders (OAD became part of OBH on July 1, 2010). OAD and OBH may be used interchangeably in the document.

OBH – Office of Behavioral Health, Department of Health and Hospitals; formerly the Office of Mental Health.

OBH-AD – Office of Behavioral Health, Addictions may be used to identify resources for individuals with addictive disorders.

OBH-MH – Office of Behavioral Health, Mental Health.

Office of Behavioral Health Integrated Information System (OBH-IIS) – DHH-OBH Web-based information system operating over the OBH wide-area network on a central SQL server. This system, planned to be comprehensive in scope, has undergone a series of enhancements to sequentially replace the remaining separate, non-integrated LAN-based legacy systems now operated by OBH statewide.

OJJ – Office of Juvenile Justice.

OMH – Office of Mental Health; now Office of Behavioral Health, Department of Health and Hospitals.

OPH – Office of Public Health.

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: 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 DOE, and 9) foster care.

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

PA – Prior Authorization.

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

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

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

PIHP – Prepaid Inpatient Health Plan is an entity 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 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.

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.

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 Public Housing Authority under an approved Housing and Urban Development (HUD) Administrative 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 income).

Per Member Per Month (PMPM) Rate – The PEPM 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.

Poverty Level – Poverty guidelines issued annually, 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.

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

Primary Care Services – Health care 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.

Primary Care Provider (PCP) – An individual physician or licensed nurse practitioner responsible for the management of a Member's health care, 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 or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.

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

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

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 160 and 164.

PRTF – Psychiatric Residential Treatment Facility.

Qualified Service Provider – Any individual or entity that is engaged in the delivery of behavioral health care 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.

QA/QI – Quality assurance/quality improvement.

QAO – Quality Assurance Officer.

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

Quality 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 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.

Redacted Proposal – 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 § 5, 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.

RFP – Request for Proposal.

RHC/FQHC – Rural Health Clinic/Federally Qualified Health Center.

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

SAMHSA – Substance Abuse and Mental Health Services Administration.

SAPT Block Grant – Substance Abuse Prevention and Treatment Block Grant.

School Based Health Center (SBHC) – A health care provider certified by the Office of Public Health that is physically located in a school, or on or near school grounds, that provides convenient access to comprehensive primary and preventive physical and mental health services for public school students.

SCLHSA – South Central Louisiana Human Services Authority.

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) – Part of the Social Security Act provides States with the authority “to share (through provision of additional services) with recipients of Medical Assistance under the State Plan cost savings resulting from use by the recipient of more cost effective medical care.” 1915(b)(3) services that could be covered under the State Plan: Examples include offering optional State Plan services, such as chiropractor services, intermediate care facility services, etc., to managed care enrollees but not to Medicaid beneficiaries in the fee-for-service (FFS) program. In other words, the State Plan would not reflect these services, but they would be provided in the managed care program. States also use 1915(b)(3) authorities to reduce or eliminate limits that exist in the State Plan on the amount, duration, and scope of covered services.

Section 1931 – Category of Medicaid eligibility for low-income parents who do not receive cash assistance, but whose income is below Louisiana’s 1996 Aid to Families with Dependent Children income threshold. Louisiana’s name for this program is Low Income Families with Children (LIFC).

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

Security Rule (45 CFR Parts 160 & 164) – Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their electronic protected health information against any reasonably anticipated risks.

Shall – Denotes a mandatory requirement.

Should, May, Can – 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.

SMI – Serious Mental Illness.

Social Security Act – The current version of 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 Healthcare Needs Population – 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 health care requirements.

Start-Up Date – The date SMO providers begin providing medical care to their Medicaid Members. Also referred to as “go-live date”

State – The State of Louisiana

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

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

State Plan – Refers to the Louisiana Medicaid State Plan.

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

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.

TANF – Temporary Assistance for Needy Families

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 State plan.

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

Title IV-E – Section of the Social Security Act of 1935, as amended, that encompasses medical assistance for foster children and adoption assistance.

Title V – Section of the Social Security Act of 1935, as amended, that encompasses maternal child health services.

Title X – Section of the Social Security Act of 1935, as amended, that encompasses and governs family planning services.

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

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

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 health care 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.

Waivers:

- 1915(b)(3)
- 1915(c)
- 1915(i)

WIC (Women, Infants and Children) – Federal program administered by the Office of Public Health that provides nutritional counseling; nutritional education; breast-feeding promotion; and nutritious foods to pregnant, postpartum and breast-feeding women and infants and children up to the age of five, who are determined to be at nutritional risk and have low to moderate income. An individual who is eligible for Medicaid is automatically eligible for WIC benefits.

Will – Denotes a mandatory requirement. Failure to include is grounds for disqualification of the entire proposal.

Willful – Refers to a conscious or intentional, but not necessarily malicious, act.

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

Glossary of Acronyms

ACT – Assertive Community Treatment

AD – Addictive Disorders

BC/DRP – Business Continuity and Disaster Recovery Plans

BH-MCO – Behavioral Health Managed Care Organization

BHSF/MVA – Bureau of Health Services Financing/Medical Vendor Administration, Department of Health and Hospitals

BESE – State Board of Elementary and Secondary Education

CAHSD – Capital Area Human Services District

CANS – Child and Adolescent Needs and Strengths assessment tool

CFT – Child and Family Team

CFR – Code of Federal Regulations

CIT – Crisis Intervention Team

CLSH – Central Louisiana State Hospital

CMS – Centers for Medicare & Medicaid Services

COB – Close of Business

COD – Co-occurring Disorders of Mental and Addictive Disorders

CSoC – Coordinated System of Care

DACTS – Dartmouth Assertive Community Treatment Scale

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-OBH-AD – Department of Health and Hospitals-Office of Behavioral Health-Addictive Disorders

DHH-OBH-MH – Department of Health and Hospitals-Office of Behavioral Health-Mental Health

DHH-OPH – Department of Health and Hospitals-Office of Public Health

DOE – Department of Education

EBD – Emotional Behavioral Disorders

EBP – Evidenced-Based Practices

ELMHS – Eastern Louisiana Mental Health System

EPSDT – Early and Periodic Screening, Diagnosis, and Treatment

FACT – Forensic Assertive Community Treatment

FFS – Fee-for-Service

FI – Fiscal Intermediary

FICA – Federal Insurance Contributions Act

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

HMO – Health Maintenance Organization

ICM – Intensive Case Management

IT – Information Technology

JLCB – Joint Legislative Committee on the Budget

JPHSA – Jefferson Parish Human Services Authority

LAN – Local Area Network

LEA – Local Education Agency

LGE – Local Governing Entities

LMMIS – Louisiana Medicaid Management Information System

LOC – Level of Care

MH/BH – Mental Health/Behavioral Health
MHBG – Mental Health Block Grant
MHRIS – Mental Health Rehabilitation Services Information System
MHSD – Metropolitan Human Services District
MITA – Medicaid Information Technology Architecture
MST – Multisystemic Therapy
NCQA – National Committee for Quality Assurance
NGBRI – Not Guilty by Reason of Insanity
OAD – Office for Addictive Disorders
OBH – Office of Behavioral Health
OAAS – Office of Aging and Adult Services
OJJ – Office of Juvenile Justice
OMH – Office of Mental Health
PA – Prior Authorization
PHI – Protected Health Information
PIHP – Prepaid Inpatient Health Plan
PRTF – Psychiatric Residential Treatment Facility
QM – Quality Management
QA/QI – Quality Assurance/Quality Improvement
RFP – Request for Proposal
RHC/FQHC – Rural Health Clinic/Federally Qualified Health Center
ROI – Return on Investment
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
SFF – Secure Forensic Facility
SFTP – Secure File Transfer Protocol
SMI – Serious Mental Illness
SPOE – Single Point of Entry
TANF – Temporary Assistance for Needy Families
WAA – Wraparound Agency
WF – Wraparound Facilitation

I. GENERAL INFORMATION

A. Background

1. DHH is one of the administrative departments within the Executive Branch of State government in Louisiana. The administrative head of DHH is the Secretary, who is appointed by the Governor. The mission of the DHH is to protect and promote health and ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana (State). DHH is dedicated to fulfilling its mission through direct provision of quality services, development and stimulation of services for others, and utilization of available resources in the most effective manner.
2. DHH is comprised of the Bureau of Health Services Financing/Medical Vendor Administration (BHSF/MVA), Office of Behavioral Health (OBH), the Office for Citizens with Developmental Disabilities (OCDD), the Office of Aging and Adult Services (OAAS), and the Office of Public Health (OPH). Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to DHH.
3. DHH, in addition to the program offices, has an administrative office (Office of the Secretary), a financial office (Office of Management and Finance), and various bureaus and boards. The Office of the Secretary is responsible for establishing policy and administering operations, programs, and affairs.
4. DHH has designated the DHH-Office of Behavioral Health (DHH-OBH) as the issuing agency for this request for proposal (RFP) and oversight of the Louisiana Behavioral Health Partnership. The mission of DHH-OBH is to promote recovery and resiliency in the community through services and supports that are preventive, accessible, comprehensive, and dynamic. The former Office of Mental Health (OMH) and the Office for Addictive Disorders (OAD) have recently been statutorily merged into the DHH-OBH, under the leadership of an Assistant Secretary within DHH. DHH-OBH and BHSF/MVA are collaborating to restructure Medicaid behavioral health services. DHH-OBH serves adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, and all people experiencing an acute mental illness, as well as individuals of all ages with addictive disorders (AD). DHH-OBH is responsible for planning, developing, operating, and evaluating public mental health (MH) and AD services for the citizens of the State through 10 geographic areas. Legislation has mandated that the administration of the Louisiana MH care system transition from inter-related geographic regions to a system of independent health care districts or authorities (also referred to as local governing entities or LGEs) under the general administration of DHH-OBH. As of January 1, 2011, there were five districts in operation and five that are in transition to becoming LGEs. The DHH-OBH Regions, LGE Districts/Authorities are listed in Table 1 below.

Table 1. DHH-OBH Regions, LGE Districts/Authorities

Region 1: Metropolitan Human Service District (MHSD)
Region 2: Capital Area Human Service District (CAHSD)
Region 3: South Central Louisiana Human Services Authority (SCLHSA)
Region 4: Lafayette
Region 5: Lake Charles

Region 6: Alexandria
Region 7: Shreveport
Region 8: Monroe
Region 9: Florida Parish Human Services Authority (FPHSA)
Region 10: Jefferson Parish Human Services Authority (JPHSA)

5. DHH-OBH is responsible for setting policy, establishing standards for the operation of the Louisiana Behavioral Health Partnership, contracting, establishing expectations for service utilization and outcomes, and measuring outcomes.
6. The BHSF/MVA has oversight responsibilities for all Medicaid programs. DHH-OBH, as the designated purchaser of managed behavioral health services for the Louisiana Behavioral Health Partnership, including children and adults described in this RFP, will work under the oversight of BHSF/MVA to assure compliance with federal financing requirements.
7. The RFP covers the management of behavioral health services known as the Louisiana Behavioral Health Partnership to serve: 1) a special target population of children eligible for the Coordinated System of Care (CSoC); 2) adults with serious mental illness (SMI) and addictive disorders, and 3) the SMO Child/Adult population (e.g., the rest of the non-institutionalized Medicaid population).
8. The CSoC is a new initiative of Governor Bobby Jindal, designed for a target population of Louisiana's children and youth with significant behavioral health (BH) challenges or co-occurring disorders in, or at imminent risk of, out-of-home placement. Out-of-home placements are defined as the following: addiction facilities, alternative schools, detention, developmental disabilities facilities, foster care, and homeless, as identified by the Department of Education (DOE), psychiatric hospitals, residential treatment facilities, and secure care facilities. The CSoC is an evidence-based approach that is part of a national movement to develop family and youth-driven care to keep children at home, in school, and out of the child welfare and juvenile justice systems. The goals of CSoC implementation include:
 - a. Reduction in the number of targeted children and youth in detention and residential settings.
 - b. Reduction of the State's cost of providing services by leveraging Medicaid and other funding sources.
 - c. Improving the overall outcomes of these children and their caregivers being served by the CSoC.
9. Louisiana's CSoC is innovative because it integrates resources from all the State's child-serving agencies to establish a coordinated system of care, while assuring payment from the appropriate funding source through the Statewide Management Organization (SMO). While some States have implemented systems of care for children, with one or more child-serving agencies as pilot programs or phases in several regions of a state, Louisiana is in the forefront of implementing a statewide coordinated system of care across all child-serving State agencies. Planning for the CSoC was initiated in 2009, and included extensive stakeholder involvement in its design.

10. In addition to DHH-OBH, the State child-serving agencies participating in the CSoC include: the Department of Children and Family Services (DCFS); DOE, including the local education agencies (LEA); OCDD; and the Office of Juvenile Justice (OJJ).
11. The Louisiana 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 provide services that will assist individuals, children, and families to achieve self-sufficiency and promote their well-being. DCFS funds the following types of MH services: intensive home-based services; Multisystemic Therapy (MST); and other outpatient services, such as psychiatric evaluations and services, residential treatment, and respite services.

As part of child welfare's recovery from the hurricanes of 2005, Louisiana collaborated with the Annie E. Casey Foundation and began a self-assessment of its use of residential care within the foster care program. This work resulted in a reduction of the agency's reliance on residential care over a three-year period. Through these efforts, DCFS also determined that children with behavioral health challenges were too often placed in foster care or residential settings due to the lack of BH services available to families in homes, schools, and communities. As a result, when the CSoC planning was initiated in 2009, DCFS identified children with BH challenges in, or at risk of, residential placements, including foster care, as a priority population for the CSoC.

As part of this RFP, DCFS is seeking assistance from the Contractor to subcontract with network providers that can deliver a continuum of services ranging from Therapeutic Foster Care and Group Home treatment, as well as certain specialized and/or restrictive treatment settings such as Psychiatric Residential Treatment Facilities (PRTFs), using evidence-informed models that support the department's permanency goals for children and their families. In addition, in home services will be necessary for children as they transition to the home of birth family, relative care takers or other placement resources. All services shall be offered within the geographic region from which the children entered the state's custody and in close proximity to their family's home when possible, in the most appropriate, least restrictive settings, consistent with their needs.

For the purposes of this RFP, continuum of care is defined as a comprehensive spectrum of services organized into a coordinated and integrated network to meet the multiple and changing needs of emotionally, medically, and behaviorally challenged children, youth and their families. It is essential that all providers support and are connected with local community partners, including family-run organizations, youth support groups, and natural helpers such as faith-based organizations to ensure continuity of services and appropriate aftercare supports. Proposers should make themselves familiar with other potential providers in the region so that a true continuum can be represented.

To the extent that the child is eligible for a Therapeutic Group Home (TGH) or PRTF level of care as defined by the DHH-OBH Services Definitions Manual (see procurement library), the child should be placed in that level of care. If the child does not meet those requirements, the child may be placed in a group home level of care. All group homes must meet and abide by federal Institutions for Mental Disease limitations

on payment. Services provided in a group home setting must be provided by a community practitioner certified and credentialed by the SMO to provide those services.

In preparation for this RFP, DCFS conducted a placement level of care assessment in September and October 2009 on all the foster children that were in specialized, therapeutic, and residential treatment settings within Louisiana. This assessment utilized a Level of Care (LOC) instrument developed by the Child Welfare League of America for Cuyahoga County, Ohio designed to determine placement needs of children. The instrument assigns a level of care between 1 – 6, with 1 being the basic foster care level and 6 being intensive Group Homes or hospitalization. The instrument is included in the procurement library. While the level of care assessment is not a therapeutic assessment, it does provide Proposers a high-level understanding of staffing intensity necessary to meet the needs of the children.

12. The DOE 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). The mission of the DOE is to ensure higher academic achievement for all students, eliminate achievement gaps, and prepare students to be effective citizens in a global marketplace. Educating the whole child, one who is healthy, safe, engaged, supported, and challenged, is a prerequisite to creating a world-class educational system. Students learn best when their academic, emotional, physical, and social needs are met. The DOE target population for the CSoC includes children and youth with BH challenges who are in, or at risk for, alternative school placement or homelessness, as defined by DOE. 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 CSoC will help to eliminate many barriers for these children and assist DOE in providing an equal opportunity for success in local schools.
13. The DHH-OCDD within DHH serves as the single point of entry (SPOE) into the DD Services System. DHH-OCDD conducts an assessment of individuals who request services to determine the person's eligibility for system entry. Eligibility is based on the definition of developmental disability contained in Louisiana R.S. 28:451.1-455.2. The Community Services regional offices, and Human Services authorities/districts serve as the points of entry for individuals to receive services from both the regional offices/human services authorities/districts and the supports and services centers. DHH-OCDD Community Services regional offices and Human Services authorities/districts offer a broad range of services, including individual and family supports (i.e., personal care, assistance, cash subsidy, respite, crisis intervention, and supported living services). The DHH-OCDD target population for the CSoC includes children and youth with co-occurring DD and mental illness/serious emotional disturbance (SED) residing in intermediate care facilities (ICFs) or nursing facilities, or individuals in imminent danger of placement, who need additional support to maintain community living.
14. The DHH-OBH target population for the CSoC is youth, up to age 21, with SED in, or at risk of, admission to a psychiatric hospital or residential treatment facility.

15. 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 and their families found in need of services by courts of juvenile jurisdiction (Families in Need of Services [FINS]). OJJ is responsible for youth assigned to care by the court system, either for supervision or custody in residential placement or secure care. OJJ also provides services to youth under local court supervision. Staff supports the Administrative Remedy Procedure disciplinary appeal process for juveniles. Seven programs are administered by OJJ: 1) Administration, 2) Swanson Center for Youth, 3) Jetson Center for Youth, 4) Bridge City Center for Youth, 5) Field (Community) Services, 6) Contract Services, and 7) Auxiliary Louisiana Housing for Juvenile Offenders. The Community Services program provides probation and parole supervision, and coordinates both residential and non-residential treatment services for delinquent youth, as well as FINS. OJJ MH services consist of residential services, including secure care, contracted residential services, community treatment, including day treatment, and prevention/diversion services. The OJJ target population for the CSoC is youth with serious BH challenges and: 1) on probation or parole supervision, **or** 2) with a status offense, **and** 3) at risk of residential placement or leaving residential placements.
16. The CSoC State Governance Body (CSoC SGB) will provide policy direction to DHH-OBH for BH services to children eligible for the CSoC provided through the SMO. The CSoC SGB is composed of the highest level executives from DHH-OBH, DCFS, OJJ, DOE, a youth representative, two family Members, an advocate, and representation from the Governor's Office.
17. In addition to the CSoC initiative, Governor Jindal wishes to improve access to services, quality of care, and efficiency in the delivery system for all children, youth, and adults eligible for BH care services.
18. DHH-OBH will provide policy direction and oversight of BH services for children and youth not involved in the CSoC, and for adults with SMI and/or AD.
19. The SMO shall have the responsibility for determining eligibility for the CSoC based upon the priority populations described in this section and telephonic screening utilizing the Child and Adolescent Needs Assessment (CANS) – Brief.

B. Purpose of RFP

The purpose of this RFP is to solicit proposals from qualified BH managed care organizations (BH-MCO) with a minimum of five years experience and demonstrated success in its provision of managed BH care services with complex, publicly-funded BH programs, to operate a pre-paid inpatient health plan (PIHP), as defined in 42 CFR 438.2, for BH services provided to children, youth, and adults.

1. The procurement of a BH-MCO, to be known as the SMO, is necessary to assist with the State's system reform goals to:
 - a. Foster individual, youth, and family-driven BH services.
 - b. Increase access to a fuller array of evidence-based home- and community-based services that promote hope, recovery, and resilience.
 - c. Improve quality by establishing and measuring outcomes.
 - d. Manage costs through effective utilization of State, federal, and local resources.

- e. Foster reliance on natural supports that sustain individuals and families in homes and communities.
- 2. Pending approval from the Centers for Medicare & Medicaid Services (CMS) of submitted State Plan Amendments (SPA) and concurrent Sections 1915 (b), (c), and (i) authorities, the SMO shall:
 - a. Manage care for eligible children/youth in need of MH and AD services, including children eligible for the CSoC, on a non-risk basis, effective on or about January 1, 2012, utilizing Medicaid, DCFS, DHH-OAD, DHH-OBH, and OJJ State General Funds (SGF) and federal block grant financing.
 - b. Manage behavioral health services for Medicaid adults with addictive 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 MMD (Major Mental Disorder); and adults who have previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance on a risk basis, effective on or about January 1, 2012;
 - c. MH and AD services for adults funded through SGF and the Substance Abuse Prevention and Treatment (SAPT) Block Grant will be managed by the SMO under terms in the contract.
- 3. This program will seek to continue the work already begun by DHH 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 practices (EBP), treatment planning, and outcome measurement.
- 4. The intent of this RFP is to award a contract to a Proposer whose proposal, in response to this RFP, is most advantageous to the State, price and other factors considered. The contract term shall begin on January 1, 2012 for two years, with the State's option to extend the contract for an additional contract year, through December 31, 2014.

C. Invitation to Propose

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

D. RFP Coordinator

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

Joseph E. Comaty, PhD, M.P.
Chief Psychologist/Medical Psychologist
Director-Quality Management Division
Development Section
Office of Behavioral Health
Louisiana Department of Health & Hospitals
P.O. Box 4049 (Bin 12)
628 N. 4th Street

Baton Rouge, LA 70821-4049
Phone: 225-342-2540
Email: BHMANAGE@LA.GOV

This RFP is available in PDF format at the following Web links:

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

<http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4>

2. All communications relating to this RFP must be directed to the DHH-OBH contact person named above. All communications between Proposers and other DHH, DCFS, DOE, or OJJ staff members concerning this RFP shall be strictly prohibited. Failure to comply with these requirements shall result in proposal disqualification.

E. Proposer Inquiries

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

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

<http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4>

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

F. Pre-Proposal Conference

A pre-proposal conference will not be held for this RFP.

G. Schedule of Events

DHH-OBH reserves the right to deviate from this Schedule of Events.

Table 2: Schedule of Events

Schedule of Events	Schedule
RFP Issued	July 8, 2011
Deadline for Receipt of Written Questions	July 15 2011
Response to Written Questions	July 29, 2011
Deadline for Receipt of Written Proposals	August 15, 2011 4:00 p.m. CDT
Evaluation Process Begins	August 17, 2011
Evaluation Complete	August 26, 2011
Contract Award Announced	September 6, 2011
Contract Negotiations Begin	September 6, 2011
Contract Begin Date	March 1, 2012

H. RFP Addenda

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

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

<http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4>

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

II. SCOPE OF WORK

A. Project Overview

1. Introduction and Background

The intent of this RFP is for DHH-OBH to contract with a BH-MCO to administer BH managed care services for children and adults. Louisiana's system reform efforts in support of effective management of BH services focus on the following strategies:

- a. Implementing 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 utilizes family and youth supports, and overall management of these services by the SMO.
- b. Improving access, quality, and efficiency of BH services for children not eligible for the CSoC, and adults with SMI and AD, through management of these services by the SMO.
- c. Transitioning BH service delivery and operations from DHH-OBH regions to human services districts/authorities, known as LGEs.
- d. Integrating MH and addictions care through combining the former Office of Mental Health and OAD into DHH-OBH, under one Assistant Secretary within DHH-OBH.
- e. Seamlessly coordinating BH services with the comprehensive health care system without losing attention to the special skills of BH professionals.
- f. Advancing a resiliency, recovery, and consumer-focused system of person-centered care.
- g. Implementing best practices and EBP that are effective and efficient as supported by the data from measuring outcomes, quality, and accountability.
- h. Leveraging SGF to appropriately obtain Medicaid financing.

2. Management of Services for Children Eligible for the CSoC

DHH-OBH intends to contract for management of children's BH services currently provided by the State of Louisiana's child-serving agencies (DCFS, DOE, DHH-OBH, DHH-OCDD, OJJ) through the SMO for the CSoC target population.

- a. In November 2009, Louisiana began its design of the CSoC by assembling a Leadership Team and a Planning Group with broad representation from the State's child-serving agencies, advocates, families, providers, and other stakeholders. The Department of Social Services (DSS), renamed DCFS effective July 1, 2010, sponsored a Project Manager who worked with the Leadership Team, comprised of representatives from the Governor's office, OJJ, DCFS, DOE, DHH-OCDD, DHH-OBH, DHH-BHSF, DHH-OBH, the Federation for Families for Children's Mental Health, a parent/advocate and a human service district (HSD). These planning efforts resulted in adopting the following CSoC approach:

- i. 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 needs at home, in school, and out of the child welfare and juvenile justice system.
- ii. An important CSoC goal is the reduction of costly, highly restrictive, out of home placement through the creation and maintenance of coordinated and effective community-based services. The CSoC also creates partnerships with public and private providers of services that target children, youth and their families in a multi-agency, multi-disciplinary system of services.
- iii. The system of care model is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with serious BH disorders and their families. Systems of care engage families and youth, in partnership with public and private organizations, to design BH services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth, and families function better at home, in school, in the community, and throughout life.
- iv. Support for and by family members within the system of care has emerged as a core strategy for improving the children's MH system of care. The system of care approach has fundamentally changed the relationships that families of children and youth involved in child-serving systems have with the agencies within those systems. Increasingly, collaboration and partnership between families and service providers have been recognized as the threads that link successful programs, policies, and practices. The development of youth involvement in MH systems of care closely follows the growth and acceptance of family-to-family support and the broader family empowerment movement, as well as the growth of consumer-provided services.
- v. Wraparound facilitation is often associated with systems of care but is actually a distinct component of a system of care. Since the term was first coined in the 1980s, "wraparound" has been defined in different ways. It has been described as a philosophy, an approach, and a service. In recent years, wraparound has been most commonly considered an intensive, individualized care planning and management process.
- vi. The organizations providing wraparound facilitation in Louisiana's CSoC are wraparound agencies (WAAs). 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".
- vii. Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and his/her family. Additionally, wraparound plans are more holistic than traditional care plans because they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving and coping skills, and

self-efficacy of the child and his/her family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

- viii. Providing comprehensive care through the wraparound process requires a high degree of collaboration and coordination among the child- and family-serving agencies/organizations in a community. These agencies and organizations need to work together to provide access to flexible resources and a well developed array of services and supports in the community. In addition, other community- or system-level supports are necessary for wraparound to be successfully implemented and sustained. Research on wraparound implementation¹, coordinated by the National Wraparound Initiative, has defined these essential community and system supports for wraparound and grouped them into six themes:

- (a) **Community partnership:** Representatives of key stakeholder groups, including families, young people, agencies, providers, and community representatives have joined together in a collaborative efforts to plan, implement, and oversee wraparound as a community process.
- (b) **Collaborative action:** Stakeholders involved in the wraparound effort work together to take steps to translate the wraparound philosophy into concrete policies, practices, and achievements that work across systems.
- (c) **Fiscal policies and sustainability:** The community has developed fiscal strategies to support and sustain wraparound and to better meet the needs of children and youth participating in wraparound.
- (d) **Access to needed supports and services:** The community has developed mechanisms for ensuring access to the wraparound process, as well as to the services and supports that wraparound teams need to fully implement their plans.
- (e) **Human resource development and support:** The system supports wraparound and partner agency staff to fully implement the wraparound model and to provide relevant and transparent information to families and their extended networks about effective participation in wraparound.
- (f) **Accountability:** The community implements mechanisms to monitor wraparound fidelity, service quality and outcomes, and to oversee the quality and development of the overall wraparound effort.

Note: Many of the community responsibilities listed above are supported by State level efforts in Louisiana, in collaboration with the CSoC Statewide Governance Board (SGB), DHH-OBH, Louisiana's child serving agencies and other stakeholders. The responsibilities of the Contractor in supporting these activities are specified through the RFP.

- ix. The wraparound process also relies on a family-driven approach that means families have a primary decision-making role in the care of their own children, as well as the policies and procedures governing care for all children in their

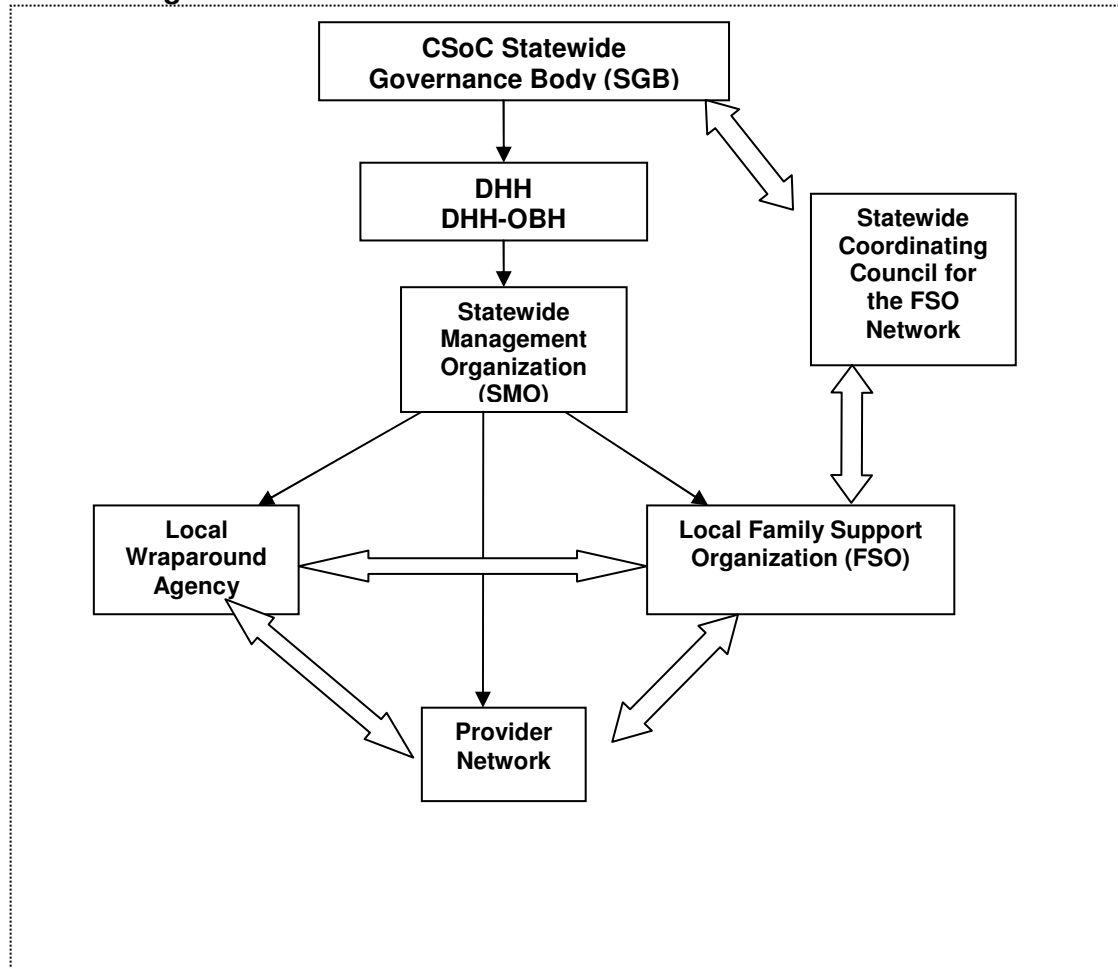
¹ <http://depts.washington.edu/wrapeval/>

community, state, tribe, territory, and nation. This includes choosing culturally and linguistically competent supports, services, and providers; setting goals; designing, implementing, and evaluating programs; monitoring outcomes; and partnering in funding decisions.

- x. Guiding principles of Family-Driven Care include:
 - (a) Families and youth, providers and administrators, embrace the concept of sharing decision-making and responsibility for outcomes.
 - (b) Families and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their families.
 - (c) All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf and may appoint them as substitute decision makers at any time.
 - (d) Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
 - (e) Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports, and advocate for families and youth to have choices.
 - (f) Providers take the initiative to change policy and practice from provider-driven to family-driven.
 - (g) Administrators allocate staff, training, support, and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families and where family and youth organizations are funded and sustained.
 - (h) Community attitude change efforts focus on removing barriers and discrimination created by stigma.
 - (i) Communities and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.
 - (j) Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes, so that the needs of the diverse populations are appropriately addressed.
- b. The CSoC SGB has the responsibility to provide policy direction to DHH/OBH in such areas as listed:
 - i. Eligibility criteria and procedures for enrollment in the CSoC.
 - ii. Parameters of service utilization and criteria for applying those parameters, including out of home placement.
 - iii. Quality indicators, reporting mechanisms, and quality feedback mechanisms.
 - iv. Requirements for WAAs and providers, and mechanisms for approving and monitoring providers.
 - v. Quality and timeliness requirements for payment system.
 - vi. Monitoring of project outcomes, including quality and cost.
 - vii. Policy and adherence monitoring.

- c. The CSoC SGB determined that CSoC-eligible children will have access to WF through WAA and family/youth support and training through Family Support Organizations (FSO). The organization of the CSoC is outlined in the table below.

Table 3: Organization of CSoC



- d. The WAA will provide intensive, individualized care planning and management through Child and Family Teams (CFT) and have the following responsibilities:
- Accept referrals from the SMO, following the SMO's telephone screening of the Child and Adolescent Needs and Strengths (CANS) Brief tool to determine eligibility for the CSoC.
 - Make initial referrals to community-based services, including an FSO, for up to 30 days or until the plan of care is developed and approved by SMO.
 - Partner with juvenile courts, schools, and other local stakeholder agencies for intake of eligible at-risk youth and their families.
 - Staff and manage the CFT process, including development of a POC within the first 30 days of enrollment, and care coordination, through intensive care management, with small staff to child ratios (e.g., 1:8 – 1:10).
 - Emphasize the identification, development and reliance on natural supports to strengthen families and achieve the POC goals.
 - Submit the POC to the SMO for approval and collaborate with the SMO to

- finalize a sustainable POC that is consistent with the needs of the child and medical necessity guidelines.
 - vii. Link families and youth to certified family and youth support and training specialists, mobile response and stabilization.
 - viii. Track individual children, services provided, and costs of services.
 - ix. Conduct UM/utilization review of individual children, consistent with agreed upon guidelines established by CSoC governance in collaboration with the SMO.
 - x. Provide quality assurance (QA) at the local level.
 - xi. Participate in outcomes management/monitoring of individual children.
 - xii. Input individual child data into a management information system (MIS) capable of needed tracking and monitoring functions and integrated with SMO MIS.
 - xiii. Work with the SMO to monitor and support development of local provider capacity for the purpose of filling gaps in service availability.
 - xiv. Partner with FSOs to provide access to certified family and cultural support specialists, certified parent trainer/group facilitators, and certified youth support and training specialists and support participation of families and youth in QA processes.
 - xv. Develop treatment plans consistent with federal requirements, as approved by the SMO.
- e. The FSO will be family-run, non-profit corporations governed by a board of directors known as its local coordination council (LCC). The statewide FSO network will coordinate its local and State activities through the creation of a state coordinating council (SCC). The initial local FSOs will partner with the CSoC SGB FSO Implementation Workgroup to support and participate in the development of the SCC to ensure state-level participation of family and youth of the CSoC.
- f. Local FSOs governed by a local coordinating council will have the following responsibilities:
- i. Provide and build capacity for State certified family and cultural support specialists.
 - ii. Provide and build capacity for State certified parent trainer/group facilitators.
 - iii. Provide and build capacity for State certified youth support and training specialists.
 - iv. Participate in the child and family team process.
 - v. Provide direct youth and family support, including psycho-education services to families and youth as providers enrolled in the Contractor network under the State's Medicaid 1915(c) CSoC SED waiver and in coordination with broader provider service delivery network.
 - vi. Participate in QA and outcomes management/monitoring at local and state levels.
 - vii. Participate in planning, policy making, and system oversight at local and state level.
- g. The SCC will have the following responsibilities:

- i. Provide initial and ongoing training to ensure capacity of family members to participate in quality monitoring activities and policy-setting at the State level, as well as to provide representation on the CSoC SGB.
 - ii. Provide family representatives to serve in quality monitoring and policy-making processes conducted by the Contractor, OBH, CSoC SGB committees, and others, as needed.
 - iii. Provide and maintain membership on the CSoC SGB to include two family representatives, two family apprentices (non-voting), and one youth member.
 - iv. Serve as an advisory council to the CSoC SGB, as needed.
 - v. In coordination with the Contractor, assist in the development and oversight of the general policies and procedures of the FSO Network.
- h. WAA and FSO will be community agencies or programs established for the CSoC. Implementation of WAA will occur through a phased-in regional planning process. Implementation of the CSoC will be organized by ACT 1225 Regions:²
 - i. Region 1: Orleans, Plaquemines, St. Bernard
 - ii. Jefferson Parish will respond separately
 - iii. Region 2: East/West Baton Rouge, East/West Feliciana, Iberville, and Pointe Coupee
 - iv. Region 3: Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington
 - v. Region 4: Ascension, Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, and Terrebonne
 - vi. Region 5: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary, and Vermilion
 - vii. Region 6: Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis
 - viii. Region 7: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn
 - ix. Region 8: Bienville, Bossier, Caddo, Claiborne, Desoto, Jackson, Natchitoches, Red River, Sabine, and Webster
 - x. Region 9: Caldwell, East/West Carroll, Franklin, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, and Union
- i. Each ACT 1225 region will have the opportunity to respond to a request for application (RFA) to be chosen as a first phase implementing region and establish a regional WAA and FSO. The CSoC SGB established guidelines for the selection of regions, and the application process will occur during a parallel timeframe to the selection of the SMO. The CSoC SGB will select the initial regions that will implement and operate the WAA and FSO.
- j. Regional application criteria will include the capacity to demonstrate, at least, the following:
 - i. Commitment by all relevant regional agencies and stakeholders, including families and youth, to implement the CSoC.
 - ii. Identification of proposed WAA and experience/current capacity for quality improvement (QI), UM, outcomes monitoring/tracking, and related administrative functions.

² Act 1225 refers to Act 1225 of 2003, incorporated as RS 46:2600.

- iii. Cross agency and family-driven service planning by proposed WAA, FSO, and stakeholder agencies.
 - iv. Family participation in governance by proposed WAA.
 - v. Plan on how proposed WAA will use technical assistance provided by State and the Contractor to fully implement CFT and wraparound consistent with the National Wraparound Principles, intensive care management, and QI/UM/outcomes monitoring/tracking, and related administrative functions.
 - vi. Assessment of provider capacity to meet the ideal service array developed by the CSoC planning effort and consistent with CMS requirements, and plan to enhance and fill gaps.
 - vii. Outreach plan, including special emphasis on schools and courts, in order to intervene and divert children and youth from expulsion and adjudication assessment of local capacity for interagency collaboration and accountability.
- k. DHH-OBH anticipates between one and five WAA will begin operations by January 1, 2012. Other WAA will be phased in during the second and third year of the SMO Contract by Region, and Jefferson Parish. A total of 10 WAA agencies, corresponding to the Act 1225 Regions and Jefferson Parish are expected to develop by 2015. Each WAA is expected to serve up to 240 children and youth at any one point in time.

Regional FSOs will also be implemented statewide in a phased-in process, in parallel with the WAA phase, beginning in 2012, under the guidance of the CSoC Governance and DHH-OBH. Support for and by family members, within the system of care, has emerged as a core strategy for improving the children's mental health system of care. The system of care approach has fundamentally changed the relationships that families of children and youth involved in child-serving systems have with the agencies within those systems. Increasingly, collaboration and partnership between families and service providers have been recognized as the threads that link successful programs, policies, and practices. The development of youth involvement in BH systems of care closely follows the growth and acceptance of family-to-family support and the broader family empowerment movement, as well as the growth of consumer-provided services. A recent literature review, sponsored by the University of South Florida (USF) Research and Training Center for Children's Mental Health, provides an excellent survey and synthesis of available evidence for this approach.³ A recent national survey of family organizations found that education, advocacy, and peer-to-peer support are key to family support.⁴ Another review of family peer-to-peer support models provided a useful conceptualization of the key mechanisms underlying the effectiveness of this approach.⁵

³ Robbins, V., Johnston, J., Barnett, H., Hobstetter, W., Kutash, K., Duchnowski, A. J., & Annis, S. (2008). *Parent to parent: A synthesis of the emerging literature*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies.

⁴ Hoagwood, K. E., Green, E., Kelleher, K., Schoenwald, S., Rolls-Reutz, J., Landsverk, J., Glisson, C., & Mayberg, S. (2008). Family Advocacy, Support and Education in Children's Mental Health: Results of a National Survey. *Admin Policy Mental Health*, 35, 73 – 83.

⁵ Ireys, H. T., DeVet, K. A., & Sakwa, D. (1998). Family support and education. In M.H. Epstein, K. Kutash, & A.J. Duchnowski (Eds.), *Outcomes for Children and Youth with Emotional Disorders and their Families: Programs and Evaluation Best Practices* (pp. 154-175). Austin, TX: Pro-Ed.

They identified four key areas:

- i. Social support helps caregivers feel a sense of belonging and being valued, and also provides new resources, both tangible and intangible.
 - ii. Peer support providers serve as links to broader social networks, in which peer support connects caregivers to community resources, people, or institutions, and thus, serves as a relationship or social network bridge-builder.
 - iii. Social comparison occurs when caregivers are better able to maintain and build self esteem in the context of receiving support from a peer who has been through a similar experience, as opposed to situations where unintended negative consequences emerge as supports or services are received from someone who has not experienced similar challenges. Because of similar experiences, the peer can understand what the caregiver is going through, but avoid the potential negative consequences of threatening comparisons.
 - iv. Empowerment appears to be supported through the peer-to-peer interaction, as caregivers see the peer supporter as a model of success, learn strategies, and access resources to help deal with their child's and family's situation.
- l. In Louisiana's CSoC, family involvement, support, and development, at all levels of the system, will be structured to support family participation and engage the diversity of families affected by systems of care. Regions are expected to be thoughtful about the different structures and FSOs in their region in order to understand how they will affect different stakeholders' experiences, level of involvement, and attainment of system goals. Through local FSOs, family members will participate in the wraparound planning process and provide support and education to families being served by the CSoC. In general, an important component of meaningful family support is that it is delivered by family peers, defined as:⁶
 - i. Currently raising or having raised a child or youth with emotional, behavioral, or MH challenges.
 - ii. Possessing current knowledge of the children's behavioral health system.
 - iii. Having experience with, and consciousness of, the struggle; recognizes the standpoint of the parent.
- m. By featuring family members as full partners working within the system of care, the Louisiana CSoC hopes to stimulate behavioral change across the system and support development of family-friendly policies and procedures within the provider agencies and among community partners. Emphasizing FSOs as system partners will support full family involvement in systems of care becoming the rule, rather than the exception.

⁶ (2008) National Federation of Families for Children's Mental Health.

- n. The FSOs will have the following roles:

- i. Provide and build capacity for certified family and cultural support specialists.
 - ii. Provide and build capacity for certified parent trainer/group facilitators.
 - iii. Provide and build capacity for youth certified support and training specialists.
 - iv. Participate in child and family team process.
 - v. Provide direct youth and family support, including psycho-education services to families and youth, as providers enrolled in the Contractor network under the State's Medicaid 1915(c) CSoC SED waiver.
 - vi. Participate in QA and outcomes and management/monitoring at local and State levels.
 - vii. Participate in planning, policy-making, and system oversight at local, district, regional, and State levels.
 - o. Oversight of FSO functions will be carried out through a LCC that will promote culturally and linguistically competent representation and ensure diverse family and youth representation from the communities and target population served; each FSO's LCC will be comprised of 60 percent family members and also include individuals from local family and child-serving organizations, district attorneys, judges, school system representatives, faith-based organizations, community leaders, and others, as determined appropriate by each individual LCC; the LCC will be responsible for the fiscal and technical oversight of the FSO.
 - p. Louisiana's seven child-serving agencies (Medicaid, OJJ, DOE, DHH-OBH, DCFS, DHH-OCDD and DHH-OPH) served 245,430 children and youth with BH challenges in State fiscal year 2009. This number is duplicative, to some degree. If a child is served by more than one agency, they are counted multiple times. Not all these children are eligible for the CSoC.
 - q. As of the date of this RFP, about 600 to 700 children are in residential placements throughout the State, supported by DCFS and OJJ and identified as in need of alternative family- and community-based BH services.
 - r. The number of CSoC children expected to receive WF, treatment planning, and intensive care coordination by WAA in year one of the contract is about 1,800 based upon the number of regions that implement WAA. As the number of regions that establish WAA increases, additional children will receive WF. The SMO must anticipate providing assistance with the development of WAA and contracting with them to provide WF services.
3. Management of BH Services for Other Children and Adults. The RFP also seeks a Contractor to manage Medicaid and Non-Medicaid BH services for children not eligible for the CSoC, and for adults with SMI and/or AD, to promote utilization of EBP and best practices and to improve access and deliver efficient, high quality services. The RFP identifies different requirements for management of Medicaid and Non-Medicaid services, including payment methods depending on the State Departments providing funding for Non-Medicaid services. These requirements are specified within the RFP.

- a. Development of the SMO coincides with the integration of the Office of Mental Health (OMH) with the Office of Addictive Disorders (OAD) to form the Office of Behavioral Health. DHH recognized and supported the practice of co-occurring assessment and treatment and the corresponding need to develop an integrated treatment delivery as the best practice for the people being served.
- b. Within regions and LGEs, services are provided through state operated, state contracted services, private comprehensive service providers, rehabilitation agencies, community addiction and mental health clinics, and certified peer support specialists.
- c. DHH-OBH embraces the goal of establishing a comprehensive community-based system of care for people of all ages. Principles that guide DHH-OBH operations are as follows:
 - i. We can and will make a difference in the lives of children and adults in the state of Louisiana.
 - ii. People recover from both mental illness and addiction when given the proper care and a supportive environment.
 - iii. The services of the system will respond to the needs of individuals, families, and communities, including culturally and linguistically diverse services.
 - iv. Individuals, families and community will be welcomed into the system of services and supports with a “no wrong door” approach.
 - v. We respect the dignity of individuals, families, communities and the workforce that serves them.
 - vi. Through a cooperative spirit of partnerships and collaborations, the needs of individuals, families and communities will be met by a workforce that is ethical, competent and committed to the welfare of the people it serves.
 - vii. We will utilize the unique skills of professionals with appropriate competencies, credentials and certifications.
 - viii. Mental illness and addiction are health care issues and must be seamlessly integrated into a comprehensive physical and behavioral health care system that includes primary care settings.
 - ix. Many people we serve suffer from both mental illness and addiction. As we provide care, we must understand, identify and treat both illnesses as primary conditions.
 - x. The system of care will be easily accessible and comprehensive and will fully integrate a continuum of prevention and treatment services to all age groups. It will be designed to be evidence-based, responsive to changing needs, and built on a foundation of continuous quality improvement.
 - xi. We will measure our results to demonstrate both improved outcomes for the people we serve and fiscal responsibility to our funders.
 - xii. We will prioritize de-stigmatizing historical biases and prejudices against those with mental illness and addictive disorders and those who provide services, through efforts to increase access to treatment. We will do this by reducing financial barriers, addressing provider bias, integrating care and increasing the willingness and ability of individuals to seek and receive treatment.
- d. DHH-OBH-MH has a total of 36 CMHCs and 19 Outreach locations operational in the State. LGEs have a total of 21 CMHCs and 10 Outreach locations in the State. The CMHCs provide an array of services including crisis services,

screening and assessment, individual evaluation and treatment, psychopharmacology, clinical casework, specialized services for children and youth, and in some areas, specialized services for those in the criminal justice system, and for person with co-occurring mental and addictive disorders. DHH-OBH-MH also provides additional community-based services either directly through the regions and Districts or through contractual arrangements, including supported living, supported employment, family/consumer support services e.g., Assertive Community Treatment, Intensive Case Management (ICM), respite, drop-in centers, peer support (known as consumer liaisons)) and school based mental health services. DHH-OBH-MH, including the LGEs, has many contracts with private agencies, funded by the Block Grant to provide a wide array of additional community based services.

- e. DHH-OBH has initiated the consolidation of the state-operated addictive disorders clinics and the mental health clinics. Previously parallel AD and MH outpatient systems are being merged to create a unified service setting, providing the infrastructure to support integrated treatment models for persons diagnosed with co-occurring mental health and addictive disorders. Many of the locally governed districts have already merged addictive and mental health operations, thus functioning like a behavioral health clinic. The provision of easily accessible and integrated care continues to be a priority for the DHH-OBH.
- f. DHH-OBH has adopted the Recovery Philosophy as a core principle upon which services are developed and rendered. The DHH-OBH advocates that services be delivered in a manner that is person-centered with services that incorporates the person's needs and individual goals. The instillation of hope and the belief that persons can recover from mental health and addictive disorders is critical in the service planning process for individuals with behavioral health needs. Behavioral supports and services should be rendered in the least restrictive manner, allowing the person to work toward increasing levels of independence.
- g. DHH-OBH-MH operates three intermediate/long term inpatient care psychiatric hospitals that have a total of 274 Adult Civil Intermediate care beds: Southeast Louisiana Hospital (SELH – 94 beds) in Mandeville, Eastern Louisiana Mental Health System (ELMHS – 120 beds) in Jackson and Greenwell Springs, and Central Louisiana State Hospital (CLSH – 60 beds) in Pineville. The capacity for civil inpatient services is currently undergoing a system change and is being actively reduced in an effort to fully develop an array of intensive community-based services. ELMHS operates 235 adult intermediate forensic beds. Statewide there are 50 inpatient beds dedicated to children/youth. There are also several facilities in the state that are operated by the Louisiana State University (LSU) Medical schools that have acute mental health beds.
- h. Currently, OBH is undergoing a major initiative in “right sizing” the mental health system. Historically, mental health services in Louisiana have been heavily weighted toward the utilization of inpatient levels of care. The current initiative is an effort to rebalance this by creating intensive community-based mental health services that can transition and support persons from the civil intermediate care hospitals to a less restrictive setting. As persons are discharged into the community through this initiative, there is a planned reduction in the capacity of the inpatient levels of care. There is a comprehensive continuity of care process

inclusive of community and hospital based clinical teams that operate together in an effort to build an effective and thorough discharge plan for individuals moving from the state hospitals into the newly developed community based services. The establishment of Assertive Community Treatment (ACT) Teams throughout much of the state has been a critical new service to support this initiative. ACT teams can be found in many regions and districts of the state including: MHSD, JPHSA, CAHSD, Region 4, Region 5, Region 6, and Region 7. The community service array has been further expanded through implementation of Intensive Case Management (ICM) teams. The ICM teams have been positioned in a number of regions and districts throughout the state as well including: SCLHSA, FPHSA, Region 4, Region 5, Region 7, and Region 8. It would be the responsibility of the Contractor to manage care delivered by both the ACT and ICM service teams. Creating housing options for the persons discharged from psychiatric inpatient care has also been an essential component of this initiative. DHH-OBH has been active in developing and utilizing the permanent supportive housing (PSH) program in the eligible areas of the state, which includes the coastal regions of the south and east Louisiana. Other therapeutic models and housing options are also being developed for portions of the state where PSH is not available.

- i. DHH-OBH recognizes the continued development of crisis intervention services and the development of local collaboratives to manage behavioral health issues in the community. The Contractor shall maintain an active role in assisting with the communications required to manage behavioral health crises in the community and referral to behavioral health services required by the individual in need. Through Act 447 legislation passed in 2008, each DHH region is to develop and implement a crisis community collaborative that consists of community partners available to support and manage behavioral health crises in the local community. These community partners include an array of public and private partners such as law enforcement, emergency department directors, psychiatric acute unit directors, coroners, behavioral health advocates, and peer supports. The Contractor should anticipate the need to familiarize itself with the local crisis collaborative and manage communications to facilitate crisis resolution.
- j. DHH-OBH continues to move toward decreased reliance on institutional and inpatient level of care for children. The capacity for children in the public psychiatric institutions has been significantly reduced throughout the years. 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. There are ongoing initiatives to support the implementation of evidence based children's practices. Non CSoC children will need to be able to access effective and coordinated services. Evidence based practices for children such as Multi-systemic Therapy (MST) and Functional Family Therapy (FFT) have been implemented throughout portions of the state as critical services available to children and their families.
- k. DHH-OBH has developed a Permanent Supportive Housing initiative that provides access to over 3,300 housing units in the Gulf Opportunity Zone (including the Capital Area, Florida Parishes, Jefferson Parish, Metropolitan and South Central Districts and Regions 4 and 5) for adults and children who qualify for this service as defined in the DHH Cooperative Endeavor Agreement for this service with the Louisiana Public Housing Authority in Office of Community

Development (OCD), Division of Administration. Note: Medicaid funding will not be utilized to pay for room and board under this waiver program except in approved Medicaid institutions such as hospitals and PRTFs.

- l. Historically, DHH-OMH authorized and monitored quality and outcomes for MH rehabilitation services operated through private Medicaid provider agencies statewide. As of July 1, 2009, the Mental Health Rehabilitation program was moved out of OMH and is currently operated under the BHSF/MVA within DHH. The Contractor will have responsibility for management of these services as part of the contract established under this RFP.
- m. Medicaid reimbursement for addiction services was suspended in Louisiana. A State Plan Amendment (SPA) submitted in 2011 and pending approval from CMS, reinstates treatment for AD under the management of the Contractor.
- n. DHH-OBH-AD services include the American Society of Addiction Medicine (ASAM) levels of care.
- o. Of the 101,105 children with SED or emotional behavioral disorders in Louisiana (based upon nationally-recognized prevalence estimates), DHH-OBH reported a caseload of 7,019 children and youth in 2010 (as of June 30, 2010).
- p. Of the 178,048 adults with SMI in Louisiana (based upon nationally recognized prevalence estimates of 5.4%), DHH-OBH reported a caseload of 36,393 adults in 2010 (as of June 30, 2010) (including LGEs).
- q. Of the 350,000 adults with AD in Louisiana (based upon nationally recognized prevalence estimates), DHH-OBH-AD served a total of 48,898 clients (33,915 unduplicated visits, and duplicated 14,983 visits) in State fiscal year (SFY) 2010. In that same year, DHH-OBH-AD served a total of 27,094 clients in outpatient and intensive outpatient, and 8,338 in inpatient settings. Of these served in outpatient and intensive outpatient, 19,498 were treated through outpatient programs and 7,596 were served in intensive outpatient programs. DHH OBH-AD provided approximately 763,007 services to these individuals in outpatient and intensive outpatient programs. DHH-OBH-AD served 8,474 persons in detoxification programs (social, medical, and medically supported) during SFY 2010.
- r. DHH-OBH-AD provided adult inpatient services during SFY 2010 and maintained 15 inpatient/residential adult short-term programs throughout the State, in six regions and three districts, with a total capacity of approximately 446 beds. There were a total of 5,307 served in inpatient adult programs and 2,817 served in residential programs.
- s. During SFY 2010, DHH-OBH-AD maintained a total of 15 beds for individuals with co-occurring mental health and substance use disorders at the Red River Treatment Center in Pineville, Louisiana (Region VI). The unit was licensed at 27 bed capacity in December 2008. OAD expanded capacity to treat adults, who required short term inpatient treatment, by adding 74 beds to its treatment continuum of care. OAD continued to maintain three adolescent residential programs throughout the State for a total capacity of 104 inpatient beds. The Springs of Recovery Center is located in the Baton Rouge area and the other two

facilities, Gateway Adolescent Treatment Center and the Cavanaugh Center, are located in the Alexandria (Region VI) and the Shreveport (Region VII) areas respectively.

4. Pending CMS Authorities:

- a. DHH submitted concurrent State Plan Amendments and waiver applications to CMS in March 2011 for the administration of Louisiana's behavioral health services program. The concurrent CMS authorities include:
 - i. 1915(b) prepaid inpatient health plan (PIHP) with mandatory enrollment and selective services contracting.
 - ii. 1915(c) children's CSoC Severely Emotionally Disturbed (SED) 1915(c) Home and Community Based Waiver concurrent waiver.
 - iii. 1915(i) State Plan Amendment (SPA) for Adult Mental Health Rehabilitation services for individuals with Serious Mental Illness (SMI).
 - iv. These concurrent authorities are administered through the 1915(b) authority. Also, DHH submitted amendments for various State Plan service categories. The CMS Authorities are available in the procurement library.

- b. Pertinent information from the CMS authorities is described in the table below:

Table 4: The five (5) SPAs pending approval from CMS

SPA	FFY 2012	FFY 2013
1. Compliance	\$ -0-	\$ -0-
2. School-based Services (SBS)	\$16.0 M	\$21.4 M
3. 1915(i) Adults Outpatient Care	\$32.2 M	\$44.0 M
4. EPSDT, Other Licensed Practitioner and Rehabilitation Children's Services Adult Substance Abuse Treatment	\$7.7 M \$31.0 M	\$10.2 M \$42.0 M
5. PRTF	\$10.1 M	\$13.5 M

Pending CMS Waiver Authorities

The 1915(b) waiver authority would have the following number of eligible children and adults as of March 2, 2011 and would include all inpatient and outpatient behavioral health care for Medicaid eligibles except for limited basic health care for CCN enrollees:

Table 5: 1915(b) Eligible children and adults as of March 2011

Population	Projected Year 1	Projected Year 2
	Calendar Year 2012	Calendar Year 2013
Non-Disabled – Child	719,252	747,362
Non-Disabled – Adult	164,360	168,550
Foster Care & Disabled Child	50,201	50,990
Disabled Adult	130,054	133,050
CSoC SED 1915(c) Waiver	900	1,500
Total Annualized Enrollment	1,064,766	1,101,452

The 1915(b) waiver is projected to cost no more than the figures in Table 6 below:

Table 6: 1915(b) waiver cost projections

Year	PMPM Cost
Year 1	\$56.39
Year 2	\$60.90

The 1915(c) waiver number of children served and total costs are projected below:

Table 7: 1915(c) waiver number of children served and total cost projections

Year	Children Served*	Total Cost
Year 1	1,200	\$7,534,392
Year 2	1,800	\$11,989,855

*The average length of stay for children/youth in the 1915(c) waiver is anticipated as 270 days. The maximum capacity for the model Wraparound Agency (WAA) is 240 children/youth. If ten WAAs are operational, 2,400 children and youth would be served when they are at full capacity.

B. Contractor Requirements

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

- 24 hour, 7 days a week toll-free telephone access line
- Member services
- Management of care
- Utilization management (UM)
- Quality management (QM)
- Grievances and appeals
- Complaints resolution
- Provider network management
- Member rights and protections
- Reporting and monitoring
- Member rights and responsibilities
- Implementation planning
- Transition planning requirements (end of contract)
- Administrative organization
- Transition planning requirements (end of contract)
- Liquidated damages
- Fraud and abuse
- Technical requirements
- Cultural competence

The Contractor shall protect confidential information and documents as described in this RFP and in accordance with 42 USC 671(a)(8), 42 USC 5106a, 45 CFR 1355.21, 45 CFR 205.50 (through 45 CFR 1355.30), and LA R.S. 46:56.

Effective BH systems respect and make every effort to understand and be responsive to cultural differences. Cultural competence is a fundamental foundation for providing individualized services and supports. In addition to recognizing that all Members and their families/caretakers bring a unique cultural background with them, the BH system shall also acknowledge and address the disparities in access and treatment that, historically, have been the experience of diverse families in traditional systems. The Contractor shall annually develop and implement a Cultural Competency Plan with specific goals and measurable outcomes that address:

- The impact of culture, ethnicity, race, gender, sexual orientation, and social class within the service delivery process, the ability of Members and families/caretakers to access and use services, and how systems within and across each Region operate.
- The fit and relevance of services and service providers to the communities within each region, and strategies to optimally engage Members and their families/caretakers in ways that reflect their culture and experiences.

Contractors with the following experience are preferred:

- a. Organizations that have more than five (5) years of BH managed care experience and demonstrated success in its contracts for the provision of managed BH care services with complex, publicly-funded BH programs, including the following experience:
 - i. Management of Medicaid and other funding sources not part of the Medicaid program such as non-federal match State general funds and grant funds.
 - ii. Management of statewide (or substantial portions of a state) Medicaid managed BH care programs.
- b. Proven track record in providing services to other governmental clients and populations similar to the covered members covered under this Contract as demonstrated by:
 - i. Experience managing care for children with severe BH challenges involved with the child welfare and juvenile justice systems, particularly those at risk of, or already in, restrictive settings outside their home;
 - ii. Experience managing care for adults with SMI and/or addictive disorders;
 - iii. Success in establishing partnerships with governmental clients representing multiple child-serving agencies, and engaging community leaders, stakeholders, and providers in the delivery of a coordinated system of care;
 - iv. Success in implementing complex public sector managed care programs consistent with the time frames listed in the Schedule of Events of this RFP;
 - v. A cohesive, integrated management structure that allows for timely decision at the local level, within a corporate framework that process access to industry-leading tools, technology, expertise, and oversight; and
 - vi. A proven reputation proven for being responsible and reliable in executing decisions based on values consistent with the principles and goals defined in this RFP.
- c. Experience and demonstrated success in collaborating with Wraparound Agencies, or similar entities that provides an intensive, individualized care planning and management process for children and their families.
- d. Experience and demonstrated success in collaborating with consumer and/or family run services, such as peer and Family Support Organizations, and incorporating peer- and family- run services into the provider network.
- e. Experience and demonstrated success in managing care for individuals residing in permanent supportive housing and other types of community housing.
- f. Experience and demonstrated success in creative approaches to implementing comprehensive and coordinated systems of care for children, youth and adults that:

- i. Identifies and implements the preferences of members and their families in the design of services and supports;
 - ii. Facilitates the development of consumer and family-run services, use of peer support, child and family teams for children and youth, and emphasizes inclusion of natural supports for people of all ages;
 - iii. Facilitates the use of self-management and relapse prevention skills;
 - iv. Promotes communication and POC development between medical and behavioral providers;
 - v. Addresses the development and maintenance of health social networks, skills, and school attendance and performance, and employment; and
 - vi. Assists the member with obtaining a stable, safe and permanent home.
- g. A flexible responsible member services approach that is respectful and responsive to callers representing diverse cultures, and provides clear information on member eligibility and services access to:
 - i. Members with SMI and severe BH challenges;
 - ii. Families that negotiate multiple systems to obtain appropriate services for their children; and
 - iii. Providers, schools, and community organizations, advocates, members of the general public and others that contact the Contractor.
- h. Experience and demonstrated success in operating a CM/UM program that successfully reduces utilization of inappropriate inpatient psychiatry hospital care, psychiatric residential treatment facilities and reduction in the use of out-of-home placements for children and youth.
- i. Experience and demonstrated success in implementing practice guidelines that promote an evidence-based culture through provider training and fidelity monitoring.
- j. Experience and demonstrated success in providing a trauma-informed delivery system through training of staff and providers.
- k. Experience and demonstrated success in operating a QM program that focuses on continuous QI with strategies that:
 - i. Drive accountability and performance;
 - ii. Contain valid, reliable metrics for outcome measurement;
 - iii. Monitor the impact of clinical and other service decisions on member and provider satisfaction and outcomes; and
 - iv. Provide adequate oversight of staff making clinical decision 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.
- l. Experience and demonstrated commitment to developing and managing qualified culturally competent provider networks that emphasize expansion of evidence-based and best practices, including community and family-based services and natural supports, including strategies that:
 - i. Emphasizes provider orientation, and ongoing training;
 - ii. Pays subcontracted providers and responds timely to provider questions and concerns; and
 - iii. Ensures the qualifications of providers meet credentialing, including state and federal requirements.
- m. Administrative efficiency through technology, including:
 - i. A supportive and responsive BH MIS and staff;
 - ii. Automated systems for detection of suspected fraud and abuse in keeping with state and federal standards and procedures;

- iii. Data-driven approaches to monitor contract requirements including individualized POC, treatment plans, crisis plans, advance directives, network adequacy, UM and outcomes monitoring;
- iv. A BH MIS that will electronically and securely interface with the DHH MMIS, the WAA, and the DHH-OBH data warehouse. The BH MIS must be capable of interagency electronic transfer to and from the participating state agencies (DHH, OBH, DCFS, DOE, & OJJ) as needed to support the operations as outlined in the RFP;
- v. A secure online web-based portal that allows providers and the State agencies (DCFS, DOE, DHH-OBH, and OJJ) to submit and receive responses to referrals and prior authorizations for services.
- vi. 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 BH MIS will regularly (e.g., bi-weekly) electronically transfer client/episode-level recipient, assessment, service, and provider data to the 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 as outlined in the Quality Management Strategy);
- vii. Safeguards to protect the confidentiality of protected health information in keeping with contemporary HIPAA standards for privacy, security, and data integrity;
- viii. Experience and demonstrated success in integrating, analyzing/ reporting, transferring, and managing large complex data sets;
- ix. Technology supports that drive accurate, timely claims management and administration operations; and
- x. Industry-leading reporting capabilities as needed by the State for effective and efficient management of the SMO operations.
- n. A proven track record of being accountable to performance requirements under large, complex contracts, including:
 - i. Examples of successful achievement of performance thresholds or guarantees that embody the children/youth and adults system principles outlined in this contract;
 - ii. Acceptance of performance measures, thresholds, and other requirements described in this Contract; and
 - iii. Capability to update performance measures as industry standards and program requirements change.

1. Covered Population and Enrollment Process

- a. The following Medicaid populations are enrolled in the waiver:
 - i. All eligible children under Medicaid and the CHIP Medicaid expansion population, including children in intermediate care facilities for the mentally retarded (ICF-MRs) and low income subsidy program and LaCHIP children with the same delivery system as Medicaid.
 - ii. All Medicaid children functionally eligible for the CSoC program.
 - iii. All Medicaid adults, including full benefit dual eligibles.
Note: Medicaid managed care enrollees in MCOs and PCCMs will be enrolled under this Contract to receive behavioral health services.

- b. The following Medicaid subpopulations are excluded from the waiver:
 - i. Medicare individuals who are not eligible for Medicaid (e.g., SLMB-only, QMB-only, QDWI).
 - ii. Adults residing in ICF-MRs.
 - iii. Stand-alone CHIP program and those services will be provided by the PIHP when the CHIP has the same delivery system as Medicaid. For those children served by the Office of Group Benefits PPO, those children are excluded from the PIHP.
 - iv. Population code 20 Medically Needy Spend Down not eligible for any inpatient or outpatient behavioral health services, including hospital and physician services.
 - v. Adults in PACE.
 - vi. Individuals receiving Family Planning from the LaMOMS program.
 - vii. Individuals receiving refugee cash assistance.
 - viii. Individuals with Tuberculosis
 - ix. Aliens Emergency Services.
- c. The following non-Medicaid populations are enrolled in the waiver:
 - i. Non-Medicaid children functionally eligible for the CSoC program.
 - ii. Adults and children eligible for OBH funding, who are not eligible for Medicaid.
 - iii. Children in OJJ and DCFS custody who are not eligible for Medicaid.
 - iv. Young Adult Program (YAP) (State funded).
 - v. Office of Youth Development (OYD) (State funded).
 - vi. Office of Community Services (OCS)/under 18 (State funded).
 - vii. State Retirees – SGF funded persons who lost eligibility for SSI and Medicaid due to cost of living increases in state/local government retirement benefits.
 - viii. LaCHIP Phase IV.
- d. Specific requirements of the Contractor for Medicaid enrollment:
 - i. The Contractor shall accept individuals in the order in which they are enrolled, without restriction.
 - ii. The Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services, race, color, gender or national origin.
 - iii. The Contractor shall not use any policy or practice that has the effect of discriminating on the basis of race, color, gender or national origin.
 - iv. The Contractor 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.
 - v. The Contractor shall specify the methods by which it will assure DHH that it does not request disenrollment for any reason.
 - vi. The Contractor will automatically re-enroll a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less.
 - vii. All eligible Medicaid beneficiaries are automatically enrolled by the State into the SMO upon eligibility determination.
- e. The State, through DHH, shall be responsible for determining the eligibility of an individual for Medicaid funded services. The State, through DHH-OBH, is responsible

for all enrollment and disenrollment into the SMO. The State automatically enrolls Medicaid beneficiaries on a mandatory basis into the SMO, for which it has requested a waiver of the requirement of choice of plans. As used in this RFP, a Medicaid enrollee means a Medicaid recipient who is currently enrolled in the Contractor's program. There are no potential enrollees in this program because the State automatically enrolls beneficiaries into the single SMO. State staff conducts the enrollment process. Louisiana is expected to receive an additional waiver of disenrollment of 42 CFR 438.56 under the pending 1915 (b) waiver. The Contractor 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 waiver, and are not covered under one of the enrolled non-Medicaid coverage groups.

- f. Enrollees in the State's 1115 Medicaid demonstration may be enrolled in this contract on or after January 1, 2012. Those enrollees will have a different benefit package than other enrollees.
- g. An individual is not eligible for Medicaid payment of services when the individual is an inmate and the facility in which the individual is residing is a public institution. Medicaid coverage of incarcerated individuals must comply with all federal requirements and the Louisiana Medicaid Eligibility Manual reissued July 28, 2010 and subsequent updates.

2. Covered Services

- a. Subject to the terms, conditions, and definitions of this Contract, the Contractor shall be responsible for the provision of all administrative services and all covered services to adults and children enrolled in the SMO.
- b. Different Members are eligible for different packages of services that will need to be tracked and provided by the Contractor. However, all Medicaid behavioral health services for inpatient and outpatient hospital services with a primary behavioral health diagnosis and community based, including clinic services, for behavioral health care, except those specifically noted below, are included under this contract for enrolled beneficiaries. The different Medicaid benefit packages include the following:
 - i. Medically necessary inpatient, emergency room, physician, other licensed practitioner, rehabilitation, and related mental health treatment services to all eligible children under Medicaid and the CHIP Medicaid expansion population with a primary behavioral health diagnosis.
 - ii. Medically necessary substance abuse for all Medicaid eligible adults.
 - iii. All medically necessary CSoC services, as well as services under the 1915(c) and 1915(b)(3) services to Medicaid children functionally eligible for the CSoC program, in accordance with the approved Plans of Care.
 - iv. 1915(i) functionally eligible Medicaid adults are eligible for medically necessary inpatient, emergency room, physician, and covered services under the 1915(i) State Plan amendment. Adults eligible to receive 1915(i) State Plan services include an adult over the age of twenty-one (21) who meets one of the following criteria:
 - (a) Persons with acute stabilization needs.
 - (b) Persons with serious mental illness (SMI) (federal definition of SMI).
 - (c) Persons with major mental disorders (MMD).

- (d) An adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance.
- v. Individuals eligible for Medicaid under the Medically Needy and CHIP categories have restricted benefit packages.

Note: Medicaid managed care enrollees in MCOs and PCCMs will be enrolled under this Contract to receive behavioral health services. The following services for Medicaid MCO beneficiaries are excluded from this Contract and included in the prepaid MCO rates. All other mental health and substance abuse services and beneficiaries are included in this waiver for Members of the PIHP:

- (a) Acute detoxification.
- (b) Mental health services provided in a medical (physical health) Medicaid MCO Member's PCP or medical office (i.e., MD, DO, or rural health clinic (RHC) other than services provided by a psychiatrist).
- (c) Mental health services provided in a federally qualified health center.
- (d) Emergency room services, except services provided to Members with primary codes of 290 through 319.

c. Non-Medicaid packages include:

- i. All medically necessary CSoC services, as well as services under the 1915(c) and 1915(b)(3) services to non-Medicaid children functionally eligible for the CSoC program in accordance with the approved Plans of Care.
- ii. Behavioral health services, including substance disorder and mental health treatment for adults and children eligible for OBH funding, who are not eligible for Medicaid.
- iii. Behavioral health services for children in OJJ and DCFS custody, who are not eligible for Medicaid.

Note: Non-Medicaid services to non-Medicaid eligibles will be paid by the SMO and billed to the participating Departments (DCFS, OJJ) through a separate invoicing process. DHH-OBH will make payments to clinics and specific contracted providers for Non -Medicaid services.

- d. The Contractor 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.
- e. Covered services shall be available statewide and provided by the Contractor through its subcontracts, except that the CSoC waiver, with its services, will be phased in according to a predetermined phase in schedule.
- f. The Contractor shall use the State Medicaid definition of "medically necessary services" in a manner that is no more restrictive than the State Medicaid program. All services, for which an Member is eligible, shall, at a minimum, cover:
 - i. The prevention, diagnosis, and treatment of health impairments.
 - ii. The ability to achieve age-appropriate growth and development.
 - iii. The ability to attain, maintain, or regain functional capacity.
- g. The amount, duration, and scope of medically necessary services provided shall be no less than the same services under the fee-for-service program, as defined in the applicable portions of Attachment F, the Louisiana Medicaid State Plan and relevant

fee-for-service provider manuals (e.g., outpatient hospital, including emergency rooms, FQHCs, and APRNs). The Contractor shall meet the minimum federal requirements for provision of Medicaid FFS services. The amount, duration, and scope of benefits under this Contract shall be no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid.

- h. Only Medicaid Members can receive Medicaid funded services.
- i. Medicaid services shall be provided by DHH-certified providers. If access problems are detected, the Contractor shall actively recruit, train, and subcontract with additional providers, including independent practitioners, to meet the needs of Members.
- j. For all modalities of care, the duration of treatment should be determined by the Member's needs and his or her response to treatment.
- k. The delivery of Medicaid State Plan, HCBS SED Waiver, and 1915 (b)(3) services shall appear seamless to all Members, but retain separate fund accountability for audit and encounter data purposes. The Contractor may only use Medicaid funds to purchase Medicaid services for Medicaid enrollees. The Contractor is encouraged to propose additional services to Medicaid beneficiaries, with prior approval from DHH-OBH and CMS. The Contractor may propose additional services to be added to the non-Medicaid service array after consultation with DHH-OBH.
- l. During the term of the Contract, the Contractor may provide cost-effective services that are in addition to those covered under the Medicaid State Plan as alternative treatment services and programs for enrolled Members under 42 CFR 438.6(e) for adults under the capitation. The cost of alternative services will not be included in capitated rate calculations. The State will only factor the State Plan services into the rates, plus any adjustments for managed care efficiency. The Contractor shall perform a cost-benefit analysis for any new services it proposes to provide, as directed by the State, including how the proposed service would be cost-effective compared to the State Plan services. The Contractor shall implement cost-effective services and programs only after approval by the State.
- m. Covered Services by Covered Populations. Table 8 on the following page outlines the covered services by covered populations

Table 8: Covered Services by Covered Populations

Service	Medicaid children	CSoC children (Medicaid and Non-Medicaid)	Medicaid adults	Medicaid adults eligible for the 1915(i)	Medically needy	CHIP in separate program	OBH adults	OBH children	OJJ/ DCFS children
Inpatient General Hospital	X	X	X	X	X	X			
Psychiatrists (Physician)	X	X	X	X	X	X	X	X	X
Psychiatric Hospital	X	X	Over age 65				X	X	
Psychiatric Residential Treatment Facility (PRTF) for under age 21	X	X				X		X	X
Rehabilitation Therapeutic Group Home (TGH)	X	X				X		X	X
Licensed Mental Health Practitioners	X	X		X					
Rehabilitation (Unlicensed Mental Health Practitioners) - Community Psychiatric Support and Treatment - Psychosocial Rehabilitation - Crisis Intervention	X	X		X			X	X	X
Rehabilitation Substance Abuse	X	X	X	X			X	X	X
1915(c) and 1915(b)(3) CSoC services - Psycho-education - Parent Support and Training - Peer Support - Independent Living Skills Building Services - Short Term Respite - Crisis Stabilization		X							
1915(b)(3) Case Conference	X	X		X			X	X	X

- n. Coverage and Payment for Emergency Services for Medicaid enrollees.
The Contractor shall be responsible for coverage, payment, and provision of outpatient emergency services and covered post-stabilization services for covered behavioral health diagnoses. This responsibility shall not replace hospitals' responsibilities under the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. The coverage will be provided consistent with 42 CFR 438.114. Payment for non-contracting hospital providers shall be consistent with the Medicaid fee-for-service fee schedule.
- o. Definitions.
- i. **Emergency medical condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 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, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.
 - ii. **Emergency services** means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under this title and that are needed to evaluate or stabilize an emergency medical condition.
 - iii. **Post stabilization services** means covered services, related to an emergency medical condition that are provided after an enrollee 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 enrollee's condition.
 - (a) In all circumstances, hospital emergency rooms are to be directed by the Contractor to be compliant with federal hospital and EMTALA requirements.
 - (b) In accordance with sections 1915(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in a PIHP shall have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.
 - (c) A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.
 - (d) The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized from an emergency medical condition for transfer or discharge from an emergency room, and that determination is binding on the Contractor.
 - (e) The Contractor shall not deny payment for treatment obtained when a Member has an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition.
 - (f) The Contractor shall not deny payment for treatment obtained when a Contractor representative instructs the Member to seek emergency services.
 - (g) The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. However, the diagnoses and/or symptoms shall be related to a covered behavioral health

condition, as defined in this contract.

- (h) Emergency services for covered conditions shall be reimbursed for Members, regardless of whether authorized in advance or whether the provider of the service is a part of the service network.
- (i) For emergency services provided to a Member by a network or non-network provider, when behavioral health diagnoses are the primary condition, the Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Contractor of the Member's screening and treatment within ten calendar days of presentation for emergency services.
- (j) For emergency services provided for behavioral health reasons by a network or non-network provider, the Contractor shall:
 - (i) Provide a minimum triage fee to the hospital, regardless of whether the facility notifies the Contractor; the triage fee shall be no less than is paid through the fee-for-service Medicaid program.
 - (ii) Reimburse the facility for emergency services provided, contingent upon the facility's compliance with notification policies.
 - (iii) Reimburse non-network providers an emergency room fee, which is no less than the state's Medicaid rate for such services.

p. Coverage and Payment for Post-Stabilization Services.

The Contractor shall be responsible for post-stabilization services in accordance with provisions set forth at 42 CFR 422.113(c) and which are listed below:

- i. The Contractor shall be financially responsible for medically necessary post-stabilization covered services that are pre-approved by a Plan provider or other representative.
- ii. The Contractor 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 Contractor for pre-approval of further post-stabilization covered services.
- iii. The Contractor 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:
 - (a) The Contractor does not respond to a request for pre-approval within one hour.
 - (b) The Contractor cannot be contacted.
 - (c) The Contractor and the treating physician cannot reach an agreement concerning the Member's care, and the Contractor's physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with the Contractor's physician, and the treating physician may continue with care of the Member until the Contractor's physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.
 - (d) The Contractor 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 Contractor.
 - (e) The Contractor's financial responsibility for medically necessary post-stabilization covered services not pre-approved ends when:
 - (i) A network physician with privileges at the treating hospital assumes

- responsibility for the Member care.
 - (ii) A network physician assumes responsibility for the Member care through transfer.
 - (iii) The Contractor's representative and the treating physician reach an agreement concerning the Member care.
 - (iv) The Member is discharged.
- q. Prior authorization and concurrent utilization review for inpatient psychiatric hospitalization.
- The Contractor will perform prior authorization and concurrent utilization review for all 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. DHH-OBH funding will pay for all other utilization reviews. The Contractor shall ensure that face-to-face inpatient psychiatric hospital concurrent utilization reviews are completed by a LMHP for each Medicaid beneficiary referred for psychiatric admissions to general hospitals, as specified for children based on the CANS screening and algorithm, consistent with R.S. 46: 153 (Louisiana Register, Volume 21, No. 6, 6/20/1995). The criteria contain a two-fold definition: severity of need and intensity of service required, both of which shall be met. Adult reviews are per R.S. 46: 153 adult admission criteria:
- i. The patient shall meet one or more of three categories for severity:
 - (a) Patient presents a danger to self.
 - (b) Patient presents as a danger to others due to a DSM-III-TR Axis I diagnosis.
 - (c) Patient is gravely disabled and unable to care for self due to a DSM-III-R Axis I diagnosis.
 - ii. The patient shall meet all intensity of service criteria:
 - (a) Ambulatory resources will not meet needs.
 - (b) Services in hospital are expected to improve condition or prevent further regression.
 - (c) Treatment of the condition requires inpatient services.
 - iii. The patient does not have an exclusionary criteria:
 - (a) Not medically stable.
 - (b) Patient with criminal charges with no DSM-III-R Axis 1 diagnosis.
 - (c) Person with anti-social behavior that is characterological.
 - (d) Persons with MR diagnosis without a DSM-III-R Axis 1 diagnosis.
- r. Concurrent utilization reviews are administrative in nature and should not be reported to Louisiana 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 utilizations fail to document medical necessity for the inpatient psychiatric treatment.
- i. Concurrent utilization review includes:
 - (a) 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 Contractor for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed no later than 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.

- (b) 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 (a). 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 Contractor 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 Contractor's referral. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of the child, the procedures specified above should be utilized.
- ii. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the Contractor shall immediately generate a prior authorization number from the Medicaid fiscal agent, and within 48 hours, notify, in writing, the provider and individual requesting the screen of the results. If denied, the Contractor shall notify the individual requesting the screen immediately, and within 48 hours provide written notification to the provider and individual requesting the screen 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.
- iii. Certification of Need for Psychiatric Residential Treatment Facilities (PRTFs). The Contractor will perform independent initial certifications of need and recertification of need for all residents seeking admission or who are admitted to a Psychiatric Residential Treatment Facilities in accordance with provisions set forth at 42 CFR 441.152 through 441.155. Certifications of need are administrative in nature and should not be reported to DHH-OBH in encounter data. There are instances where an individual personally presenting at the PRTF may be admitted by PRTF staff. However, Medicaid will not reimburse for treatment until the Certification of Need is completed and the enrollee's assignment has been correctly identified.
 - (a) Through the Certification of Need, the Contractor shall ensure that:
 - (i) Ambulatory care resources available in the community do not meet the treatment needs of the recipient.
 - (ii) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
 - (iii) 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.

- (b) The Certification of Need and re-certifications shall be completed by a team, independent of the facility, that:
 - (i) Includes a physician.
 - (ii) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry.
 - (iii) Has knowledge of the individual's situation.
- (c) 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, 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. In order to ensure that the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the Contractor 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). Recertification shall occur within 90 days of admission and again every 60 days thereafter. In order 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.
- (d) PRTF Certification of Need includes:
 - (i) Emergent and Urgent Inpatient Psychiatric Concurrent Utilization Reviews, where psychiatric residential treatment is recommended in lieu of inpatient psychiatric hospitalization. When an emergent inpatient psychiatric concurrent utilization review is requested, due to concerns regarding the safety of the child, the Contractor shall screen the emergency request utilizing an emergency exception screening protocol for after hours/weekend as approved by DHH-OBH. PRTF emergency exception screening procedures should be initiated. If psychiatric residential treatment is recommended, and the individual is currently in a place of safety, the independent certification shall be completed prior to admission and within seven (7) calendar days of the Contractor's receipt of the request.
 - (ii) Planned Psychiatric Screening: A certification of need is initiated, if the individual is experiencing chronic psychiatric symptoms that create a substantial risk of harm to self or others, or a child who is so unable to care for his or her own physical health and safety as to create a danger to their life. The child is currently in a place of safety and not experiencing an imminent psychiatric crisis. In this instance, the screening including the independent team shall be completed within seven (7) calendar days of the Contractor's receipt of the request.
 - (iii) PRTF Emergency Exception Screening Procedure. A request for an Emergency Exception Screen for a PRTF will be based on the custodial case manager's assessment of the child. This assessment will determine that the youth is in such a mental condition and/or situation as to render them without a safe living arrangement. The Exception process allows for a temporary delay in the screen and CBST requirement. The screen and independent certification are still required to occur within seven (7) days of the request for an emergency exception screen, but the child can be admitted to the

facility while the independent certification occurs.

- (iv) The Contractor will have a specific list of designated individuals who are authorized to request an Emergency Exception. When an emergency exception screen is needed, the custodial case manager will notify their designated individual, who will contact the Contractor through the established protocols. The designated individual will request the emergency exception screen and requested timeframe needed for completion.
 - (v) The Contractor will notify the responsible subcontract of this emergency exception request. A resident can be admitted to a PRTF, upon acceptance by the facility, using the Emergency Exception Screen. The admission screen shall be completed by the LMHP certifying the need within 48 hours of admission. The LMHP will certify that this is an exception screen and that the independent certification has not yet been completed. The independent certification will be completed within seven (7) days of the request for an emergency exception to determine if the resident needs can be met by the PRTF or if the youth should be diverted to community based services. If the certification determines that the resident's needs can best be served in the community, then the resident shall be moved from the PRTF. If the youth is not moved, the placing agency or guardian will be responsible for payment after such determination.
 - (vi) It is expected that the Contractor will make these requests a priority. The Contractor will monitor the time it is taking to respond and will work to find alternative solutions if they cannot meet the required timeframe. If the Contractor has not responded within the designated timeframe, the custodial case manager will notify the Contractor, so that follow-up can occur.
- (e) In addition to certifying need, the Contractor shall:
- (i) Be responsible for tracking the Member's authorization period for psychiatric residential treatment and providing notification to the responsible party when a re-certification is due.
 - (ii) Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility:
 - (a) Upon completion of the Certification of Need, if the inpatient admission is approved, within 48 hours the Contractor shall notify, in writing, the provider and individual requesting the certification of the results. If denied, the Contractor shall notify the individual requesting the certification immediately, and, within 48 hours, provide written notification to the provider and individual 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.
 - (iii) Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen.
 - (iv) Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions.
 - (v) Work with the Medicaid Fiscal Agent to determine retroactive eligibility and assignment, when applicable.

- iv. The Contractor will work with OBH to develop prior authorization and concurrent utilization review of therapeutic group home and other residential levels of stays, including group homes, non-medical group homes, and therapeutic foster care.
- v. Authorization and integration of Medicaid funded school-based behavioral services.
- vi. The Contractor is responsible for receiving information from Louisiana public schools regarding services available under the schools and the assessed needs of children in schools.
- vii. The Contractor will receive information from the Individualized Healthcare Plan (IHP) for all students referred by the LEA. The IHP will include all behavioral services, units, etc. for which schools will seek reimbursement. (Please refer to the Procurement Library for a copy of the IHP.)
- viii. The IHP for students with disabilities is the prior authorization for services; no additional authorization is needed for current level of service provided by the LEA.
- ix. A reimbursement mechanism/methodology for crises intervention, in the school setting, for students with disabilities will be included in the prior authorization process.
- x. The information from the IHP, including needs and school services provided, will be integrated into the Contractor's care management and prior authorization systems. It will be made available to treatment planners and WAA in order to facilitate understanding of the totality of the child's needs and services being received.
- xi. All children receiving school-based Medicaid behavioral health services will be screened using the CANS brief screening.
- xii. The Contractor will review the plan and coordinate with the WAA and/or treatment planner, if one is involved.
- xiii. The Contractor will provide consultation and education regarding effective treatments for the eligible child with behavioral health needs.
- xiv. The Contractor will work with the school to identify additional resources in the community for the child.
- xv. Claims from school-based behavioral health providers will be submitted to the Contractor for authorization and payment. The Contractor will authorize payment for school-employee provided services, but will not pay those claims. Instead, the Contractor will forward approved claims to the State for payment through a mutually agreed upon payment mechanism. The Contractor will pay school-based behavioral health providers who are not school employees.
- xvi. The Contractor will review the delivery of services through the schools to ensure that services authorized were delivered as approved and notify the school, DOE, and Medicaid if services are not rendered consistent with the individualized education plan (IEP).
- xvii. To assist in this process, DOE will develop a mechanism to share systematically with the Contractor the dates, service provided, type of service (individual or group), frequency, provider name, and service goals. IEP dates (most recent), behavioral plan data, and evaluation date can also be included, if necessary. All data elements (including those from IHP) can be forwarded to Contractor from the LEA. Data reports from the Contractor to LEAs and DOE would ideally include:
 - (a) All students referred to the Contractor (by district and by state)
 - (b) Name

- (c) Date of birth
 - (d) Ethnicity
 - (e) Gender
 - (f) Disability
 - (g) School name
 - (h) CSoC services authorized by the Contractor
 - (i) List of Providers (per Region)
 - (j) Name of WAA facilitator assigned to case
 - (k) Name of family service coordinator assigned
 - (l) Dates of WAA team meetings
 - (m) Dates of child/family team meetings
 - (n) Child specific outcome data from participating agencies/providers
 - (o) Progress monitoring report
 - (p) Monthly reimbursement report per district/per state
- s. Youth with DD and co-occurring behavioral and/or mental health.
- i. The Contractor will provide treatment planning to youth residing in public SSCs (ICF-MR) and experiencing significant co-occurring behavioral and/or mental health concerns, which impact their ability to successfully live in a community setting and/or may result in interaction with the legal system:
 - (a) These youth will receive a waiver opportunity 1915(c) upon transitioning from the SSC.
 - (b) They will be maintained in the Mental Retardation/Developmental Disabilities (MR/DD) 1915(c) waiver as the primary waiver with OCDD oversight, as per current processes.
 - (c) They will concurrently receive the 1915(b) waiver for the child and family team and wraparound mental health services/treatment planning (those services not covered in the MR/DD 1915(c) waiver).
 - ii. Youth living with family/foster family and experiencing significant co-occurring behavioral and/or mental health concerns, which jeopardizes their ability to remain in their current living situations (i.e., crisis referral for alternate living situation initiated) and/or may result in interaction with the legal system:
 - (a) These youth may qualify for the ROW crisis diversion option.
 - (b) They will receive the ROW services through the 1915(c) waiver, as the primary waiver with OCDD oversight, as per current processes.
 - (c) They will concurrently receive the 1915(b) waiver for the child and family team and wraparound mental health services/treatment planning (those services not covered in the 1915(c) waiver)).
 - iii. Youth living with family/foster family and experiencing significant co-occurring behavioral and/or mental health concerns, which, if they do not receive supports, may later jeopardize their ability to remain in their current living situations and/or may result in interaction with the legal system:
 - (a) These youth qualify for a 1915(c) waiver or ICF/DD level of care but do not have access to the waiver currently. These children may be on the registry.
 - (b) They will receive the 1915(b) waiver for the child and family team and wraparound mental health services/treatment planning and all other services available in the 1915(b) waiver.
 - (c) They will access any other appropriate EPSDT services through the Medicaid State Plan.

- (d) The Wraparound Facilitator and Child and Family team, if necessary, can ask for an EPSDT exception for medically necessary services.
 - (e) When a 1915(c) waiver option is available, they will receive those services as their primary waiver consistent with the above notes. (NOTE: While these individuals will not be receiving 1915(c) waiver services, the option of receiving the 1915(b) and EPSDT services, while waiting, still provides greater access to needed behavioral and mental health services, with some residential service assistance, which for many youth, if accessed early, can still have a significant positive impact on outcomes.)
- iv. Youth residing in private ICF/DDs and experiencing significant co-occurring behavioral and/or mental health concerns which impact their ability to successfully live in a community setting and/or may result in interaction with the legal system:
 - (a) These youth may qualify for the ROW conversion option or may receive a NOW offer as per the registry.
 - (b) If available, they will receive services through the 1915(c) waiver, as the primary waiver with OCDD oversight as per current processes.
 - (c) If 1915(c) waiver services are available, they will concurrently receive the 1915(b) waiver for the child and family team and wraparound mental health services/treatment planning (those services not covered in the 1915(c) waiver).
 - (d) If the 1915(c) waiver services are not yet available, each individual situation will need to be assessed to determine if a return home with 1915(b) and EPSDT services would be successful or if the individual shall await a 1915(c) option. Child and Family team, if necessary, can ask for an EPSDT exception for medically necessary services.
- t. Procedure for non-covered EPSDT service identified as medically necessary for a Child and Family Team:
 - i. For a non-covered service in the Louisiana State Plan:
 - (a) As much information regarding the recipient is gathered, including age, diagnosis, condition, medical records relative to the service being requested.
 - (b) Information regarding the provider, enrollment status, qualifications for rendering service as appropriate is gathered.
 - (c) Information regarding the requested service is gathered. This information would include, but not be limited to, reasons/policy for non-coverage, applicable rules and SPA, alternative services, etc. All supporting information for coverage and medical necessity in individual case is gathered.
 - (d) This information is presented to the Medicaid Medical Director.
 - (e) The Medicaid Medical Director reviews 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.
 - (f) If approved for medical necessity, then a determination of availability of federal financial participation (FFP) is made. 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.

- (g) The payment of authorized services that are normally not a Medicaid covered benefit are specially handled through the system to ensure payment for the specified recipient occurs and no other non-intended recipients' services are paid.

- ii. The Contractor shall reimburse or contract with at least one FQHC in each medical practice region of the State (according to the practice patterns within the State), if there is an FQHC appropriately licensed to provide substance abuse or specialty mental health under State law and to the extent that the FQHCs meet the provider qualifications outlined in the State Plan/waiver for those services.

Note: Medicaid MCO enrollees will have a choice of receiving FQHC services through their Medicaid MCO health plan, which includes reimbursement for all behavioral health services covered by the FQHC. Reimbursement for Medicaid MCO enrollees receiving services through FQHCs is through the Medicaid MCO program, and a choice of at least one entity with FQHC access is offered. If there are no FQHCs in the Medicaid MCO network area to choose from, then the Medicaid MCO must pay for the access out of network. FQHC services for Medicaid MCO enrollees choosing to receive services through FQHCs will not be reimbursed through the Contractor, to ensure that duplicate payment does not occur. 638 Tribal clinics providing basic behavioral health care (e.g., physician, APRN, or PA) are reimbursed through the Medicaid MCO or any eligible Indian Managed Care Entity (IMCE), using the prospective rate for any Medicaid MCO enrollee. If there are any 638 clinics providing behavioral health, the Contractor will be required to contract with and reimburse that clinic consistent with the SMDL #10-001 and allow any Indian to choose to receive covered services from an eligible and qualified behavioral health I/T/U provider, consistent with that guidance and any forthcoming regulations.

- iii. CSoC Home- and Community-Based Services (HCBS) Waiver for Children With a Serious Emotional Disturbance (SED Waiver).

- (a) The Contractor shall deliver all HCBS SED waiver services to 1915 (b)/(c) enrollees under the HCBS Waiver for Children with a SED waiver, as well as provide those services to children functionally eligible for the CSoC program but not enrolled in the program – tracking the appropriate 1915(b)(3) or non-Medicaid funding source. The establishment and implementation of the SED waiver program, this Contract, or any other action by DHH-OBH and/or the Contractor, does not establish an entitlement to SED waiver eligibility and/or services for any individual or group of individuals not enrolled in the waiver.
- (b) At all times and in all activities, the Contractor shall comply with the currently approved SED 1915(b)/(c) waiver. The Contractor will strive to implement new federal and state initiatives in HCBS in a timely manner. The Contractor will cooperate with all federal and state HCBS reviews and will implement corrective actions required as a result of those reviews consistent with federal direction.
- (c) The Contractor will conduct SED 1915(b)/(c) waiver functions in compliance with the currently approved federal waiver. Functions may be

delegated to subcontracts only if such delegation is approved by the State and consistent with the approved waiver. Contractor functions include, but are not limited to:

- (i) Disseminate information concerning the HCBS SED waiver to all potential enrollees.
- (ii) Utilize State approved marketing and educational materials.
- (iii) Assist individuals with waiver enrollment. This function includes:
 - Serving as the single point of entry including: application, eligibility determination, and referral for all persons who are seeking services under the waiver.
 - Assisting individuals with obtaining the determination of financial eligibility from the DHH eligibility offices and ensuring this is updated annually (may be delegated to WAA).
 - Determining the initial Level of Care for eligible individuals and ensure that the Level of Care is annually re-determined in compliance with the waiver.
- (iv) Oversight of the development and management of the Plan of Care (POC) by the WAA.
- (v) Working in conjunction with the Parent/Caretaker, Wraparound Facilitator, and Members of the Child and Family Team, and the PCP in developing the Plan of Care and insuring that the appropriate services are available.
- (vi) Ensure that any non-Contractor provided services in the Plan of Care are provided through a contractual or affiliation agreement or subcontract whereby the Contractor manages the billing payment and treatment oversight.
- (vii) Conduct utilization management and review functions which include:
 - Perform prior authorization of waiver services.
 - Conduct level of Care evaluation activities.
 - Review participant service plans to ensure that waiver requirements are met.
 - Manage waiver enrollment against approved limits.
 - Monitor waiver expenditures against approved levels.
- (viii) Ensure an Adequate Provider Network which includes:
 - Recruit Providers.
 - Credential Providers.
 - Subcontract with qualified, eligible providers.
 - Conduct training and technical assistance regarding waiver requirements.
 - Develop the CSoC HCBS SED Waiver Provider Manual (including operational policies and procedures) consistent with the federal application and DHH policies and procedures. The provider manual shall specifically include the seclusion and restraint policy consistent with the approved CMS 1915(c) waiver.
- (ix) Provide a notice of action as indicated in the SED waiver.
- (x) Establish Grievance System consistent with federal requirements and ensure that a written copy of the grievance and appeal procedures is given, at least annually, to all waiver recipients.

- (d) In performing the above functions, the Contractor agrees to:
 - (i) Provide or arrange for the delivery of services specified in the authorized and approved Plan of Care for each individual identified as an SED Waiver enrollee. Natural supports and local providers should be used to the extent possible and appropriate. If the Contractor or WAA cannot provide, nor secure from another provider, medically necessary services, DHH-OBH will be notified immediately. This shall include provision of SED waiver services and services available through the Medicaid State Plan. SED waiver services shall include respite, parent support, peer support, independent living, and crisis stabilization.
 - (ii) Authorize all HCBS SED waiver services, prior to their delivery, on a month-to-month basis.
 - (iii) Ensure that all HCBS SED waiver enrollees are receiving at least one HCBS SED waiver service monthly.
 - (iv) Ensure that OBH has access to reports for prior-authorization with the ability to randomly check prior authorized plans of care for compliance with federal requirements.
 - (v) Provide all reports, as specified in this contract, with separate fund accountability and performance indicators specific for HCBS SED waiver enrollees to be utilized for review, renewal, and audit purposes. The Contractor should have the ability to separately report any service, financial, or program issue that relates to the SED waiver/CSoc, distinct from any other service area under this Contract.
 - (vi) Participate in a quality assurance/quality improvement process established by OBH, as required by the federal waiver process, to include, but not be limited to, level of care, plan of care, choice, qualified provider, or health and welfare. This includes participation in all independent reviews, as specified by the department, and to take corrective action, if deemed necessary by the department.
- iv. Advance Directives.

The Contractor shall comply with the requirements of 42 CFR 422.128 for maintaining written policies and procedures for advance. The Contractor shall maintain written policies and procedures that meet requirements for advance directives in Subpart I of part 489.

 - (a) Advance directives are defined in 42 CFR 489.100.
 - (b) The Contractor shall maintain written policy and procedures concerning advance directives, with respect to all adult individuals receiving medical care by, or through, the Contractor.
 - (c) The Contractor shall provide adult enrollees with written information on advance directives policies and include a description of applicable State law. The written information provided by the Contractor shall reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.
- v. The Contractor shall provide written information to those individuals, with respect to the following:
 - (a) Their rights under the law of the State.
 - (b) The organizations' policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.

- (c) The Contractor shall inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.
- vi. Other Medicaid requirements.

The Contractor and its subcontractors shall comply with all Medicaid requirements of the State Plan, 1915(b) and 1915(c) concurrent waivers, the 1915(i) State Plan Amendment, and Quality Improvement Strategy as approved by CMS including all health and welfare monitoring required to ensure enrollee safety (e.g., provider monitoring, critical incidents, medication errors, restraints, restrictive interventions, etc).

3. Toll-Free Telephone Line/Member Services Requirements

Member Service Representatives (MSRs) provide the single point of entry for all individuals that seek information about the Contractor's services. This includes members or others calling on behalf of members. 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 Contractor's operations. For Members seeking services or information related to their ISP, the MSR will transfer the call to a Care Manager (refer to #8 below) for care coordination and referral to services.

- a. The Contractor shall develop, implement, and maintain a Member services call center responsive to all individuals, including, but not limited to:
 - i. Children, youth and their families/caregivers (birth, foster families, kinship care givers); providers; WAA staff; FSOs, including peer support specialists; family and cultural support specialists; schools; OJJ, including probation and courts with juvenile jurisdiction; PCPs or CCN providers; DCFS caseworkers/supervisors; and staff from DHH-OCDD, DOE and DHH-OBH, including Regions or Human Service Districts.
 - ii. Adults and their families/caregivers, PCPs or CCN providers, peer support specialists and probation or parole, or other staff of DHH or other state agencies, including the Regions, or Human Service Districts, calling on behalf of an adult or his/her family/caregiver.
- b. The Contractor's Member services department shall operate as the common single point of entry for all children, adults, and their families/caregivers (including children and adults already receiving services) and perform the following functions:
 - i. Provide access to a 24-hour, 7 days per week, 365 days per year, toll-free line that meets the following minimum standards:
 - (a) The toll-free number shall be approved by DHH-OBH.
 - (b) The Member line shall be answered by a live voice at all times.
 - (c) There shall be 24-hour, 7 days per week, 365 days per year capacity for crisis response and service authorization by LMHP care managers.
 - (d) There shall be 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.

- (e) All Member and provider calls shall be answered within 30 seconds.
- (f) Separate Member and provider telephone lines are permitted.
- (g) Separate call tracking and record keeping shall be established for tracking and monitoring provider and Member phone lines.
- (h) Call abandonment rates should not exceed 3%.
- ii. 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 Contractor to a new Contractor, or to the State, at the end of the contract term.
- iii. Ensure that the toll-free (1-800) number shall be publicized throughout Louisiana and listed in the directory of all local telephone books.
- iv. Manage the Member call center function to respond to inquiries.
- v. Assist and triage callers who may be in crisis by effectuating an immediate transfer to a care manager. The call shall be answered within 30 seconds and only transferred via a warm line to a LMHP.
- vi. Respond to individuals with limited English proficiency through the use of bilingual/multi cultural staff or language assistance services. Bilingual/multi cultural staff, at a minimum, shall speak English, Vietnamese, Spanish and any other language spoken by at least 5% of the eligible population.
- vii. The Contractor is required to make every reasonable effort to overcome any barrier that consumers may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the consumer in his/her spoken language, and/or access to a phone-based translation service, so that someone is readily available to communicate orally with the consumer in his/her spoken language. The Contractor shall require providers to have staff available to communicate with the consumer in his/her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the consumer in his/her spoken language.
- viii. Provide general information and orientation regarding all aspects of the program and operations. The Contractor shall have in place a comprehensive program to provide all Members, not just those who access services, with appropriate information, such as information about mental health treatment services, available providers, and education related to recovery, resilience and best practices, as well as Member rights. In developing these materials, the Contractor shall obtain input from consumers, secondary consumers and/or family Members and other stakeholders who can inform both the content and presentation of the information.
- ix. Interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner.
- x. Provide a Member service approach that ensures working with all parties involved in the children's and adults' systems of care to establish program eligibility.
- xi. Respect the caller's privacy during all communications and calls.
- xii. Assist callers with issues and concerns regarding service referrals, authorizations, payments, training, or other relevant inquiries, regarding service provision, eligibility or payment; a separate provider services line is also permitted to address provider issues.
- xiii. Work with individuals and their families/caregivers to obtain eligibility for other supportive services, such as, but not limited to, Medicaid and community

organizations; for complex eligibility matters, Members should be referred to the Contractor's care management staff.

- xiv. Assist and inform individuals and their families/caregivers about required eligibility documents and/or obtaining such documentation.
- xv. 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 their family Member (e.g., how to obtain an evaluation for a child). For the CSoC, provide information to families about resources available through the FSOs and WAA.
- xvi. Facilitate access to information on available service requirements and benefits.
- xvii. Provide information on how to file a grievance or appeal, and document the information received.
- xviii. Implement a grievance process, including logging all grievances, assisting as appropriate in the resolution of grievances, and notifying the Member regarding the resolution, in accordance with DHH-OBH and federal requirements. The MSRs shall be able to distinguish between a grievance and a Member appeal and know how to resolve or triage these calls to the appropriate personnel.
- xix. Implement a grievance and appeals system that meets requirements of subpart F of 42 CFR 438.
- xx. 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. Refer reconsiderations, appeals and QOC issues to Contractor's care manager or other designated staff to handle.
- xxi. Physically locate the call center and Member Services in the State of Louisiana. After-hour call center services shall also be performed at a site physically located in Louisiana.
- xxii. Utilize a language line translation system for callers whose primary language is not English. This service shall be available 24/7/365.
- xxiii. Have available, at all times, a TDD and/or relay systems.
- xxiv. Provide periodic live monitoring of Member service calls for QM purposes.
- xxv. Ensure that written material is in an easily understood language and format. Written material shall 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.

c. Member Website.

- i. The Contractor shall develop and maintain a customized Website that provides online access to Member service information. The Contractor shall organize the Website to allow for easy access of information by children, youth, families/caregivers, providers, stakeholders, and the general public, in compliance with Section 508 of the U.S. Rehabilitation Act. Prior written approval from DHH-OBH is required for all content appearing on the Website. Web content shall be written in easily understood language and format that is no higher than a fifth grade level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to ensure accuracy. The text shall be printed in at least a ten-point, preferably twelve-point font and shall be easily read by Members or their families/caregivers with varying degrees of visual impairment or limited reading proficiency. It shall include:

- (a) Call center telephone number.
- (b) Member services contact information, including e-mail address.
- (c) Eligibility information.
- (d) Hours of operations.
- (e) Information on how to access BH services.
- (f) Crisis response information and toll-free crisis telephone numbers.
- (g) An explanation of the requirements and benefits of the plan.
- (h) Emergency preparedness and response. This section shall include current 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 evaluation from their homes or communities or other preparedness-related activities. This section should include information that shall be displayed in easy to find and easy to follow instructions written at the fifth grade level. Languages deemed as necessary to the location include English, Spanish, and Vietnamese. The Website shall include hyperlinks to State and federal preparedness Websites.
- (i) Holistic health information and related links to health and wellness promotion articles.
- (j) Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for children receiving services, their families/caregivers, providers, and stakeholders to become involved.
- (k) Information regarding advocacy organizations, including how children, youth, young adults, and other families/caregivers may access advocacy services.
- (l) A hyperlink to the DHH-OBH / CSoC Websites.
- (m) Instructions on how to file a grievance or appeal.
- (n) Instructions on how to report suspected provider fraud and abuse that includes DHH's toll-free telephone number: 1-800-488-2917 and the following Website:
<http://www.dhh.louisiana.gov/offices/fraudform.asp?ID=92>
- (o) Any other documents as required by the CSoC Governance or DHH-OBH.

d. Member Information.

The Contractor shall:

- i. Develop, distribute, and post to the Website (when appropriate) Member information and instructional materials to Members or their families/caregivers that are in an easily understood format and written at no higher than a fifth grade level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. The text shall be printed in at least ten-point, preferably twelve-point font and be easily read by Members or their families/caregivers with varying degrees of visual impairment or limited reading proficiency.
- ii. Notify Members, in writing, that alternative formats are available and how to access them. The Contractor shall review all informational materials intended for distribution throughout the contract and implementation period and obtain DHH-OBH approval at least 30 days prior to the contract start date or use of the materials.
- iii. Translate all vital material, when a language other than English is spoken by 1,000 individuals or 5% (which is, at least, Vietnamese and Spanish, whichever

is less) of Members in Louisiana that also have limited English proficiency (LEP). At a minimum, vital material includes Notices of Action, consent forms, communications requiring a response from the Member or his/her family/caregiver and all reconsiderations and requests for State fair hearing information.

- iv. Translate other non-vital, generally provided materials when a language other than English is spoken by 3,000 individuals or five percent (5%), whichever is less, of Members in Louisiana that also have LEP, which is, at least, Vietnamese and Spanish.
- v. 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 30 days in advance of the intended effective date. **The cost of postage shall be included in the contract price. No extra payment shall be made to the Contractor for postage.**
- vi. Provide or make oral interpretation services available, free of charge, to all Members or their families/caregivers, including all non-English languages, not just those the State identifies as prevalent as described above.

e. Member Handbook.

- i. New Members receive an enrollment packet from the Contractor explaining the program. The informational packet is mailed to all new Members upon determination of enrollment. The informational packet includes a handbook with information regarding client rights and responsibilities and a provider directory. The handbook will be reviewed by the FSO Statewide Coordinating Council during its development, as well as the literacy program at Louisiana State University (LSU) Shreveport. All language will be written at the fifth reading grade level.
- ii. The Contractor shall develop and obtain written approval from DHH-OBH prior to publishing, distributing, and posting to its Website a Member Handbook in English, Spanish, and Vietnamese that provides information to all children, youth, adults and their families/caregivers. At a minimum, the Member Handbook shall include the following materials:
 - (a) The principles and goals of the CSoC and the Behavioral Health Services Program, including distinct information for eligible children/youth and their families/caregivers and adults.
 - (b) Where and how to access BH services, provider information (including emergency or crisis services), a description of covered BH services and key CSoC information, (e.g., the role of the Contractor, WAA and FSO).
 - (c) Family's/caregiver's role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families.
 - (d) Generic information on the treatment of BH conditions and the principles of family, child, youth and young adult's engagement; resilience; strength-based and evidence-based practice; and best/proven practices.
 - (e) Generic information on the treatment of BH conditions and the principles of adult, peer, and family engagement and recovery; and strength-based and evidence-based practices.
 - (f) Any limitations involving families/caregivers or providing information for adult persons who do not want information shared with family Members, including

age(s) of consent for BH treatment.

- (g) The Contractor's Member service telephone number.
- (h) How to identify and contact the WAA and the FSO.
- (i) How to change providers.
- (j) Oral interpretation is available for any language, and written document interpretation is available in all prevalent languages (English, Spanish, and Vietnamese) and how to access these services.
- (k) Copy of the Member Bill of Rights, as specified in 42 CFR § 438.100.
- (l) Information regarding advance directives, including:
 - (i) Member rights under the law of the State.
 - (ii) The Contractors' policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
 - (iii) That complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.
- (m) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Member's service area, including identification of providers that are not accepting new patients. This may be a summary of information with reference to the Website of the Contractor where an up-to-date listing is maintained.
- (n) Any restrictions on the Member's freedom of choice among network providers.
- (o) Information on grievance and fair hearing procedures, and for Members, the information specified in § 438.10(g)(1).
- (p) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that Members understand the benefits to which they are entitled.
- (q) Procedures for obtaining benefits, including authorization requirements.
- (r) The extent to which, and how, Members may obtain benefits, including family planning services, from out-of-network providers.
- (s) The extent to which, and how, after-hours and emergency coverage are provided, including:
 - (i) What constitutes emergency medical condition, emergency services, and post stabilization services, with reference to the definitions in § 438.114(a).
 - (ii) The fact that prior authorization is not required for emergency services.
 - (iii) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent.
 - (iv) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the Contract.
 - (v) The fact that, subject to the provisions of this section, the Member has a right to use any hospital or other setting for emergency care.
- (t) The post stabilization care services rules consistent with this contract.
- (u) Policy on referrals for specialty care and for other benefits not furnished by the Member's PCP.
- (v) Cost sharing, if any. Any cost sharing imposed on Medicaid enrollees shall be in accordance with 42 CFR 447.50 through 42 CFR 447.60 (same as

- permitted in FFS).
- (w) How and where to access any benefits that are available under Medicaid for Medicaid eligibles but are not covered under the contract, including any cost sharing and how transportation is provided. For a counseling or referral service that the Contractor does not cover, because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. The State shall provide information on how and where to obtain the service.
 - (x) Grievance, appeal, and fair hearing procedures and timeframes, in a State-developed or State-approved description that shall include the following:
 - (i) For State fair hearing:
 - The right to hearing.
 - The method for obtaining a hearing.
 - The rules that govern representation at the hearing.
 - (ii) The right to file grievances and appeals.
 - (iii) The requirements and timeframes for filing a grievance or appeal.
 - (iv) The availability of assistance in the filing process.
 - (v) The toll-free numbers that the Member can use to file a grievance or an appeal by phone.
 - (vi) The fact that, when requested by the Member:
 - Benefits will continue if the Member files an appeal or a request for State fair hearing within the timeframes specified for filing.
 - 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.
 - Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
 - (y) Annual notification to all Medicaid Members of their disenrollment rights.
Note: There are no disenrollment rights under the Louisiana contract.
 - (z) Additional information that is available upon request, including the following:
 - (i) Information on the structure and operation of the MCO or PIHP.
 - (ii) Physician incentive plans as set forth in 438.6(h) of this chapter.
- iii. The Contractor shall distribute the Member Handbook to each new Member or his/her family/caregiver within 10 days of being registered with the Contractor or first receiving a covered BH service, whichever is earlier. Unless otherwise instructed by DHH-OBH, the Contractor shall distribute, in sufficient quantities, the Member Handbook to WAA, FSOs, and other CSoc system partners at least 30 days prior to the contract start date and when requested. The Contractor shall also distribute the Member Handbook to key providers and other sites, as designated by DHH-OBH, to assist with distributing materials to adult Members.
 - iv. The Contractor shall review the Member Handbook at least annually and distribute an updated version to each Member or his/her family/caregiver, WAA, FSO, and other CSoc partners, and others designated by DHH-OBH, on or before October 1 of each year. The Contractor shall update the Member Handbook and submit it to DHH-OBH within 30 days, with any changes determined by DHH-OBH in the Behavioral Health Services

Program, including the CSoC. If there are no changes at the annual update, then the Contractor shall notify Members of the right to request information listed, at least once a year. If the Contractor makes changes to the Member Handbook, at a time other than the annual update, the Contractor shall distribute the revised version 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.

f. Member Communications.

The Contractor shall provide to Members, their families/caregivers, and/or providers any of the following:

- i. Notices of Action and Notices of Decision, which shall be delivered in compliance with the language, time frame, and content requirements of federal and State law and this contract.
- ii. When the Contractor terminates a contract, provider agreement, or suspends or terminates referrals to a qualified service provider, the Contractor shall deliver written notice of termination within 15 days of the termination notice to DHH-OBH and to each child, youth, and family/caregiver that is currently receiving or has received BH services within the last 180 days from the terminated provider. In these instances, the Contractor shall suggest an alternative provider and contact information to the child, youth, young adult, and his/her family/caregiver at the time of notice of termination of a provider.
- iii. Newsletters, policy advice, and any other materials that require distribution, as negotiated between the Contractor and DHH-OBH.
- iv. Other than the Member Handbook, which shall be provided to all new Members upon enrollment and upon request, the Contractor shall timely and accurately disseminate and communicate information required by DHH-OBH, subject to the terms of the final Contract. The Contractor shall disseminate information prepared by the federal government, DHH-OBH, or other State agencies to Members or their families/caregivers, subject to the terms of the final Contract. The Contractor shall submit all Member or family/caregiver informational materials to DHH-OBH for written approval prior to distribution. At a minimum, the Contractor shall distribute new and updated information to the following groups: Members or their families/caregivers, service providers, community stakeholders, and DHH, DCFS, DOE, and OJJ.
- v. The State permits indirect marketing by the Contractor or selective contracting fee-for-service providers (e.g., radio and TV advertising for the Contractor in general). The Contractor is allowed to attend health fairs, sponsor community forums, radio spots, print media, etc. and provide general outreach, so long as the entity does not target its materials directly to Medicaid beneficiaries. The following definitions apply:
 - (a) Marketing Materials means materials that are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, or PCCM can reasonably be interpreted as intended to market to potential Members.
 - (b) Cold call marketing means any unsolicited personal contact by the MCO, PIHP, PAHP, or PCCM with a potential Member for the purpose of marketing as defined in this paragraph.
 - (c) Marketing means any communication, from an MCO, PIHP, PAHP, or PCCM to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll

in that particular MCO's, PIHP's, PAHP's, or PCCM's Medicaid product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP or PCCM's Medicaid product.

- vi. Marketing materials and plans shall be accurate and not mislead, confuse, or defraud the recipients or DHH-OBH. The Contractor shall not distribute any marketing or informational materials without first obtaining OBH's approval. Once materials are approved, the Contractor shall distribute marketing materials to its entire service area. Informational materials shall be distributed to its entire Membership, unless otherwise approved by OBH.
- vii. Because there is no choice of Contractors, the State prohibits gifts and incentives to Members.
- viii. The Contractor shall ensure that in marketing to Members:
 - (a) Materials are distributed to its entire service area.
 - (b) The Contractor does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
 - (c) The Contractor does not, directly or indirectly engage in door-to-door, telephone, or other cold-call marketing activities.
 - (d) Marketing materials do not contain any assertion or statement (whether written or oral) that:
 - (i) The recipient shall enroll in the BH-MCO in order to obtain benefits or in order not to lose benefits.
 - (ii) The Contractor is endorsed by CMS, the federal or State government, or similar entity.
 - (e) In all advertisements, publications, and printed materials that are produced by the Contractor and that refer to the Louisiana Specialized Behavioral Health program, it shall state that the Contractor is the SMO for DHH. In all communications with the public, while acting in accordance with this Contract, the Contractor shall identify itself as the SMO for DHH.

4. Management of Care

- a. Care management is the overall system of medical and psychosocial management encompassing, but not limited to, UM, care coordination, discharge planning following restrictive levels of care, continuity of care, care transition, and QM. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for Members requiring specialized BH services and linkages to primary medical care services. These activities shall include scheduling assistance, monitoring, and follow-up for Member(s) requiring specialized BH services.
- b. The Contractor shall develop and maintain a care management function that ensures covered BH services are available when and where individuals need them. The Contractor shall provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The care management system shall have sufficient LMHP care managers (CMs) to respond 24 hours per day, 7 days per week, and 365 days per year to Members, their families/caregivers, or other interested parties calling on behalf of the Member.
- c. The CM shall make referrals to qualified providers or to the WAA for CSoC eligible Members, for immediate, urgent, and routine needs within the following

appointment access standards, with the requirement that children/youth eligible for the CSoC will at least meet the urgent appointment standard:

- i. 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 others, or extreme compromise of ability to care for oneself leading to physical injury.
 - ii. 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 without current evidence of such behavior. and
 - iii. 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.
- d. The Contractor and its providers shall meet management of care standards in section 4c i, ii, iii for timely access to care and services, taking into account the urgency of need for services.
- e. The network providers shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
- f. The Contractor 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.
- g. The CM shall determine if the individual has a PCP, and if not, refer the individual to a PCP in the Coordinated Care Network (CCN):
 - i. Allow each Member to choose his or her provider to the extent possible and appropriate.
 - ii. If the Contractor would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service is not required to do so if the Contractor objects to the service on moral or religious grounds.
 - iii. If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it shall furnish information about the services it does not cover as follows:
 - (a) To the State.
 - (b) With its application for a Medicaid contract.
 - (c) Whenever it adopts the policy during the term of the contract.
 - (d) It shall be consistent with the provisions of 42 CFR 438.10.
 - (e) It shall be provided to potential enrollees before and during enrollment.
 - (f) It shall be provided to enrollees within 90 days after adopting the policy with respect to any particular service.
- h. 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 Contractor'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 health care services furnished to the Member.

- i. Document the date of annual well care visits and track to assure primary care visits are scheduled and kept.
- j. Obtain signature for release of information from the Member or the family/caregiver for children, to coordinate care with the PCP and other health care providers.
- k. If medications are prescribed by the Contractor providers, obtain a list of medications prescribed by PCP and other specialists for a complete and reconciled medication list that is updated every 90 days.
- l. 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 mental 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.
- m. Coordinate care with the PCP, with the individual's authorization, to promote overall health and wellness.
- n. Coordinate the services the Contractor furnishes to the Member with the services the Member receives from any other MCO.
- o. Share with other MCOs serving the Member the results of its identification and assessment of any enrollee with special health care needs (as defined by the State) so that those activities need not be duplicated.
- p. To ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164, specifically describes the requirements regarding the privacy of individually identifiable health information. Health plans must comply with these requirements if they meet the definition of health plan found at 160.103: group health plan; health insurance issuer; HMO; Medicaid programs; SCHIP program, any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care. CMS recommends that Medicaid Managed care contracts include a provision that states that the MCO/PIHP/PAHP, as applicable, is in compliance with the requirements in 45 CFR Parts 160 and 164.
- q. If requested, the Contractor shall offer a second opinion from a qualified health care professional within the network or arrange for a second opinion outside the network at no cost to the Member.
- r. The Contractor is required to focus coordination for the treatment programs of those who are considered high risk or high needs; the Contractor shall identify

people with high needs and initiate ongoing treatment planning and service coordination with the consumer and others working with the consumer. The Contractor will be required to work in concert to address the needs of dually diagnosed individuals.

- s. In order to identify enrollees with special mental health care or substance use treatment needs, the Contractor is required to screen all Members to identify special needs enrollees who meet the criteria for:
 - i. Any individual with IV drug use, pregnant Substance Abuse users, substance using women with dependent children or co-occurring disorders;
 - ii. Children with behavioral health needs in contact with other child serving systems not eligible for CSoC;
 - iii. Children eligible for CSoC; and
 - iv. Adults eligible for the 1915(i) HCBS services. Adults eligible to receive 1915(i) State Plan services include: An Adult over the age of 21 who meets one of the following criteria is eligible to receive State Plan HCBS services:
 - (a) Persons with acute stabilization needs.
 - (b) Persons with SMI (federal definition of Serious Mental Illness).
 - (c) Persons with MMD (Major Mental Disorder).
 - (d) An adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance.
- t. The Contractor is required to produce a treatment plan for enrollees determined to need a course of treatment or regular care monitoring. The treatment plan shall be:
 - i. 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 Contractor, its staff or subcontracts will develop the plan informing the PCP of the final plan.
 - ii. Approved by the entity in a timely manner, if this approval is required.
 - iii. In accord with any applicable State quality assurance and utilization review standards.
 - iv. For enrollees determined to need a course of treatment or regular care monitoring, the Contractor shall ensure that the treatment plan in place allows enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.
- u. In the CSoC where a WAA is available, the Treatment Planning is performed by the WAA. For all other enrollees identified as special needs individuals, the Contractor, its staff or an independent community practitioner shall develop the treatment plan.
 - i. 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 are needed, at minimum every 6 months to review the treatment plan and more frequently when changes in the consumer'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. Treatment Planners will be certified after completion of specialized training in the Treatment Planning Philosophy, 1915(b) waiver and 1915(i) State Plan HCBS rules and processes, service eligibility and associated paperwork, and meeting facilitation. Medical necessity of any State Plan Rehabilitation services shall be determined by a licensed mental health practitioner or physician conducting an assessment consistent with state law, regulation and policy.

- ii. For children and youth, the Contractor shall follow the process outlined in the 1915(b) and 1915(c) waivers. See the State Plans and waivers for more information. The process includes:
 - (a) Determining at the initial contact/telephonic screening if the child/youth requires emergent care and, if yes, refer the child/youth to crisis services immediately. Prior authorization of emergency services is not required.
 - (b) Determining if the child/youth is eligible for the CSoC (through use of the telephonic assessment using the CANS - Brief approved by DHH-OBH), and on eligibility criteria specified in the Covered Populations section of this RFP.
 - (c) If the child is eligible for the CSoC and the family/caregiver resides in a region that has a WAA, referring the child and his/her family/caregiver to an independent evaluator for completion of the CANS -Comprehensive assessment, to the Family Support Organization for family support during the process, and to the WAA responsible for wraparound team engagement, development of an individual POC, and immediate access to medically necessary services.
 - (d) Requiring the WAA to:
 - (i) Offer a choice of child and family team (CFT) wraparound facilitators (WF).
 - (ii) Authorize CSoC covered services, consistent with medical necessity, for up to 30 days during the assessment and planning period, with the exception of inpatient and residential treatment services, which shall be prior authorized by the Contractor.
 - (iii) Assist the family with Medicaid enrollment if the child is not already Medicaid eligible.
 - (iv) Convene the CFT to develop an individual treatment plan known as the Plan of Care (POC). The CFT should be comprised of individuals that child/youth and family/caretakers want to assist in the development of the POC, including other family members, natural supports, providers, custodial case managers, and advocates. The WAA will assist the child/youth and family/caretakers with establishing the CFT.
 - (v) The POC must be developed with the participation of the independent LMHP who completed the CANS – Comprehensive in collaboration with the CFT. The independent LMHP responsible for completing the assessment shall develop the assessment with the CFT and participate in the development of and approval of the POC, but shall not be a provider on the POC. The independent LMHP will sign off on the POC, if any Medicaid rehabilitation services are recommended.
 - (vi) Schedule and conduct a pre-certification home visit.

- (vii) Determine if the 1915(c) Level of Care (LOC) is met and verify that the child meets the CSoC LON.
- (viii) Verify that the child/youth has a primary care provider (PCP) and if not, assist the child/youth and the family/caregiver with referrals to obtain a PCP. Ensure that the PCP is involved in the development of the POC if he/she desires. If not, ensure that the PCP receives information necessary to provide care to the child. At a minimum, the PCP will receive a copy of the completed POC.
- (ix) Coordinate care with the PCP, with the authorization of the family/caregiver, to address overall health and wellness.
- (x) Facilitate the timely development of the POC with the involvement of: the child/youth, family/caretaker, providers, and peer mentor or family liaison/educator, LMHP in service planning, when clinically appropriate, and subject to the approval of the child/youth and his/her family/caregiver.
- (xi) Emphasize POC services, including evidence-based/ best practices and supports that meet the needs of the child/youth, promote resiliency, rely on natural supports, and are sustainable. Natural supports are personal associations and community resources that assist with strengthening the family/caretaker and assist the child/youth in promoting resiliency.
- (xii) Submit the POC or review and approval by the Contractor.
- (e) Reviewing the POC prepared by the CFT to confirm: 1) timely development; 2) adequacy and QOC; 3) use of evidence-based/best practices, natural supports, and sustainability of the plan in promoting resiliency and recovery; 4) coordination with PCP; and 5) cost of care limitations were met.
- (f) Approving or providing feedback to the WAA on possible modifications to the POC for review with the CFT.
- (g) Collaborating with the WAA until the POC is approved.
- (h) If the child/youth is ineligible for the CSoC, but is eligible for DCFS or OJJ services, or if the child/youth is an IV drug user, pregnant substance abuse user, a substance abusing woman with dependent children or the child/youth has a dual diagnosis, or is eligible for the CSoC, but there is no WAA in the child's/youth's geographic region or no available opening at the WAA, the Contractor shall provide the following care management functions:
 - (i) The Contractor, its staff, or an independent assessor provides an independent evaluation and POC consistent with the findings of the evaluation.
 - (ii) 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.
 - (iii) Outreach to the child/youth or his/her family/caregiver if there is no follow-through with recommended services.
 - (iv) Review the individualized treatment plans developed by assigned providers to fulfill the POC and confirm: 1) timely development; 2) the adequacy and QOC; 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.

- (v) 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.
- (vi) Provide ongoing care management to review the appropriateness, quality and level of care, discharge, and transition planning.
- (i) For children/youth who are not eligible for CSoC, DCFS or OJJ, an IV drug user, pregnant substance abuse user, substance abusing woman with dependent children, or a child/youth with dual diagnosis, the Contractor will determine if the child is eligible for medically necessary services and prior authorize necessary services. If the child needs rehabilitation services, the Contractor will refer the child to a provider who will develop a rehabilitation service plan consistent with the Medicaid state plan requirements. The rehabilitation service plan shall be prior authorized by the Contractor.
- (j) For adults, the Contractor shall:
 - (i) Determine at the initial contact/telephonic screening if the individual calling requires a crisis response and, if necessary, refer the individual for crisis services immediately. Emergency services do not require prior authorization.
 - (ii) Determine if the individual is eligible for BH services based upon DHH-OBH eligibility criteria specified under the covered populations description of this RFP.
 - (iii) If the adult is not eligible for the 1915(i) criteria, if the adult is an IV drug user, pregnant substance abuse user, or substance abusing woman with dependent children or dual diagnosis, the Contractor, its staff, or a subcontracting provider, who will not provide services to the child, provides an independent evaluation consistent with the American Society for Addiction Medicine (ASAM-PPC) for addiction and develops an individualized treatment plan consistent with DHH-OBH specified treatment planning requirements found in the Service Descriptions Manual available in the Procurement Library.
 - (iv) If the adult is a substance abuser not meeting treatment planning requirements, not eligible for the 1915(i), or is a DHH-OBH non-Medicaid eligible adult not meeting 1915(i) criteria, then Contractor will determine if the adult is eligible for medically necessary services and prior authorize necessary services. If the adult needs rehabilitation substance abuse services, the Contractor will refer the adult to a provider who will develop a rehabilitation service plan consistent with the Medicaid state plan requirements and the ASAM-PPC for addiction. The rehabilitation service plan shall be prior authorized by the Contractor.
 - (v) If the adult is eligible for the 1915(i) criteria, the Contractor will refer the Member to a LMHP for an independent evaluation, utilizing the LOCUS for adult mental disorders and development of a treatment plan consistent with the requirements specified in this section.
 - (vi) Review all treatment plans and rehabilitation service plans to confirm:
 - 1) timely development; 2) the adequacy and QOC; and 3) participation

- of the Member and desired participants in treatment planning, when clinically appropriate and subject to the approval of the Member.
- (vii) Refer the Member to appropriate provider/providers offering clinically appropriate and medically necessary services; ensures a choice of credentialed providers.
 - (viii) Provide outreach to Members that do not follow through with recommended services.
 - (ix) Coordinate care with medical providers to assess and address medical-behavioral co-morbidities.
 - (x) Provide ongoing care management to ensure appropriateness, quality and level of care, discharge, and transition planning.
- (k) For all Members, the Contractor's CM shall develop and implement strategies to reduce risk to Members and families/caretakers, including, at a minimum:
- (i) Identifying Members who are in need of more intensive monitoring or support, or that have high-risk needs that have not been addressed.
 - (ii) Offering alternative services when requested services are denied.
 - (iii) Following up with Members who do not appear for appointments or adhere to service plans.
 - (iv) Following up with Members who are discharged from facilities providing 24-hour levels of care within 72 hours, to ensure access to, and attendance at, ambulatory follow-up appointments.
 - (v) Conducting treatment planning with individuals that frequently depend on crisis services. For children receiving WF, collaborate with the appropriate WAA to review the individual POC and adjust services to address over-reliance on crisis services.
- (l) Utilization Management. UM is the component of care management that evaluates the medical necessity of health care services according to established criteria and practice guidelines to insure 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.
- (m) The Contractor shall implement a UM program that has sufficient LMHPs, including licensed addictions counselors (LACs), as well as a board-certified psychiatrist and a board-certified addictionologist, available 24 hours per day, 7 days per week.
- (m) The Contractor shall provide UM staff, both experienced and specifically assigned to children, youth, adults, and older adults.
- (n) The Contractor's UM program shall comply with federal utilization control requirements, including the certification of need and recertification of need for continued stay inpatient settings, including psychiatric residential treatment facilities. The Contractor shall require inpatient hospital and residential treatment centers 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 441 and 456. The Contractor shall actively monitor UM activities for compliance with federal and DHH-OBH requirements and adherence to its QM/UM Plan. The Contractor's UM Program shall comply with relevant sections of Louisiana State Statute LA R.S. 22 LA RS 22:1122.
- (o) The Contractor shall:

- (i) Incorporate the Medicaid definition of medically necessary covered BH services, service definitions, practice guidelines, and levels of care into Contractor documents, where applicable.
- (ii) Place appropriate limits on service delivery (applying criteria, such as medical necessity, or for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose.
- (iii) Not arbitrarily deny a required service solely because of the BH Member's diagnosis, type of illness, or condition (this also applies to the Contractor's subcontracts).
- (iv) Not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member, according to federal regulations at 42 CFR 210(e).
- (v) Develop and implement processes (based in part on clinical decision support, claims and outcome data and medical record audits) for each provider and WAA that monitor for under- and over-utilization of services at all levels of care, including monitoring BH providers' utilization of services by race, ethnicity, gender, and age.
- (vi) Require providers to maintain medical record content consistent with the utilization and control requirements of 42 CFR 456. For medical records and any other health and enrollment information that identifies a particular enrollee, the Contractor shall establish and implement procedures consistent with confidentiality requirements in 45 CFR parts 160 and 164.
- (vii) Review utilization data to ensure services are being provided in a manner consistent with medical necessity for individuals of all ages, consistent with DHH-OBH principles, and for medical necessity consistent with the CSOC Principles for eligible CSOC children. When a Contractor detects over- or under-utilization, the Contractor shall develop and implement strategies to bring utilization to the expected level. The Contractor shall specifically monitor and track utilization of the following services:
 - Crisis services
 - 24 hour levels of care, including inpatient and residential
 - Out-of-home placements for children/youth
 - Other intensive services, to ensure utilization is consistent with practice guidelines.
- (p) Monitor and analyze pharmacy data for under- and over-utilization and potential inappropriate utilization. The Contractor shall monitor for medication side effects, adverse drug interactions, Member adherence, and indications of prescription abuse. DHH-OBH shall provide pharmacy claims data to the Contractor for Members utilizing specialized BH services.
- (q) Develop and monitor Members' utilization of BH services to ensure Title XIX and Title XXI reimbursement is not made beyond the service limitations specified in Section 2 Covered Services.
- (r) Monitor and analyze utilization data from DHH for members that have received BH services from other sources besides the Contractor (e.g., FQHC/RHC, CCN). The Contractor 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.

- (s) Actively monitor and analyze utilization and cost data for covered BH services, including wraparound services performed by WAA, by provider type. The Contractor shall report complete and accurate utilization data to DHH-OBH in a manner and format prior approved by the DHH-OBH.
- (t) Provide the WAA and contracted service providers with technical assistance regarding UM policies and procedures and the application of medical necessity criteria and practice guidelines.
- (u) Assist the WAA with specialized training to develop and manage sustainable POC with CFT, consistent with UM policies and procedures.
- (v) Collaborate with OJJ and schools to coordinate the discharge and transition of children and youth leaving secure facilities for the continuance of prescribed medication and other BH services prior to reentry into the community, including the referral to a WAA or other providers.
- (w) Collaborate with jails and prisons in Louisiana to coordinate the discharge and transition of adult Members involved in the justice system for the continuance of prescribed medication and other BH services prior to reentry into the community, including referral to community providers.
- (x) In accordance with 42 CFR § 438.210(b) the Contractor shall:
 - (i) Have written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization Member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner.
 - (ii) Have mechanisms to ensure consistent application of review criteria for authorizations decisions and consult with the requesting provider as appropriate.
 - (iii) Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
 - (iv) Provide 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 as per 42 CFR §431.201.
 - (v) The Contractor shall provide for the following decisions and notices: In regards to standard authorization decisions, the Contractor shall provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:
 - The Member or the provider requests extension or
 - The Contractor justifies to DHH upon request a need for additional information and how the extension is in the Member's best interest

- v. Expedited authorization decisions.
 - i. For cases in which a provider indicates, or the Contractor 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 Contractor shall make an expedited authorization decision and provide notice, as expeditiously as the Member's health condition requires, and no later than three working days after receipt of the request for service.
 - ii. The Contractor may extend the three (3) business day time period by up to fourteen (14) calendar days, if the Member requests an extension, or if the Contractor justifies to DHH, upon request, a need for additional information and how the extension is in the Member's best interest.

w. Referrals for Permanent Supportive Housing.

The Contractor shall assure Permanent Supportive Housing (PSH) referral and service arrangements are made available in each of the six districts/ regions of the Gulf Opportunity Zone (including the Capital Area, Florida Parishes, Jefferson Parish, Metropolitan and South Central Districts and Regions 4 and 5) for Medicaid eligible and non-Medicaid eligible adults and children who qualify for this service as defined in the DHH Cooperative Endeavor Agreement with the Louisiana Public Housing Authority in Office of Community Development (OCD), Division of Administration. (Refer to Procurement Library.) Note: Medicaid funding will not be utilized to pay for room and board under this waiver program except in approved Medicaid institutions such as hospitals and PRTFs. Medicaid funds will not be utilized for managing the care of non-Medicaid eligibles or for the coordination and referral of non-Medicaid covered services. (Refer to Section K. Payment terms for non-Medicaid eligible individuals and non-Medicaid covered services.)

- i. PSH eligibility is established by a household being in need of PSH. A household is considered to be in need of PSH if a member of the household has a physical, mental, or emotional impairment which is expected to be of long, continued or indefinite duration; substantially impedes ability to live independently without supports; and is of a nature that such ability could be improved by more suitable housing conditions. Such a substantial, long-term disability may include, but is not limited to the following categories:
 - a. Serious Mental Illness;
 - b. Addictive Disorder (i.e., individuals in treatment/recovery from substance abuse disorder); Developmental Disability, i.e., mental retardation, autism, or other disability acquired before the age of 22;
 - c. Physical, sensory, or cognitive disability occurring after the age of 22;
 - d. Disability caused by chronic illness (e.g., persons with HIV/AIDS who are no longer able to work); and
 - f. Age-related disability (i.e., frail elderly).

Most of the individuals in the above categories, but not all, are Medicaid eligible or Medicaid enrolled.

- ii. For the purposes of this RFP, the Contractor shall be responsible for the coordination of covered behavioral health services as specified in the RFP for individuals with serious mental illness and addictive disorders. The Contractor may directly assume these tasks or sub-contract these tasks to a qualified

organization, as long as any sub-contractor is not a direct services provider of behavioral health services.

- iii. For persons who qualify for PSH in the categories referenced above whose care will not be managed by the Contractor, the DHH Office or contracted management entity responsible for services for those populations will be responsible for referrals and services arrangements of individuals who meet PSH eligibility criteria. This responsibility is defined in the cooperative program agreement.
 - iv. Based on current information, a majority of individuals in the PSH program will qualify for services managed by the Contractor. Thus, DHH-OBH may request the successful Contractor manage PSH referral and behavioral health service arrangements for individuals with: Developmental Disabilities; physical, sensory or cognitive disability occurring after the age of 22; disability caused by chronic illness; and age related disability in the future. Payment for management of these additional populations would be negotiated with the Contractor as part of Contractor administrative responsibilities.
- x. Practice Guidelines.
- The Contractor shall adopt, disseminate, and apply practice guidelines developed in collaboration with DHH-OBH for the CSoC and others the Contractor chooses to adopt for all Members, consistent with CMS requirements in 42 CFR 438.236. The Practice Guidelines must be approved by the State of Louisiana. The Contractor shall utilize medical management criteria and practice guidelines that:
- i. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
 - ii. Consider the needs of Members.
 - iii. Are adopted in consultation with contracted health care professionals.
 - iv. Are reviewed and updated periodically as appropriate, but at least annually.
 - (a) As part of the implementation planning for this Contract, the Contractor shall collaborate with DHH-OBH and the CSoC Governance on the development of appropriate practice guidelines.
 - (b) The Contractor shall use practice guidelines as a basis for decisions regarding UM, Member education, provider education, coverage of services, and other areas to which practice guidelines apply. The Contractor shall implement practice guidelines in a manner that includes steps to maintain and ensure fidelity to the guidelines. At a minimum, the Contractor shall monitor practice guidelines implementation annually through peer review processes and collection of fidelity measures.
 - (c) Using information acquired through quality and UM activities, the Contractor shall recommend to DHH-OBH each year the implementation of practice guidelines within the BH delivery system, including measures of compliance, fidelity, and outcomes and a process to integrate practice guidelines into care management and utilization reviews.
 - (d) The Contractor shall disseminate the practice guidelines to qualified service providers and the WAA and, upon request, to Members utilizing BH services. The Contractor shall also provide WAA and qualified network providers with technical assistance and other resources to implement the practice guidelines.

5. Quality Management Requirements

QM is a comprehensive approach incorporating QA monitoring and ongoing QI processes to coordinate, assess, and continually improve the delivery of quality BH care furnished to enrollees.

- a. The Contractor shall operate a comprehensive QM program that includes constant evaluation of the Contractor's operations and the specialized BH systems of care under its management, including the WAA. The Louisiana quality improvement strategy (QIS) (incorporated herein by reference) shall be included in the Contractor's overall QM plan. At a minimum, the Contractor will utilize the QIS to detect both under-utilization and over-utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs. The Contractor's QM plan must be approved by the State of Louisiana.
- b. The Contractor shall maintain a sufficient number of qualified QM personnel to implement the requirements of this Contract, including reviewing performance standards, measuring treatment outcomes, and assuring timely access to care.
- c. The Contractor shall provide a mechanism for the input and participation of Members, families/caretakers, the CSoC Governance, DHH-OBH, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.
- d. The Contractor shall develop, implement, and maintain a comprehensive program for quality assurance/performance improvement (QA/PI) consistent with federal requirements at 42 CFR 438.240 and with the UM program required by CMS for DHH-OBH's overall Medicaid program, as described in 42 CFR 456.
- e. The QA/PI program shall include a system of performance indicators and Member/family outcome measures that address different audiences and purposes. The Contractor shall implement and maintain a formal outcomes assessment process that is standardized, reliable, and valid in accordance with industry standards.
- f. The Contractor shall report, from the start of the Contract (at a minimum), on the goals, objectives, and measures identified in the DHH CMS QIS.
- g. On an annual basis, the Contractor shall ensure and report to the State its performance, using standard measures required by the State and outlined in the QIS.
- h. In addition, CMS, in consultation with states and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by states in their contracts with Contractors.
- i. The Contractor shall develop and implement outcome measures with input from, and the participation of, CSoC Governance, DHH-OBH, Members, family Members, and other stakeholders. The Contractor shall report to DHH-OBH the results and findings of its outcome measures compared to expected results and

findings, including performance improvement efforts and activities planned/taken to improve outcomes. The Contractor shall use an industry-recognized methodology, such as SIX SIGMA or another method(s) for analyzing data. The Contractor shall demonstrate inter-rater reliability testing of evaluation, assessment, and UM decisions.

- j. The Contractor shall conduct at least two (2) performance improvement projects outlined in the QIS that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The Contractor shall report the status and results of each project to the State as requested. Each performance improvement project shall be completed in a reasonable time period, so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. The performance improvement projects shall involve the following:
 - i. Measurement of performance using objective quality indicators.
 - ii. Implementation of system interventions to achieve improvement in quality.
 - iii. Evaluation of the effectiveness of the interventions.
 - iv. Planning and initiation of activities for increasing or sustaining improvement.
- k. The Contractors QA/PI program shall meet the following requirements:
 - i. Include QM processes to assess, measure, and improve the QOC provided to Members in accordance with:
 - (a) All QM requirements identified in this contract.
 - (b) The DHH CMS QIS.
 - (c) All State and federal regulatory requirements.
 - (d) Other applicable documents incorporated by reference.
 - ii. Identify and resolve systems issues consistent with a continuous QI approach.
 - iii. Disseminate information to the DHH-OBH, the CSoC Governance, and its participating agencies, Members, providers, and key stakeholders, including families/caregivers.
 - iv. Solicit feedback and recommendations from key stakeholders, subcontracts, Members, and families/caregivers, and use the feedback and recommendations to improve the QOC and system performance.
 - v. Measure and enforce adherence with the goals and principles of the CSoC and DHH-OBH through the following strategies, at a minimum:
 - (a) Methods and processes that include in-depth chart reviews and interviews with key persons in the Member's life.
 - (b) Use of findings to improve practices at the subcontract and Contractor levels.
 - (c) Timely reporting of findings and improvement actions taken and their effectiveness.
 - (d) Dissemination of findings and improvement actions taken and their effectiveness to key stakeholders, committees, Members, families/caregivers, and posting on the Contractor's Website.

- (e) Completion of a sample of quarterly chart reviews for Members served under the SED waiver and related performance improvement monitoring, on a quarterly basis, under the direction of DHH-OBH. The SED Waiver chart reviews include reviewing the initial clinical eligibility packet to ensure children/youths meet the SED criteria and the required level of care, reviewing the family choice assurance document (freedom of choice) to ensure family choice, reviewing the notice of action, which explains the right to appeal, comparing the Plan of Care to the database to ensure that identified services are being provided, and reviewing the Plan of Care development through the wraparound process.
- (f) The Contractor shall collect data and conduct data analysis with the goal of improving QOC within the BH system. The Contractor's information system will support the QA/PI process by collecting, analyzing, integrating, and reporting data necessary to the State's QIS. 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 enrollee and provider characteristics as specified by the State and on services furnished to enrollees through an encounter data system. The system shall ensure that data received from providers is accurate and complete by:
 - (i) Verifying the accuracy and timeliness of reported data.
 - (ii) Screening the data for completeness, logic, and consistency.
 - (iii) Collecting service information in standardized formats to the extent feasible and appropriate.
- (g) The Contractor shall participate in the review of QI findings and shall take action as directed by DHH-OBH. The Contractor shall monitor subcontracted provider QI activities to ensure compliance with federal and State laws, regulations, CSoC requirements, this Contract, and all other QM requirements.
- (h) The Contractor shall form a QA/PI Committee. The Contractor's Medical Director shall serve as either the chairperson or co-chairperson.
- (i) The Contractor shall have, in effect, a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.
- (j) The Contractor shall participate in developing, implementing, and reporting on performance measures and topics for performance improvement projects (PIPs) required by other State or federal agencies, including PI protocols or other measures, as directed by DHH-OBH.
- (k) The Contractor shall report to DHH-OBH the National Outcome Measures (NOMS) required for SAMHSA block grants and any federal discretionary grants in which the DHH-OBH may participate.
- (l) The Contractor shall report performance data to DHH-OBH, BHSF, DCFS, OJJ, OCDD, and DOE in formats approved, in advance, by DHH-OBH.

- (m) The Contractor shall have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities, and avoid review and monitoring activities unlikely to affect service delivery or QOC.
- (n) The Contractor shall conduct an annual Member satisfaction survey as directed and prior approved by DHH-OBH.
- (o) The Contractor shall monitor and evaluate qualified service providers in order to promote improvement in the QOC provided to Members. The Contractor shall detail a provider monitoring plan in the required Annual Quality Management Plan.
- (p) The Contractor shall conduct peer review to assess quality of care.
 - (i) Submitting a monthly status report to DHH-OBH by the fifteenth day of the each month that summarizes (a) to (e) and (g) and (f) above for the preceding month.
 - (ii) The Contractor shall provide an Outcomes Management and Quality Improvement Plan that includes, but is not limited to, the following:
 - Call center performance in answering calls.
 - Child, youth, young adult and families/caregivers satisfaction with the WAA and other providers.
 - Reliability and timeliness of service.
 - Decision-making processes.
 - Service utilization, including trends, outliers, and length of stay in each service.
 - Seven and 30-day post-discharge (residential and acute care) ambulatory follow-up appointment.
 - Racial and ethnic disparities (e.g., under-utilization of services by particular racial/ethnic groups).
 - Disproportional (e.g., over-utilization of out-of-home (OOH) services by racial/ethnic minorities).
 - Network adequacy.
 - Costs of services provided (by type of service, average cost per child, and in the aggregate).
 - Attainment of positive outcomes by service line and system wide, including clinical and functional outcomes and system-wide outcomes, such as utilization of OOH services.
 - Performance indicators/measures developed specifically for the CSoC by the Contractor in collaboration with CSoC Governance, under the direction of DHH-OBH, including, but not limited to:
 - Number of children placed in restrictive settings outside their home.
 - Crisis services utilization.
 - Number of persons served in EBPs and promising practices that have been implemented to fidelity.
 - Emergency department utilization.

- Utilization of HCBS.
- Utilization of natural supports and claims paid services.
- School attendance.
- Juvenile justice involvement.
- Readmissions to psychiatric inpatient facility.

(q) Performance indicators shall be measured for the BH Services program and the CSoC, as a whole, and for each provider individually.

I. Quality Management and Utilization Management reporting.

The Contractor shall monitor and report QM and UM data and other performance improvement activities to DHH-OBH. The Contractor shall submit, in writing to DHH-OBH, in a format prior approved by DHH-OBH, the following QM/UM deliverables:

i. Addressing QOC:

- (a) EQR Reviews/Independent Assessments. The Contractor and its subcontracts shall cooperate with DHH-OBH in any annual, external, independent reviews performed by an EQRO or independent assessor of quality outcomes, timeliness of, and access to services upon DHH-OBH request.
- (b) QM Reviews. The Contractor shall make available records and other documentation, and ensure subcontracts' participation in, and cooperation with, any QM reviews. This may include participation in staff interviews and facilitation of BH Member/family/caregiver and subcontract interviews. The Contractor shall use QM review findings to improve QOC. The Contractor shall take action to address identified issues, as directed by DHH-OBH.
- (c) The Substance Abuse Mental Health Services Administration (SAMHSA) Core Reviews (SAPT and CMHS Block Grants). The Contractor and its subcontracts shall cooperate with and participate, as required, in SAMHSA core reviews of services and programs funded through the SAPT and CMHS Performance Partnership Grants. Core review findings shall be communicated to the Contractor's QM program and shall be used by the Contractor to enhance and improve the delivery of grant-related services for Members. The development and implementation of a corrective action plan with specific, measurable, and time-limited corrective action steps is also required if weaknesses/challenges are identified during the core review. The corrective action plan shall be approved and accepted by SAMHSA and/or DHH-OBH.

- m. Performance Guarantees. In addition to the above performance measures, DHH-OBH has defined performance guarantees that are subject to penalties. These performance guarantees and the process for administering penalties are defined in Section IV, Contractual Requirements of this RFP

6. Grievance and Appeals

The Contractor shall have a grievance system that complies with 42 CFR §438 Subpart F. The Contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable State and federal laws.

- a. The Contractor's appeals procedure, and any changes thereto, shall be approved in writing by DHH prior to their implementation and shall include, at a minimum, the requirements set forth in this document. The Contractor shall refer all Contractor Members who are dissatisfied with the Contractor or its Contractor, in any respect, to the Contractor's designee authorized to review and respond to appeals and require corrective action. The Member must exhaust the Contractor's internal appeal procedures prior to accessing the State Fair Hearing process.
- b. The Contractor shall not create barriers to timely due process. The Contractor shall be subject to sanctions if it is determined by the Department that the Contractor has created barriers to timely due process, and/or, if 10% or more of grievance decisions appealed to a State Fair Hearing level within a twelve (12) month period have been reversed, or otherwise resolved, in favor of the Member. Examples of creating barriers shall include, but not be limited to:
 - i. Including binding arbitration clauses in Contractor Member choice forms.
 - ii. Labeling grievances as inquiries or complaints and funneled into an informal review.
 - iii. Failing to inform Members of their due process rights.
 - iv. Failing to log and process grievances and appeals.
 - v. Failure to issue a proper notice, including vague or illegible notices.
 - vi. Failure to inform of continuation of benefits.
 - vii. Failure to inform of right to State Fair Hearing.
- c. Definitions pertaining to Grievances and Appeals.
 - i. Appeal. A request for review of an action, as "action" is defined in this section.
 - ii. Grievance. An expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. 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. The term is also used to refer to the overall system that includes grievances and appeals handled at the Contractor level.
 - iii. Action means:
 - (a) The denial or limited authorization of a requested service, including the type or level of service.
 - (b) The reduction, suspension, or termination of a previously authorized service.
 - (c) The denial, in whole or in part, of payment for a service.
 - (d) The failure to provide services in a timely manner, as defined in this RFP.
 - (e) The failure of the Contractor to act within the timeframes provided in this RFP.

- (f) For a resident of a rural area with only one Contractor, the denial of a Medicaid Member's request to exercise his or her right, under 42 CFR. § 438.52(b)(2)(ii), to obtain services outside the Contractor's network.
- d. General Requirements of the Grievance System.
 - i. Grievance System. The Contractor shall 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 Contractor's appeal process has been exhausted.
 - ii. Filing Requirements:
 - (a) Authority to File. A Member may file a grievance and a Contractor level appeal, and may request a State Fair Hearing, once the Contractor's appeals process has been exhausted.
 - (b) A network provider, acting on behalf of the Member and with the Member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a Member.
 - (c) Timing. The Member must be allowed thirty (30) calendar days from the date on the Contractor's notice of action. Within that timeframe the Member or a representative acting on their behalf may file an appeal or the provider may file an appeal on behalf of the Member.
 - (d) Procedures. The Member may file a grievance either orally or in writing with the Contractor. The Member or a representative acting on their behalf, or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal request.
 - iii. Notice of Grievance and Appeal Procedures. The Contractor shall ensure that all Contractor Members are informed of State Fair Hearing process and of the Contractor's grievance and appeal procedures. The Contractor shall provide to each Member a Member handbook that shall include descriptions of the Contractor's grievance and appeal procedures. Forms on which Members may file grievances, appeals, concerns or recommendations to the Contractor shall be available through the Contractor, and must be provided upon request of the Member. The Contractor shall make all forms easily available on the Contractor's Website.
 - iv. Grievance/Appeal Records and Reports. The Contractor shall maintain records of grievances and appeals. A copy of grievance 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.
 - (a) The Contractor shall electronically provide DHH-OBH with a monthly report of the grievances/appeals in accordance with the requirements outlined by DHH-OBH, to include, but not be limited to: Member's name and Medicaid number; summary of grievances and

- appeals; date of filing; current status; resolutions and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.
- (b) The Contractor shall be responsible for promptly forwarding any adverse decisions to DHH-OBH for further review/action upon request by DHH-OBH or the Contractor Member. DHH-OBH may submit recommendations to the Contractor regarding the merits or suggested resolution of any grievance/appeal.
- v. Handling of Grievances and Appeals. The grievance and appeal procedures shall be governed by the following requirements:
 - a) General Requirements. In handling grievances and appeals, the Contractor shall meet the following requirements:
 - (i) Give Members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
 - vi. Acknowledge receipt of each grievance and appeal. Send an acknowledgement letter via the U.S. Postal Service to the originator of the appeal or grievance within three business days.
 - vii. Ensure that the individuals who make decisions on grievances and appeals are individuals:
 - a) Who were not involved in any previous level of review or decisions
 - b) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the Member's condition or disease:
 - (i) An appeal of a denial that is based on lack of medical necessity.
 - (ii) A grievance regarding denial of expedited resolution of an appeal.
 - (iii) A grievance or appeal that involves clinical issues.
- e. Special Requirements for Appeals.
The process for appeals shall:
 - i. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and shall be confirmed in writing, unless the Member or the provider requests expedited resolution.
 - ii. Provide the Member a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. (The Contractor shall inform the Member of the limited time available for this in the case of expedited resolution.)
 - iii. 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.
 - iv. Include, as parties to the appeal:

- (a) The Member and his or her representative or
 - (b) The legal representative of a deceased Member's estate
- f. Special requirements for grievances involving Quality of Care (QOC) concerns. The Contractor shall address QOC concerns through the grievance process. This includes investigating, analyzing, tracking, trending, disposing, and reporting, including adherence to all relevant DHH-OMH critical incident reporting requirements and the following:
 - i. Conducting follow-up with the Member or family/caregiver to determine the immediate BH care needs are met, including follow-up after discharge from inpatient levels of care within 72 hours.
 - ii. Referring grievances with QOC issues to the Contractor's peer review committee, when appropriate.
 - iii. Referring or reporting the grievance QOC issue(s) to the appropriate regulatory agency, child or adult protective services and DHH-OBH for further research, review, or action, when appropriate.
 - iv. 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.
- g. Training of Contractor Staff.
The Contractor's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the Member and providers.
- h. Identification of Appropriate Party.
The appropriate individual or body within the Contractor having decision making authority, as part of the grievance/appeal procedure, shall be identified.
- i. Failure to Make a Timely Decision.
Appeals shall be resolved no later than stated time frames and all parties shall be informed of the Contractor's decision. If a determination is not made by the above time frames, the Member's request will be deemed to have been approved as of the date upon which a final determination should have been made.
- j. Right to State Fair Hearing.
The Contractor shall inform the Member of their right to seek a State Fair Hearing if the Member is not satisfied with the Contractor's decision in response to an appeal.
- k. Notice of Action Language and Format Requirements.
The notice shall be in writing and shall meet the language and format requirements of 42 CFR. §438.10(c) and (d) to ensure ease of understanding.
- l. Content of Notice.
The notice shall explain the following:
 - i. The action the Contractor or its Contractor has taken or intends to take.
 - ii. The reasons for the action.
 - iii. The Member's or the provider's right to file an appeal with the Contractor.
 - iv. The Member's right to request a State Fair Hearing, after the Contractor's appeal process has been exhausted.
 - v. The procedures for exercising the rights specified in this section.

- vi. The circumstances under which expedited resolution is available and how to request it.
 - vii. The Member's rights to have benefits continue 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.
- m. Timing of Notice.
- i. The Contractor shall mail the notice within the following timeframes:
 - (a) 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 431.214.
 - (b) For denial of payment, at the time of any action affecting the claim.
 - (c) For standard service authorization decisions that deny or limit services, as expeditiously as the Member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:
 - (i) The Member, or the provider, requests extension.
 - (ii) The Contractor justifies (to DHH-OBH upon request) a need for additional information and how the extension is in the Member's interest.
 - (d) If the Contractor extends the timeframe in accordance with above, it shall:
 - (i) 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.
 - (ii) Issue and carry out its determination, as expeditiously as the Member's health condition requires, and no later than the date the extension expires.
 - (iii) On the date the timeframe for service authorization as specified above expires.
 - ii. For expedited service authorization decisions where a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than three (3) working days after receipt of the request for service.
 - iii. The Contractor may extend the three (3) business day time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies (to DHH-OBH upon request) a need for additional information and how the extension is in the Member's interest.
 - iv. DHH-OBH may conduct random reviews to ensure that Members are receiving such notices in a timely manner.
 - v. Resolution and Notification.
 Basic Rule: The Contractor shall dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the Member's health condition requires, within the timeframes established below.

- vi. **Specific Timeframes:**
 - (a) **Standard Disposition of Grievances.** For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the Contractor receives the grievance.
 - (b) For grievances with a QOC, the investigation shall be completed within 14 days or sooner, as appropriate, based on severity of concern/Member condition.
- vii. **Standard Resolution of Appeals.** For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the Contractor receives the appeal. This timeframe may be extended as described in this section.
- viii. **Expedited Resolution of Appeals.** For expedited resolution of an appeal and notice to affected parties, the timeframe is established as three (3) working days after the Contractor receives the appeal. This timeframe may be extended as described in this section.
- ix. **Extension of Timeframes.** The Contractor may extend the timeframes by up to fourteen (14) calendar days if:
 - (a) The Member requests the extension.
 - (b) The Contractor 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.
- x. **Requirements Following Extension.** If the Contractor extends the timeframes, it shall, for any extension not requested by the Member, give the Member written notice of the reason for the delay.
- n. **Format of Notice.**
 - i. **Grievances.** The Contractor shall notify a Member of the disposition of a grievance via a letter to the originator of the grievance containing, at a minimum:
 - (a) Sufficient detail to foster an understanding of the QOC resolution.
 - (b) A description of how the Member's BH care needs have been met.
 - (c) A contact name and telephone number to call for assistance or to express any unresolved concerns.
 - ii. **Appeals.** For all appeals, the Contractor shall provide written notice of disposition. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.
- o. **Content of Notice of Appeal Resolution.**

The written notice of the resolution shall include the following:

 - i. The results of the resolution process and the date it was completed.
 - ii. For appeals not resolved wholly in favor of the Members:
 - (a) The right to request a State Fair Hearing, and how to do so.
 - (b) The right to request to receive benefits while the hearing is pending, and how to make the request.
 - (c) That the Member may be held liable for the cost of those benefits if the hearing decision upholds the Contractor's action.

- p. Requirements for State Fair Hearings.
DHH shall comply with the requirements of 42 CFR §§431.200(b), 431.220(5) and 42 CFR §§438.414 and 438.10(g)(1). The Contractor shall comply with all requirements as outlined in this Contract and by DHH-OBH.
- i. Availability. If the Member has exhausted the Contractor level appeal procedures, the Member may request a State Fair Hearing within thirty (30) days from the date of the Contractor's notice of resolution.
 - ii. Parties. The parties to the State Fair Hearing include the Contractor, as well as the Member and his or her representative or the representative of a deceased Member's estate.
- q. Expedited Resolution of Appeals.
General rule: The Contractor shall establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
- i. Punitive Action. The Contractor shall ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's appeal.
 - ii. Action Following Denial of a Request for Expedited Resolution. If the Contractor denies a request for expedited resolution of an appeal, it shall:
 - (a) Transfer the appeal to the timeframe for standard resolution in accordance with this section of the RFP.
 - (b) 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.
 - iii. This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.
 - iv. Failure to Make a Timely Decision. Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the Contractor's decision. If a determination is not made by the above timeframes, the Member's request will be deemed to have been approved as of the date upon which a final determination should have been made.
 - v. Process. The Contractor is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The Member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required.
 - vi. The Contractor 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.
- q. Authority to File.
The Medicaid Member or their provider may file an expedited appeal either orally or in writing. No additional Member follow-up is required.
- r. Format of Resolution Notice.

In addition to written notice, the Contractor shall also make reasonable effort to provide oral notice.

- s. Continuation of Benefits While the Contractor Appeals And State Fair Hearing Is Pending.
 - i. Terminology.
 - (a) As used in this section, "timely" filing means filing on or before the later of the following:
 - (i) Within ten (10) days of the Contractor mailing the notice of action.
 - (ii) The intended effective date of the Contractor's proposed action.
- t. Continuation of Benefits.

The Contractor shall continue the Member's benefits if:

 - i. The Member or the provider files the appeal timely.
 - a) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
 - b) The services were ordered by an authorized provider.
 - c) The original period covered by the original authorization has not expired.
 - d) The Member requests extension of benefits.
- u. Duration of Continued or Reinstated Benefits.

If, at the Member's request, the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one of the following occurs:

 - i. The Member withdraws the appeal.
 - ii. Ten (10) days pass after the Contractor mails the notice, providing the resolution of the appeal against the Member, unless the Member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.
 - iii. A State Fair Hearing Officer issues a hearing decision adverse to the Member.
 - iv. The time period or service limits of a previously authorized service has been met.
- v. Member Responsibility for Services Furnished While the Appeal is pending.

If the final resolution of the appeal is adverse to the Member, that is, upholds the Contractor's action, the Contractor 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).
- w. Information about the Grievance System to Providers and Contractors.

The Contractor shall provide the information specified at 42 CFR. § 438.10(g)(1) about the grievance system to all providers and Contractors at the time they enter into a contract.
- x. Recordkeeping and Reporting Requirements
 - i. Reports of grievances and resolutions shall be submitted to DHH. The Contractor shall not modify the grievance procedure without the prior written approval of DHH. At a minimum, grievances and appeals will contain the following information:
 - (a) The name and contact information of the originator of the grievance or appeal.

- (b) A description of the grievance or appeal, including issues, dates, and involved parties.
 - (c) All steps taken during the investigation and resolution process.
 - (d) Corrective action(s) implemented and their effectiveness.
 - (e) Evidence of the resolution.
 - (f) A copy of the acknowledgement and resolution letters.
 - (g) Any referral made by the Contractor to a regulatory agency, a licensing board or agency or DHH-OBH.
 - (h) Any notification made by the Contractor to DHH-OBH or a regulatory or licensing agency or board.
- y. Effectuation of Reversed Appeal Resolutions.
- i. Services not Furnished While the Appeal is Pending. If the Contractor or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires.
 - ii. Services Furnished While the Appeal is Pending. If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, the Contractor shall pay for those services, in accordance with this Provider Agreement.

7. Provider Network Management

a. Network Management Functions.

The Contractor shall provide the following network management and development functions:

- i. Selecting, training, and retaining qualified service providers.
 - (a) Consistent with requirements in 42 CFR 438.214, and because of historic quality of care behavioral issues in the State, the Contractor shall have written credentialing and recredentialing policies consistent with federal and state regulations for selection and retention of providers, credentialing and re-credentialing, and nondiscrimination.
 - (b) The Contractor is required to contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the state of Louisiana credentialing criteria, who agree to the standard contract provisions, and who wish to participate.
 - (c) The Contractor must demonstrate that its providers are credentialed to the EQR during annual review.
 - (d) The Contractor is required to provide, at least, as much access to services as exist within Medicaid's fee for service program.
 - (e) Within the Plan's provider network, recipients have a choice of the providers which offer the appropriate level of care.
 - (f) The Contractor shall comply with La. R.S. 40:2201 et seq, La. R.S. 40:2211 et seq and La. R.S. 40:2242, which speaks to participation of essential community

- providers.
- (g) Rehabilitation providers shall be employed by a rehabilitation agency, school, or clinic licensed and/or certified and authorized under State law to provide these services unless another qualified provider is necessary to fill any service gaps existing in the Contractor.
 - (h) Rehabilitation agencies shall be certified by DHH. Mental health and/or addiction clinics shall meet the licensure standards for psychiatric facilities providing clinic services as determined by the BHSF.
 - (i) The Contractor shall collaboratively develop networks with service accessibility in addition to Rehabilitation agencies, schools and clinics and required to sub-contract with providers necessary to fill any service gaps existing in the Contractor.
 - (j) Enrollees will have free choice of providers within the Contractor network and may change providers.
 - (k) If an individual joins the Contractor and is already established with a provider who is not a Member of the network, the Contractor will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network.
 - (l) In addition, if an enrollee needs a specialized service that is not available through the network, the Contractor will arrange for the service to be provided outside the network if a qualified provider is available.
 - (i) If the Contractor's network is unable to provide necessary medical services covered under the contract to a particular member the Contractor must adequately and timely cover these services out-of-network for the Member, for as long as the Contractor is unable to provide them.
 - (ii) The Contractor must coordinate with Out-of-network providers with respect to payment. The Contractor must ensure that cost to the Member is no greater than it would be if the services were furnished within the network.
 - (iii) Except in certain situations, Members will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area.
 - (m) Maintaining a list of network providers that is available to Members, the Member's family/caregiver and referring providers in hard copy and electronically.
 - (n) Responding to provider inquiries, by coordinating with, or expeditiously referring inquiries to persons within, the Contractor's organization that can provide a timely response.
 - (i) Expeditiously developing provider subcontracts and enforcing the subcontract terms.
 - (ii) Managing the seamless transition of services or providers for Members because of a change in network composition.
 - (iii) Performing credentialing of qualified service providers, including prescribers, practitioners, facilities, FSOs and WAA. The process the Contractor uses to conduct credentialing, privileging, and re-credentialing shall be approved by DHH-OBH.
 - (iv) The Contractor shall evaluate every prospective provider's ability to perform the activities to be delegated prior to contracting with any provider or subcontract.

- (v) The Contractor is not obligated to contract with any provider unable to meet contractual standards.
- (vi) The Contractor is not obligated to continue to contract with a provider who does not provide high quality services or who demonstrates utilization of services that are an outlier compared to peer providers with similarly acute populations and/or compared to the expectations of the Contractor and State.
- (vii) The Contractor's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- (viii) The Contractor 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. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. 42 CFR 438.12 (a) of this section may not be construed to:
 - Require the Contractor to contract with providers beyond the number necessary to meet the needs of its enrollee.
 - Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
 - Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to Member.
- (o) The Contractor shall have a written contract that specifies the activities and report responsibilities delegated to the provider; and provides for revoking delegation, terminating contracts, or imposing other sanctions if the provider's performance is inadequate.
- (p) The Contractor shall monitor all providers' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations.
- (q) The Contractor shall identify deficiencies or areas for improvement, and the provider shall take corrective action in the following areas:
 - (i) Monitoring and reporting network turnover.
 - (ii) Monitoring and reporting requests for a change in provider.
 - (iii) Providing routine technical assistance and support to WAA and consumer- and family-operated organizations.
 - (iv) Continually monitoring access to network services and provider capacity to maintain a sufficient number of qualified service providers, FSOs, and WAA to deliver covered BH services for Members, including provision of services to persons with limited proficiency in English.
 - (v) Complying with service provider monitoring and reporting requirements in accordance with this Contract.
- (r) The Contractor shall have a sufficient number of network management staff to carry out the functions required in this Contract including staff for network development, provider relations, network reporting and overall network management.
- (s) The Contractor shall provide Members with timely access to a comprehensive

array of specialized BH services delivered by culturally-competent, qualified service providers. The existing statewide FFS provider network and providers offering services through DHH-OBH, DCFS, DOE, OJJ, and OCDD contracts require expansion and modifications to address the needs of all eligible children, including those eligible for the CSoC, adults with SPMI and COD, and Members with addictive disorders.

- (t) The Contractor shall develop and maintain a comprehensive network that is consistent in size and variety with the existing statewide FFS network and the existing contracted providers' network offering services through DHH-OBH, DCFS, DOE, OJJ, OCDD (nursing facilities for individuals age 21 and under with BH challenges) on or before the Contract start date.
- (u) The Contractor shall maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the entity shall consider the following:
 - (i) The anticipated Medicaid enrollment.
 - (ii) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular contract.
 - (iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
 - (iv) The numbers of network providers who are not accepting new Medicaid patients.
 - (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.
- (v) The Contractor shall submit the documentation ensuring adequate capacity and services, as specified by the State, and, specifically, as follows, but no less frequently than:
 - (i) At the time it enters into a contract with the State.
 - (ii) At any time there has been a significant change (defined as more than 1% change in the Contractor's network) in the Contractor's operations that would affect adequate capacity and services, and also including-- Changes in services, benefits, geographic service area or payments, or Enrollment of a new population in the Contractor.
- (w) Annually, the Contractor shall submit documentation to the State to demonstrate, in a format specified by the State, that it:
 - (i) Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of Members for the service area.
 - (ii) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area.
- (x) The Contractor shall emphasize the development of culturally competent community-based services, including evidence-based and best practices for Members of all ages.

(Please note: A listing of the current service delivery system for children and

adults is available in the procurement library.)

b. Network Development.

The Contractor shall submit for DHH-OBH approval a network development and transformation plan for Members of all ages.

- i. For children and youth the Contractor shall submit a plan for transforming the current service delivery system into a comprehensive system that:
 - (a) Includes qualified service providers and community resources designed and contracted to deliver care that is strength-based, family-focused, community-based, and culturally competent.
 - (b) Includes specific services for children eligible for the CSoC as defined in this Contract. WAA and FSO organizations will be phased-in by region. The Contractor shall collaborate with DHH-OBH to select WA and FSO.
 - (c) Is of sufficient size and scope to offer Members a choice of providers for all covered BH services.
 - (d) Make uniformly available over time recognized EBPs, best practices and culturally competent services that promote resilience through nationally recognized integrated service models.
 - (e) Targets the development of family- and community-based services for 600-700 children/youth in out of home placements
 - (f) Increases access to family- and community-based services and reduces reliance on group home and other residential placements.
- ii. Children/youth not eligible for the CSoC will be eligible to receive certain services delivered through the CSoC provider network, as defined in the Covered Services and Covered Populations sections of this Contract. The network shall be of adequate size to meet the needs of these children/youth.
- iii. The Contractor shall address the needs of all Members and address the following requirements:
 - (a) Have a fully operational network of crisis response providers available 24 hours per day, 7 days per week as of the Contract start date.
 - (b) Contract with FSO for delivery of family and peer support services immediately in regions selected for initial WAA and FSO implementation.
 - (c) Develop and maintain, subject to DHH-OBH prior written approval, minimum standards for certified peer and family support FTEs per 100 children within 24 months of the Contract.
 - (d) Contract with sufficient number of qualified providers with knowledge and experience in providing services to individuals residing in permanent supportive housing in areas of the State where this type of housing.
 - (e) Conduct a needs assessment to identify unmet service needs in its service delivery system within nine months after the Contract start date. The Contractor shall submit a plan to DHH-OBH to meet the unmet service needs as part of its network development plan within 12 months after the Contract start date.
 - (f) Maintain a sufficient number of accessible 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.
 - (g) Develop and maintain a database that contains real-time information identifying, according to ZIP code and by provider type, provider appointment availability, contracted capacity and out-of-region or out-of-network service alternatives.

c. Access to Services and Network Adequacy.

The Contractor shall submit a detailed network plan to DHH-OBH as part of the required implementation plan, within 90 days prior to the “go live” date of the program for review that includes strategies to ensure uninterrupted services to Members and that major components of the current network delivery system are not adversely affected by transition to managed care.

- i. The Contractor shall develop, manage, maintain, and support a network of qualified service providers consistent with the goals and principles of DHH-OBH and the CSoC.
- ii. The Contractor shall design the network to deliver BH treatment, rehabilitation, and support services, while optimizing the use of natural and informal supports that meet the individualized needs of eligible BH children and youth in, or at risk of, out-of-home placement and their families/caregivers, other children, and adults.
- iii. The Contractor shall design the network to assure persons eligible for permanent supportive housing have access to services necessary to obtain and sustain their housing.
- iv. The Contractor shall design the network to deliver culturally and linguistically appropriate services in home-and community-based settings and assist Members to achieve their individual recovery goals or service plans.
- v. The Contractor shall, through its provider network, comply with all of the service delivery requirements in this Contract and maintain the minimum number of qualified providers by provider type or service in conformance with:
 - (a) The Contractor’s annual Contractor Network Plan for adults with SMI and/or addictive disorders.
 - (b) The Contractor’s annual CSoC Network Development Plan minimum network requirements, as approved by DHH-OBH.
 - (c) Any changes to either of the two preceding documents, as approved, in advance and in writing, by DHH-OBH.
- vi. At a minimum, the Contractor shall develop and maintain a network sufficient in size and composition to meet the needs of Members based on the following factors:
 - (a) Growth trends in eligibility and enrollment, including:
 - (i) Current and anticipated numbers of Title XIX and Title XXI eligibles.
 - (ii) Current and anticipated numbers of Non-Title XIX and non-Title XXI children.
 - (iii) Current and anticipated numbers of other non-Title XIX adults.
 - (iv) Current and desired service utilization trends, including:
 - Prevalent diagnoses.
 - Age, gender, and race/ethnicity characteristics of the enrolled population.
 - (b) Best practice approaches.
 - (c) Network and contracting models consistent with DHH/OBH and CSoC Goals and Principles.
 - (d) Accessibility of services, including:
 - (i) The number of current qualified service providers in the network who are not accepting new referrals.
 - (ii) The geographic location of providers and Members considering distance, travel time, and available means of transportation.

- (iii) Availability of services with physical access for persons with disabilities.
 - (e) Cultural and linguistic needs, including the Member's prevalent language(s) and sign language.
 - (f) Quality and provider profiling data, including:
 - (i) Appointment standard data.
 - (ii) Treatment and functional outcome data.
 - (iii) Results of "mystery shopper" surveys or other qualitative review activities.
 - (iv) Unmet needs data and need for specialty care, including:
 - Volume of single case agreements and out-of-network referrals.
 - Specialized service needs of Members.
 - (v) Members diagnosed with developmental/cognitive disabilities.
 - (vi) Number of prescribers required to meet BH Members' medication needs.
 - (g) Grievance and appeal data.
 - (h) Issues, concerns, and requests identified by other State agency personnel, local agencies, and community stakeholders.
 - (i) Member satisfaction, including BH Member satisfaction survey data.
- d. Network Standards.
- The Contractor shall have the following network standards:
- i. Require crisis response providers to respond to referrals 24 hours per day, 7 days per week, and 365 days per year.
 - ii. Have qualified service providers deliver covered BH services, with BH professionals and paraprofessionals who are fluent in speaking the Member's primary or preferred language. In cases where the Member's primary or preferred language is rarely spoken in the geographic service area, services shall be delivered with the assistance of a qualified interpreter.
 - iii. Have sites that are easily accessible to all Members. The Contractor shall assess the accessibility of the locations and appointment hours of all service sites by ZIP code and submit an expansion plan to DHH-OBH as part of the annual Contractor Work Plan. Upon DHH-OBH approval, the Contractor shall implement the expansion plan to expand access to underserved areas of the State.
 - iv. Have qualified service providers to administer programs and services for priority populations consistent with the requirement of the SAPT Block Grant. The network shall provide the following:
 - (a) Priority access for pregnant females.
 - (b) Specialized programs and services for pregnant women, substance abusing women, and women with young children.
 - (c) Services for IV drug abuse.
 - (d) HIV early intervention services. and
 - (e) Primary prevention services for individuals and families who do not require covered BH services
 - v. Ensure providers deliver services in community-based settings, including achieving specific targets for expansion.
 - vi. Offer choice to Members in selecting a WF and/or other qualified service provider.
 - vii. Comply with enrollment/disenrollment procedures in the Contractor's standard provider network contract.

- viii. Make Members and families/caregivers, WAA, FSOs, and qualified service providers aware of the availability of second opinions and provide second opinions at no cost to the BH Member.
- ix. Have a sufficient number of qualified service providers with knowledge and expertise to deliver covered BH services and supports to CSoC children with developmental disabilities meeting the nursing facility level of care, and coordinate and deliver continuity of care services to Members reaching the age of majority to alleviate/minimize service disruption or mandatory changes in service providers.
- x. Have 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. The Contractor shall publish and disseminate a schedule of after-hours and weekend appointment availability for each provider site.
- xi. Develop and maintain standards for the delivery of culturally appropriate services for Latino, African American, and Native American, Vietnamese, and other minority BH Members.
- xii. The Contractor shall require the WAA, FSOs and qualified service providers to respond to referrals for immediate, urgent, and routine needs within the following appointment access standards:
 - (a) Emergent appointment within one hour of request.
 - (b) Urgent appointments within 48 hours of referral.
 - (c) Routine appointments within 14 calendar days, with the requirement for referring children/youth eligible for the CSoC within at least the urgent appointment standard.
 - (d) Respond and deliver services consistent with the person's cultural, linguistic, and spiritual heritage and preferences.
 - (e) Have sufficient staff available to deliver culturally appropriate services for Latino, African American, Native American and other minority Members.
 - (f) Coordinate and ensure continuity of care between BH specialists, PCPs, and other health care specialists.
 - (g) Coordinate and ensure continuity of care of BH services with DCFS, OJJ, DOE, and DHH-OBH.
 - (h) Utilize youth-certified peer support specialists, certified family and cultural support specialists and certified peer specialists for adults.
- e. Network requirements for children eligible for DCFS services.
 - i. DCFS believes that children are best served within families and therefore placement in any residential setting is a point in time intervention responding to the needs of the children.
 - ii. The Contractor shall subcontract with group home providers that are compliant with current licensing regulations available through the internet at: <http://www.dss.louisiana.gov/>
 - iii. The Contractor shall subcontract with providers offering the following services:
 - (a) Therapeutic Foster Care (TFC). Currently, TFC services are defined as community-based surrogate family services provided to children living in foster care who require an intensive period of treatment before reunification. In the new CSoC it is anticipated that TFC will be modified and children screened as requiring treatment components will receive Professional Resource Family Care or Multidimensional Treatment Foster Care (MTFC) as defined in the service definitions. When the child does not qualify for receive Professional Resource

Family Care or MTFC, a child in DCFS custody may receive a lesser level of TFC. The primary goal of TFC service is to decrease problem behavior and to increase developmentally appropriate normative and pro-social behavior in children and adolescents who are in need of out-of-home placement. Children will come to TFC via referrals. TFC intervention is multifaceted and occurs in multiple settings. Components include:

- Behavioral parent training and support for TFC foster parents
- Family therapy for biological parents (or other aftercare resources) utilizing licensed community providers enrolled with the SMO
- Skills training for children utilizing community practitioners enrolled with the SMO
- Supportive therapy for children utilizing licensed community providers enrolled with the SMO
- School-based behavioral interventions and academic support
- Psychiatric consultation and medication management, when needed utilizing licensed community providers enrolled with the SMO

Working in partnership with the child, the child's family, and other persons identified by the placing agency, towards the goals outlined in the family's and/or child's case plan, TFC services allow the child to benefit from a home environment and community-based setting while receiving intensive treatment and clinical services. These placements are not intended for initial placements into foster care or long term placements unless assessments clearly indicate the need for this intensity of therapeutic support. TFC placements should serve to meet a child's specific treatment needs until he is ready to be stepped down to a lower level of placement restrictiveness.

Children are assessed to need this level of placement through the CANS screening which is not appropriate for higher or lower levels of care such as Professional Resource Family Care and MTFC or regular basic foster care. All children placed in these settings should be continually re-evaluated to determine the continued need for therapeutic foster care services. Children in this program are placed in foster families (one or two children per family) whose members are trained and can provide a structured environment in which participants can learn social, and display age appropriate, emotional skills. The Contractor shall ensure TFC providers address the following requirements:

- Meet Louisiana Child Placing Agencies licensing standards;
- Behavioral parent trainings and supports are provided for TFC foster parents;
- Family therapy (or other aftercare resources) is provided to biological parents utilizing licensed community providers enrolled with the SMO;
- TFC children receive skills training utilizing community providers enrolled with the SMO;
- TFC children receive needed supportive therapies utilizing licensed community providers enrolled with the SMO;
- TFC children receive needed school-based behavioral interventions and

academic supports;

- TFC youth receives psychiatric consultation and medication management, when needed utilizing licensed community providers enrolled with the SMO;
- Siblings shall be placed together in TFC homes if one of the children qualifies for TFC placement. If the other child does not qualify for TFC services, he/she shall receive the basic foster care board rate;

(b) Non-Medical Group Homes.

The Contractor shall subcontract with providers that offer non-Medical Group Homes. DCFS believes that children are best served within families and therefore placement in any residential setting is a point in time intervention responding to the needs of the child and treatment continuum that supports a family and its community. 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.

Group Home care should only be considered when such placement is the most appropriate service available to meet the needs of the child being considered for placement. For the child entering placement, Group Home provides a chance to work on issues in a structured, safe and orderly environment. Group Home care presents an opportunity to improve the safety, permanency, and well-being of a child through a specialized offering of services that are flexible to meet the particular needs of a child and his or her family or other permanency resource. This planning includes the identification and pursuit of the most appropriate permanency goal for the child, whether to return to the family of origin, foster family, adoptive family, or to another adult permanency resource.

To the extent that the child is eligible for a Medicaid Therapeutic Group Home or PRTF level of care and was screened to need those levels of care through the CANS, the child should be placed in those levels of care. All group homes must meet and abide by federal Institutions for Mental Disease limitations on payment. Services provided in a group home setting must be provided by a community practitioner certified and credentialed by the SMO to provide those services.

(c) Basic Group Home Level.

The basic level of care requires a setting, which provides room and board. Basic Group Home rates have no treatment component. The facility provides an environment where treatment can be effective, but no treatment is provided by facility staff. The SMO will encourage effective milieu for this level of care including reinforcement of skill building taught in treatment. The SMO will reimburse the enrolled facility for room and board (OJJ, DCFS or family will reimburse SMO) using non-Medicaid funds. The SMO will reimburse individual practitioners enrolled with the SMO for behavioral health treatment of residents. The child may have Medicaid card for physical health treatment.

- All Basic Group Homes must have 16 beds or less;
- Basic Group Homes may have children that need behavioral health care (BH diagnosis or psychotropic medications);

- Children living in Basic Group Homes attend school in public school system;
- Basic Group homes must meet Child Residential Facility licensing standards;
- Services provided in a Basic Group Home setting must be provided by a community practitioner certified and credentialed by the SMO to provide those services;
- Basic Group Home staff should have special training in working with at-risk children and in crisis intervention strategies;
- The trained staff provides 24-hour supervision.
- Shall participate in the DCFS Family Team Conferences or WAA CFT to plan for the child and support the permanency goal of the child;
- Services provided within the residential setting shall be individualized, strength-based, and culturally competent and guided by a service planning team that includes residential staff, community providers, natural supports, child, and family (extended family, birth family, adoptive family, etc.) as appropriate. Goals in the service plan and services offered shall support timely movement through the continuum and DCFS permanency goals for the child;
- Shall support child's relationship with family through allowing in-person visits in the facility or contact via phone, mail, email, etc. or by providing the child transportation to attend scheduled visits with family members in accordance with the child's case plan;
- Shall provide education and support to the child's parent(s) to develop parental capacity and to prepare them for resuming care of the child as applicable;
- Shall collaborate with providers of other services in the continuum, as well as community providers, to ensure transition through the continuum and linkage to community services to support permanency goals;
- Services offered to children and families shall be continually assessed for effectiveness no less than quarterly;
- Shall make every effort to transport child back to school of origin, when determined appropriate by DCFS;
- Shall ensure that children receive clinical therapy services from community providers, including individual, group and family therapy in conjunction with any behavioral programming as needed;
- Shall maintain accurate records of all personal and clothing allowance fund transactions for each child. At time of discharge from the program, any remaining balance in the child's personal allowance account shall be paid to the child. When a child is discharged from the program any remaining balance in the child's clothing account shall be paid to the agency by check made out to DCFS, P.O. Box 3318, Baton Rouge, LA, 70821;

- Shall submit quarterly reports to the DCFS Foster Care Worker describing services provided during the months and the child's and provider's progress toward achieving the goals as outlined in the service plan. Reports must be received by the 20th day of the following month outlining goals achieved from the previous months;
- Shall report outcome data on a quarterly basis (1st quarter data July – September, 2nd quarter date January – March, 3rd quarter data April – June, and 4th quarter data July – September). This report should be sent to the Division of Foster Care Services in the DCFS State Office.

(d) Group Home Diagnostic Centers /Step-down.

One sub-component of Non-Medical Group Homes includes diagnostic centers. The diagnostic centers shall be used to provide intensive, short term, placement for children during their assessment. During placement, these children must receive the full array of services. The placement shall not exceed sixty-days (60).

- The Contractor shall subcontract with network providers that meet the following Group Home Diagnostic Center Requirements;
- Shall meet Non-Medical Group Home Level requirements; and
- The SMO will ensure that discharge planning shall begin at admission to ensure transition of the child prior to the 60 day timeline. Complete a discharge summary within 14 days for planned discharges or immediately for unplanned discharges.

(e) Mothers with Infant Level.

This program provides a living arrangement for pregnant teenagers, which allows the young mother and her infant to remain in the placement after the birth of her child. The program assists with care for the infant during the hours that the young mother is attending an educational/vocational program developing her skills in parenting and preparing for independent living with the assistance of the Provider. The program design should accept pregnant mothers at any stage of pregnancy and provide services for a maximum of 18 months following the birth of the baby. For infants in custody of DCFS, the regular board rate will be paid to the Provider. For non custody infants, the Provider may receive a special board payment up to \$264 monthly (this is not eligible for the YAP child). Providers offering the Group Home Mother with Infant shall meet the following requirements:

- Non-Medical Group Home Level requirements;
- Shall ensure that the mother receives routine and emergency medical care, including pre-natal and post-natal care;
- Shall provide assistance to the mother in arranging child care and other needed services for the infant;
- Shall ensure that community providers provide group or individual counseling regarding decision making for the mother and her infant, responsibilities of parenthood, and conflict resolution. Ensure that crisis intervention is obtained, as needed;

- Transition planning to a permanent living arrangement for the child and baby shall begin within 3 months following the birth of the child;
 - Provider shall not be responsible for providing direct care services to the non custody infant other than supervision. Transportation services are allowable if the mother is present.
- iv. The Contractor shall develop the following network capacity in collaboration with DCFS, with the understanding that the network capacity requirements may change due to the needs of individual children:
- (a) Table 9 below reflects the number of Non-Medical Group Home Diagnostic Center beds DCFS eligible children currently require statewide:

Table 9: Non-Medical Group Home Diagnostic Center/Step-down Beds

State	Total
Total	106

- (b) Table 10 below reflects the number of Non-Medical Group Home Mother and Infant beds DCFS eligible children currently require statewide:

Table 10: Non-Medical Group Home Mother and Infant Beds

Statewide total	8
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- (c) Table 11 below reflects the number of Psychiatric Residential Treatment Facility (PRTF, PRTF addiction disorder, Therapeutic Group Home and Basic Group Home) eligible children as well as addiction disorder adult residents currently statewide:

Table 11: Other Residential

	Total
PRTF	250
PRTF addiction disorder	150
Therapeutic Group Home	275
Basic Group Home	100
Non-Medical Group Home including Mother and Child and Diagnostic/Step Down	106
Adult residential Addiction Disorder	390
Total	1,271

- v. The Contractor shall require provider to meet the following requirements:
- (a) 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 current cost to the Provider is \$45.25 (this rate may increase). Document that each employee is free of convictions of has successfully passed a criminal background check.
- (b) 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 the 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.

- (c) 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 months, or both.
 - (d) More information on the State Central Registry Disclosure requirements can be found at Residential Licensing and Regulatory Services.
- vi. The Contractor shall track the following provider outcomes in collaboration with DCFS:
- (a) Absence of maltreatment
 - Number of Child Protection Investigations
 - Number of substantiated investigations
 - (b) Children have permanency and stability in their living situations
 - Current continuum level
 - Length of time in current continuum level
 - (c) Reasons for delay in movement
 - (d) Planned and unplanned discharges
 - (e) Runaways
 - (f) Psychiatric hospitalizations
 - (g) Visiting with parents and siblings/preserving connections
 - (h) Worker visits (applicable to specialized and TFC placements) - percent of compliance
 - (i) Child visits with parent/connections - percent of compliance
 - (j) Child visits with siblings - percent of compliance
 - (k) Children receive appropriate services to meet their educational, physical, and mental health needs
 - (l) Medical – percent of compliance with annual physical/dental appointments/screenings and follow ups
 - (m) Mental Health – Mental health diagnoses; percent of compliance with medication administration and appointments
 - (n) Education – percent of compliance with child's school attendance, staff participation in IEP meetings, adherence to IEP parent requirements, and meeting child's special needs (e.g. tutoring)

f. Annual Network Development Plan.

- i. The Contractor shall submit to DHH-OBH an annual network work plan (Contractor Work Plan), which contains specific action steps and measurable outcomes that are aligned with the goals and principles of the CSoC and DHH-OBH and the DCFS network requirements. The work plan shall encompass services for all Members, but contain separate sections for provider networks for covered services described in this RFP for children and adults. The Contractor Work Plan shall take into account regional needs and incorporate region-wide, network-specific goals and objectives developed in collaboration with DHH-OBH and the CSoC Governance. The Contractor shall include in the Plan a narrative and statistical analysis consistent with the DHH-OBH assessment methodology. At a minimum, the analysis shall be derived from:
 - (a) Quantitative data, including performance on appointment standards/appointment availability, eligibility/enrollment data, utilization data, the network inventory, demographic (age/gender/race/ethnicity) data, and the number of single case agreements by service type.
 - (b) Qualitative data (including outcomes data), when available; grievance information; concerns reported by eligible or enrolled Members; grievance, appeals, and request for hearings data; BH Member satisfaction survey results, and prevalent diagnoses.
 - (c) A description of services and programs for substance abuse prevention and treatment services funded through the SAPT Block Grant. In developing the description, the Contractor shall review and analyze capacity data, including wait list management methods for SAPT Block Grant Priority populations and requirements as specified in the MH block grant plan.
 - (d) Status of provider network issues within the prior year that were significant or required corrective action by DHH-OBH, including findings from the current Contractor's annual Administrative Review.
 - (e) A summary of network development efforts conducted during the prior year.
 - (f) Plans to correct any current material network gaps and barriers to network development.
 - (g) Priority areas for network development activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing the priorities.
 - (h) The participation of Members, family Members/caretakers, providers, including state-operated providers, WAA and other community stakeholders in the annual network planning process.
- ii. The Contractor's Work Plan shall be approved by DHH-OBH. The Contractor shall submit progress reports as requested by DHH-OBH.

g. Network Development Functions.

The Contractor shall have a sufficient number of qualified staff to manage the network, including staff to manage the transition of service delivery from existing qualified service providers to qualified service providers. Unless approved in advance by DHH-OBH, the Contractor shall not delegate network management, network reporting, and assurance of network sufficiency. The Contractor shall not delegate credentialing and privileging of providers, unless approved by DHH-OBH in advance.

- i. The Contractor shall develop and implement policies and procedures to monitor

and demonstrate that the network is of sufficient size, scope, and types of providers to deliver all covered BH services and satisfy all the service delivery requirements of this Contract, the Services Definitions Manual, and the SAPT and MH Block Grants, which are available in the procurement library.

h. Qualified Service Provider Selection.

The Contractor shall select and subcontract with qualified service providers. All qualified service providers under subcontract shall meet minimum qualification requirements in accordance with the DHH-OBH Covered Behavioral Health Services Manual and credentialing and privileging requirements in accordance with DHH-OBH standards.

- i. When selecting qualified service providers for a subcontract, the Contractor shall evaluate information from the following sources: QM 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; BH 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.
- ii. When selecting providers for a subcontract, the Contractor shall require providers to:
 - (a) Obtain a unique national provider identifier (NPI).
 - (b) Operate within their license and scope of practice.
 - (c) Obtain and maintain all applicable insurance coverage, in accordance with the Terms and Conditions of this Contract.
- iii. The Contractor 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.
- iv. The Contractor shall evaluate and make a determination to retain providers utilizing performance and QI data acquired while delivering services under this Contract.
- v. The Contractor shall clearly describe and disseminate the process and criteria to be used for terminating provider participation. If the Contractor 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.
- vi. The Contractor shall concurrently notify DHH-OBH and BHSF of its decision to terminate a provider.
- vii. The Contractor shall not subcontract with providers excluded from participation in federal health care programs, pursuant to Section 1128 or Section 1128(A) of the Social Security Act.
- viii. The Contractor shall not discriminate against any provider based solely on the provider's type of licensure or certification. In addition, the Contractor shall not discriminate against providers that serve high-risk populations or specialize in treating BH conditions that are costly. This provision does not prohibit the Contractor from limiting the size or scope of its provider networks, or establishing procedures to control costs, to meet the needs of the Members it is required to serve in this Contract.
- ix. The Contractor shall conduct credentialing and privileging in accordance with the DHH-OBH Services Definitions Manual. When necessary, the Contractor shall

- utilize processes to expedite temporary (or provisional) credentialing and privileging to maintain network sufficiency or to add specialty providers.
- x. The Contractor shall maintain a sufficient number of qualified staff to expeditiously process the credentialing and privileging of qualified service providers.
 - xi. The Contractor shall develop and maintain methods to communicate policies, procedures and relevant information to providers through secure or public Web pages, including a Provider Manual developed to disseminate all relevant information to qualified service providers.
 - xii. The Contractor shall give all qualified service providers and subcontracts access to the DHH-OBH Services Definition Manual and the Contractor's Provider Manual, and any updates, either through the Contractor's website, or by providing paper copies to providers who do not have Internet access.
 - xiii. The Contractor shall provide, in accordance with national standards, claims inquiry information to qualified service providers and subcontracts via the Contractor's Website.
 - xiv. The Contractor shall not restrict or inhibit providers in any way from freely communicating with or advocating for a Member regarding BH care, medical needs, and treatment options, even if the person needs services that are not covered or if an alternate treatment is self-administered. The Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Member who is his or her patient:
 - (a) For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - (b) For any information the Member needs in order to decide among all relevant treatment options.
 - (c) For the risks, benefits, and consequences of treatment or non-treatment.
 - (d) For the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
 - xi. The Contractor shall require providers to communicate information to assist a Member to select among relevant treatment options, including the risks, benefits, and consequences of treatment or non-treatment; the right to participate in decisions regarding his or her BH care; and the right to refuse treatment and to express preferences about future treatment decisions.
- i. Out-of-Network Services.
- When the Contractor is not able to deliver a medically necessary covered BH service, the Contractor shall timely subcontract with an out-of-network provider to deliver the same service until a network provider is available. The Contractor shall expeditiously authorize services and reimburse the out-of-network provider in these circumstances.
- j. Provider Training.
- The Contractor shall develop and implement comprehensive provider training and support a training program for providers to gain appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements of this Contract. The Contractor shall:
- i. Have a sufficient number of qualified staff and allocate sufficient financial resources to provide training to all service providers.
 - ii. Develop and implement training opportunities for qualified providers, including

FSO, and technical assistance and training for specifically for WAA, FSOs and family- and consumer-operated providers.

- iii. Include a cultural competency component in each training topic.
 - iv. Educate and require providers to use evidence-based practices, promising practices, and emerging best practices.
 - v. Educate providers on billing and documentation requirements.
 - vi. Provide required orientation and training for all subcontracted providers new to the Contractor's network.
 - vii. Develop and implement an annual training plan that addresses all training requirements, including involvement of Members and family Members in the development and delivery of trainings.
- k. Physician Incentive Plans.
- The Contractor shall comply with the requirements set forth in 42 CFR 422.208 and 422.210.
- i. The Contractor may operate a physician incentive plan only if no specific payment can be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.
 - ii. The Contractor shall disclose the following information regarding a physician incentive plan to DHH-OBH upon request:
 - (a) 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.
 - (b) The type of incentive arrangement, e.g., withhold, bonus, capitation.
 - (c) The percent of withhold or bonus (if applicable).
 - (d) The panel size, and if clients are pooled, the approved method used.
 - (e) If the physician/group is at substantial financial risk, proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.
 - iii. If the physician/group is put at substantial financial risk for services not provided by physician/group, the Contractor shall ensure adequate stop-loss protection to individual physicians and conduct annual Member surveys. Survey results shall be disclosed to the State and, upon request, disclosed to beneficiaries.
 - iv. The Contractor shall provide information on its physician incentive plans to any Medicaid Member upon request (this includes the right to adequate and timely information on a physician incentive plan.)
 - (a) The Contractor is required to disclose all physician incentive agreements to DHH-OBH and to Members who request them. The Contractor shall disclose to DHH-OBH the information on physician incentive plans contained in 42 CFR 422.208 and 422.210 prior to initiation of a new incentive plan agreement, or upon request of DHH-OBH or CMS. The Contractor shall also comply with physician incentive plan requirements set forth in 42 CFR 438.6(h), which apply to contract arrangements with subcontracted entities.
- l. Network Reporting.
- The Contractor shall provide the following network notifications and reports.

- i. Quarterly written network status reports in a format approved by DHH-OBH according to the following schedule

The Contractor shall submit written Quarterly System of Care Network Development Plan Status reports in a format approved by DHH-OBH and according to the following schedule:

<u>Due Date</u>	<u>Reporting Period</u>
October 15	July 1 through September 30
January 15	October 1 through December 31
April 15	January 1 through March 31
July 15	April 1 through June 30

- ii. The Contractor's Quarterly Network Status reports shall include separate sections reporting changes by qualified service providers (organized by provider type), WAA and FSOs by zip code with DHH-OBH region and for CSoC, by zip code within Act 122 Regions. Each section shall include the following elements for 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.
- iii. If a provider loss results in a material gap or network deficiency, the Contractor 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. As part of the Quarterly Network Status reports, the Contractor shall report progress in accordance with the Annual Provider Network Development Plan to increase service capacity in areas requiring further development, including barriers encountered and actions planned to eliminate the barriers.
- iv. Notification Requirements for Changes to the Network. The Contractor shall notify and obtain written approval from DHH-OBH, before making any material changes in the size, scope, or configuration of its network, as described in the Contractor's Annual Provider Network Development Plan. A material change includes any event that affects service delivery and includes a reduction in workforce at a qualified service provider level; any plan to not fill, or delay filling, staff vacancies; or termination of a subcontract held by a WAA, FSO, the crisis provider and other qualified providers. The Contractor shall notify DHH-OBH, in writing within one day of the Contractor's knowledge of an expected, unexpected, or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the provider network. The notice shall include:
 - (a) Information describing how the change will affect service delivery, availability, or capacity of covered BH services.
 - (b) A plan to minimize disruption to the BH Member's care and service delivery.
 - (c) A plan for clinical team meetings with the BH Member and his/her family/caregiver to discuss available options and revise the service plan to address any changes in services or service providers.
 - (d) A plan to correct any network deficiency.

- v. The Contractor shall notify DHH-OBH in writing within five days if a subcontract fails to meet licensing criteria, or if the Contractor decides to terminate, suspend, limit, or materially change qualified service provider or the WAA subcontract. This notification is required if the decision affects network sufficiency, including circumstances that require Members to transition care to a different provider. The notice shall include:
 - (a) The number of Members affected by the termination, limitation, suspension, or material change decision, including the number of Title XIX and Title XXI and non-Title XIX and non-Title XXI BH Members affected by program category, i.e., children eligible for the CSoC, adults eligible for the 1915 (i), etc.
 - (b) A plan to ensure that there is minimal disruption to the BH Member's care and service delivery.
 - (c) The Contractor shall require the BH Member's original provider to be responsible for transitioning his/her Members until the BH Member has attended the first appointment with the new provider.
 - (d) A plan for clinical team meetings with the BH Member and his/her family/caregiver to discuss available options and to revise the service plan to address any changes in services or service providers.
 - (e) A plan to communicate changes to affected Members, including provision of required notices.
- vi. DHH-OBH may require the Contractor to submit a written transition plan for Members affected by these network changes. The Contractor shall track all Members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure service continuity. At a minimum, the Contractor shall track the following elements: name, Title XIX or Title XXI status, date of birth, population type, current services the Member is receiving, services that the Member 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 may require the Contractor to add other elements based on the particular circumstances. DHH-OBH will require the Contractor and its providers, where applicable, to use common data elements to match existing required data fields specified by DHH-OBH.
- m. Annual Network Inventory.

The Contractor shall submit to DHH-OBH, by May 30 of each contract year, a written Annual Network Inventory in a format prior approved by DHH-OBH. The Contractor shall prepare the network inventory to quantify the number of qualified service providers, including the WAA, FSOs, and the crisis response providers available within the network as follows:

 - i. Each category of covered BH services as identified by DHH-OBH.
 - ii. Specialty BH service providers, including providers with expertise to deliver services to persons with developmental disabilities, non-English speaking persons, and other specialties as identified by DHH-OBH.
 - iii. Peer support and consumer- and family-delivered or run services.

n. Prescriber Sufficiency Assessment.

The Contractor shall submit to DHH-OBH the written Annual Prescriber Sufficiency Assessment by May 30 of each contract year and the written Quarterly Prescriber Sufficiency Assessment reports in accordance with Exhibit A of this Contract and in a format prescribed by DHH-OBH. The Contractor 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 of Louisiana. Capacity should be compared to the number of enrolled Members by geographic location.

- i. The Contractor shall provide periodic reports and profiles to qualified service providers and the WAA comparing their performance, when subject to the same standards and measures. The Contractor shall conduct site visits as needed or requested by DHH-OBH. The Contractor shall utilize the reports in conjunction with other QM indicators to coordinate QI activities between the Contractor, the WAA and other qualified service providers.

o. Network and Provider Subcontracts.

The Contractor shall enter into written subcontracts with WAA, FSOs and qualified service providers to deliver covered BH services to Members. Upon request, the Contractor shall submit sample copies of all provider subcontracts to DHH-OBH for approval prior to the Contract start date.

- i. All provider subcontracts shall include the following provisions:

- (a) The name and address of the subcontract.
- (b) The method and amount of compensation, reimbursement, payment, or other considerations provided to the provider.
- (c) Identification of the population to be served by the provider, including the number of Members the provider is expected to serve.
- (d) The amount, duration, and scope of covered BH services to be provided.
- (e) The term of the provider's subcontract, including beginning and ending dates, and procedures for extension, termination, and renegotiation.
- (f) Specific provider subcontract duties relating to coordination of benefits and determination of third-party liability.
- (g) 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 Contractor, when applicable.
- (h) Maintenance of a cost record keeping system.
- (i) Compliance with the requirements in the Contractor QM and UM plans and QM program.
- (j) Uniform terms and conditions of the contract.
- (k) 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 Contractor.
- (l) 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.

- (m) Incorporation by reference of the DHH-OBH Service Definitions Manual and the Contractor's Provider Manual and language that the provider subcontract complies with all requirements stated in this Contract.
- (n) Compliance with encounter reporting and claims submission requirements in accordance with the Contractor's Provider Manual, including payment withhold provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting.
- (o) The right of a provider to appeal a claims dispute in accordance with the Contractor's Provider Manual.
- (p) Assistance to Members to understand their right to file grievances and appeals in accordance with the Contractor's Provider Manual shall be provided by the provider.
- (q) Compliance by the subcontract with audits, inspections and reviews in accordance with the Contractor's Provider Manual, including any reviews the Contractor or DHH-OBH may conduct.
- (r) Cooperation of the provider with the Contractor, other providers and/or State employees in scheduling and coordinating its services with other related service providers that deliver services to Members.
- (s) 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 that interferes with, delays, or hinders service delivery by another provider by State employees.
- (t) Timely implementation by the provider of DHH-OBH or Contractor decisions related to a grievances, serious mental illness grievance, Member appeal, or claims dispute.
- (u) 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 BH Member, according to 42 CFR 438.12(e).
- (v) When applicable, submission to DHH-OBH of the NOMs, including access to services, engagement in services, independent and stable housing, employment, and employment training rates.
- (w) When applicable, Members reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in providers.
- (x) The DHH-OBH definition of medically necessary covered BH services and the DHH-OBH levels of care are incorporated by reference.
- (y) 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.

8. Member's Rights and Responsibilities

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

a. Member rights.

A Member's Bill of Rights shall be provided to Members or their families/caregivers as part of the new Member information in the Member handbook and upon request by a Member or his/her family/caregiver. 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:

- i. The right to receive information as described in 42 CFR 438.10 and throughout the RFP and Contract.
 - ii. The right to be treated with respect and with due consideration for his or her dignity and privacy.
 - iii. 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.
 - iv. The right to receive rehabilitative services in a community or home setting, or in a nursing home setting.
 - v. The right to participate in decisions regarding his/her care, including the right to refuse treatment; and the right to the following:
 - (a) Complete information about his/her specific condition and treatment options, regardless of cost or benefit coverage, and the right to seek second opinions.
 - (b) Information about available experimental treatments and clinical trials and how such research can be accessed. and
 - (c) Assistance with care coordination
 - vi. The right to be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation, or convenience.
 - vii. The right to appeal or express a concern about the Contractor, or the care it authorizes, and receive a response in a reasonable period of time.
 - viii. The right to receive a copy of his/her 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 164.
 - ix. 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 438 Subpart I.
 - x. The right to choose his or her provider to the extent possible and appropriate, in accordance with 42 CFR 438.6(m).
 - xi. The right to be furnished behavioral health care services in accordance with 42 CFR 438.206 through 438.210.
 - xii. Freedom to exercise the rights described herein without any adverse effect on the Member's treatment by DHH, the Contractor or the Contractor's subcontracts or providers.
- b. Member Responsibility.
- The Member's responsibilities shall include, but are not limited to:
- i. Informing the Contractor of the loss or theft of his/her ID card.
 - ii. Being familiar with Contractor procedures to the best of the Member's abilities.
 - iii. Calling or contacting the Contractor to obtain information and have questions clarified.
 - iv. Providing participating network providers with accurate and complete information related to their care.

- v. 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.
- vi. Making every effort to keep any agreed upon appointments, and follow-up appointments.

9. Special Requirements for the Management of DHH-OBH Non-Medicaid Services

The Contractor 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 clients and non-Medicaid services within a Non-Medicaid OBH provider network. Medicaid eligibles receiving Medicaid eligible services through clinics and contracts will be immediately served under the SMO. Over the three year time frame addressed by this RFP, the goal is to transition all adult non-Medicaid eligible participants from the current non-Medicaid SMI and AD population to a non-Medicaid benefit program managed by the Contractor.

- a. The Contractor will provide the following administrative services to qualified and enrolled Non-Medicaid eligible members:
 - i. 24/7 telephonic availability for screening and referral to emergency services and service providers.
 - ii. Authorization of inpatient services, and up to 30 days of interim outpatient treatment services
 - iii. 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 Survey (LOCUS) or other OBH approved methods (based on OBH set criteria) as indicated.
 - iv. Based on assessment recommendations, authorize the development of a treatment plan and prior authorize the appropriate services (service package) available within the OBH designated non-Medicaid benefit program.
 - v. Provide client level data on services provided and service provider.
 - vi. Provide concurrent review and level of care decisions based on assessments and treatment planning.
 - vii. Provide an expedited and standard appeals process
 - viii. Refer the non-Medicaid clients to the eligible service provider and track treatment effectiveness before the reauthorization of additional services.
 - ix. Summary reporting and trend analysis of services and outcomes.
 - x. Enroll into the SMO network existing DHH-OBH/LGE providers and DHH-OBH/LGE operated MH and /or AD clinics, and Access to Recovery (ATR) vendors.
 - xi. Invoice 1/12th of the negotiated annual administrative services fees and requisite client level and summary reports to DHH-OBH on a monthly basis. DHH-OBH and LGE providers will be paid directly by the DHH-OBH or LGE for treatment and support services authorized by the Contractor.
- b. The Contractor shall work with DHH-OBH to accomplish the comprehensive management of services to the Non-Medicaid SMI and AD populations throughout the duration of the Contract:
 - i. Identify, utilizing existing DHH-OBH data sets, the individuals with SMI and/or AD who qualify for enrollment as members in the Non-Medicaid SMI/AD Limited-Benefit Program.
 - ii. Establish 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 SMI/AD Medicaid CSoC program.
- iii. Design credentialing standards for the non-Medicaid providers that adhere to criteria established by DHH-OBH.
 - c. The Contractor shall provide a transition plan for enrolling eligible members into the CSoC program, consistent with the health and eligibility status of the non-Medicaid enrolled membership 60 days prior to the next operating year authorized under the contract. Eligibility screening for Medicaid/Medicare benefits are required on all members prior to the authorization of services specified on the Plan of Care

10. Reporting and Monitoring (Financial Management)

The Contractor shall have a sufficient number of qualified staff and accounting personnel 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 and expenses associated with those revenue sources separately.

- a. The Contractor shall develop and maintain internal controls to prevent and detect fraud.
- b. Federal Financial Participation. The Contractor shall maintain a self balancing set of records in accordance with Generally Accepted Accounting Procedures. The Contractor agrees to maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of Contractor invoices. Such documents, including all original claim forms, shall be maintained and retained by the Contractor for a period of six (6) years after the contract expiration date or until the resolution of all litigation, claim, financial management review or audit pertaining to the contract, whichever is longer.

The Contractor 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. The DHH-OBH may inspect and audit any financial records of the entity or its subcontracts.

- c. Federal Financial Participation and Access to Records, Books, and Documents. The Contractor agrees to maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of Contractor invoices. Such documents, including all original claim forms, shall be maintained and retained by the Contractor for a period of six (6) years after the contract expiration date or until the resolution of all litigation, claim, financial management review or audit pertaining to the contract, whichever is longer.
 - i. Upon reasonable notice, the Contractor shall provide the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the scope of work. The Contractor 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-DHH-OBH. The Contractor 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.
- ii. Access shall be provided to the following officials and/or entities:
 - (a) The United States Department of Health and Human Services or its designee.
 - (b) The Comptroller General of the United States or its designee.
 - (c) DHH-OBH or its designee.
 - (d) The Office of Inspector General.
 - (e) Any independent verification and validation Contractor or quality assurance Contractor acting on behalf of DHH-OBH.
 - (f) The Louisiana Legislative Auditor or its designee.
 - (g) A local, state or federal law enforcement agency.
 - (h) A special or general investigating committee of the Louisiana Legislature or its designee.
 - (i) Any other local, state or federal entity identified by DHH-OBH, or any other entity engaged by DHH-OBH.
 - iii. The Contractor agrees to provide the access described within the State of Louisiana wherever the Contractor maintains such books, records, and supporting documentation. The Contractor further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. The Contractor shall require its Contractors to provide comparable access and accommodations.
 - iv. The Contractor shall provide DHH-OBH and its designees, which may include auditors and inspectors, with access to Contractor 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:
 - (a) Capacity to bear the risk of potential financial losses.
 - (b) Services and deliverables provided.
 - (c) Determination of the amounts payable under the contract.
- d. Detection of fraud, waste and/or abuse; or other purposes DHH-OBH deems necessary to perform its regulatory function and/or enforce the provisions of the contract.
- i. The Contractor shall provide any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections. If, as a result of an audit or review of payments made to the Contractor, DHH-OBH and its designees discover a payment error or overcharge, DHH-OBH and its designees shall notify the Contractor 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 Contractor, or to collect such funds directly from the Contractor. The Contractor 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 Contractor have resulted in errors in payments to the Contractor, the Contractor shall indemnify DHH-OBH for any losses resulting from such errors, including the cost of audit.
 - ii. The Contractor understands that the State Legislative Auditor, Office of the Governor, Division of Administration and Department Auditors of those

designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a six year period following final payment. Contractor grants to the State of Louisiana, through 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 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 Contractor shall ensure that this clause concerning the authority to audit funds received indirectly by Contractors through the Contractor and the requirement to cooperate is included in any contract it awards, and in any third party agreements.

- iii. The Contractor shall ensure compliance with or outline corrective action plans for any finding of noncompliance based on law, regulation, audit requirement, or generally accepted accounting principles or any other deficiency contained in any audit, review, or inspection conducted. This action shall include the Contractor's delivery to DHH-OBH, for approval, a Corrective Action Plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s). Contractors shall bear the expense of compliance with any finding of noncompliance under this contract.
 - iv. Upon DHH-OBH request, the Contractor shall provide a copy of those portions of the Contractor's and its Contractors' internal audit reports relating to the services and deliverables provided to DHH-OBH under the contract.
- e. Financial Reporting.
- The Contractor shall comply with federal and state laws and /or DHH-OBH 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, 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 contract monitor. DHH-OBH may at its discretion develop other financial reporting requirements (FRRs) that are designed to evaluate the specific operations of the Contractor related to this contract.
- i. 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.
 - ii. 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.
 - iii. The Contractor shall implement processes for verifying the accuracy and timeliness of reported data, screen the data for completeness, logic, and consistency, and collect service information in standardized formats. The Contractor shall submit timely, accurate, and complete data or shall be subject to

corrective action, notice to cure, sanction, or other remedies available under this Contract.

- iv. The Contractor shall develop an accounting and financial reporting system that tracks revenue and expenses associated with various funding streams/sources separately.
- v. In addition to the annual audit requirements discussed within this section, the Contractor 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:
 - (a) Balance Sheet.
 - (b) Income Statement.
 - (c) Statement of retained earnings.
 - (d) Other financial and utilization data, to be determined, and in a format that will be prescribed by OBH, but to be utilized to evaluate and monitor the performance and operations of the Contractor.
 - (e) Monthly reporting, when required, will be due 30 days after the end of each month.
 - (f) Annual disclosure and additional financial information requests that will be developed and in a format prescribed by OBH.
- vi. The Contractor shall report the managed care days and payments to hospitals in order to comply with Section 1932(g) and 42 CFR § 447.229 reporting requirements:
 - (a) 1932 g) Identification of Patients for Purposes of Making DSH Payments. Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require the entity either—(1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1886(d)(5)(F) and 1923; or (2) to include a sponsorship code in the identification card issued to individuals covered under this title in order that a hospital may identify a patient as being entitled to benefits under this title.
 - (b) 42 CFR § 447.299 Reporting requirements. (c) Beginning with each State's Medicaid State plan rate year 2005, for each Medicaid State plan rate year, the State must submit to CMS, at the same time as it submits the completed audit required under §455.204, the following information for each DSH hospital to which the State made a DSH payment in order to permit verification of the appropriateness of such payments: (7) IP/OP Medicaid managed care organization payments. The total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals.
- f. Budget Tracking System (Early Warning System).

The Contractor in conjunction with DHH-OBH shall develop a system to track revenue, expenditures, utilization, cost per service and recipients in service by funding source. The purpose of the report 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 is needed to ensure proper accounting for budget expenditures at each of the participating state agencies (DHH-OBH, DOE, DCFS, and OJJ).

 - i. The Contractor shall provide annual projections with monthly reporting to gauge expenditure patterns.

- ii. Contractor shall adhere to State of Louisiana budget timeline in order to assure DHH-OBH can submit timely and accurate budget information.
- g. Protection against Liability and Insolvency. Subject to provisions in 42 CFR §438.106 and pursuant to Section 1932 (b)(6), Social Security Act (as enacted by section 4704 of the Balanced Budget Act of 1997), if the Contractor becomes insolvent, the Contractor shall not hold Members liable and Members shall not be held liable for the following:
 - i. The Contractor's debts in the event of insolvency.
 - ii. Covered services provided to the Member, for which the state does not pay the Contractor.
 - iii. Covered services provided to the Member, for which DHH or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual referral or other arrangement.
 - iv. Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.
- h. Solvency and Corporate Financial Condition.

The Contractor shall be licensed or certified by the Louisiana Department of Insurance pursuant to Title 22 of the LA revised statutes consistent with RS 22:12 and RS 22:47. The Contractor shall meet all requirements of a qualified plan in RS 40:2211 including those listed at RS 40:2242. The Contractor shall be certified by the Louisiana Secretary of State to do business in Louisiana. The Contractor shall, at all times, maintain capitalization and surplus requirements set forth in L.A. R.S. 22:254. In addition, the Contractor's financial solvency shall be evaluated by the Louisiana Department of Insurance. DHH-OBH shall review the Contractor's solvency and financial condition during the Contractor Enrollment 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 Contractor'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. The PIHP must cover continuation of services during insolvency to enrollees for the duration of period for which payment has been made, as well as for inpatient admissions up until discharge.
- i. Non-Allowable Costs.

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 Contractor to an organization or entity in the form of cash, property or services rendered from Contractor program funds. In addition, the Contractor:

 - i. Shall not make charitable donations or contributions from Contractor program funds.
 - ii. 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 Contractor does not report such charitable contributions or donations as an Allowable Expense.
- j. The Contractor shall not use funds paid to the Contractor 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 State Legislature:
- i. 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 State Legislature.
 - ii. 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.
 - iii. Contractors who submitted a proposal shall file the require certification that each tier will not use Federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a Member of Congress, officer or employee of Congress, or an employee of a Member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award.
- k. Performance Bond.
- The Contractor shall obtain and maintain a performance bond, 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 Contractor shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor shall be in material breach of this Contract if it fails to maintain or renew the performance bond as required by this Contract.
- i. The Contractor shall obtain a performance bond in an amount equal to ten percent (10%) of annual payments.
 - ii. The Contractor shall obtain a performance bond with an adjusted amount, in the event the estimated annual amount of payments increases, no later than thirty (30) days after notification by DHH-OBH of the amount required.
 - iii. The Contractor agrees that if it is declared to be in default of any material term of this Contract, DHH-OBH shall, in addition to any other remedies it may have under this Contract, obtain payment under the performance bond or performance bond substitute for the following:
 - (a) Making fund available through a concursus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this Contract.
 - (b) Reimbursing DHH-OBH for any payments made by DHH-OBH on behalf of the Contractor.
 - (c) Reimbursing DHH-OBH for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by DHH-OBH. and
 - (d) Making 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 Contractor.

- (e) The Contractor shall reimburse DHH-OBH for expenses exceeding the performance bond amount.

I. Medical Loss Ratio Requirements.

Payments made to the Contractor for TXIX adult at-risk capitated services will require a minimum medical loss ratio of 85% based on modified net income to include provisions of the Affordable Care Act (ACA) and related adjustments to net income. The formula will be provided as part of the financial reporting templates and instructions prescribed by OBH after contract award. The Contractor will rebate amounts less than an MLR of 85% for TXIX adult at-risk capitation payments by August 1st of the calendar reporting period. The basis for the modified MLR percentage and amounts rebatable will include ACA related additions and subtractions to net income adopted by the NAIC and modified for the LA OBH Medicaid program.

m. Third Party Liability/Coordination of Benefits.

The Contractor shall be responsible for identifying health insurance for their Members. If the Contractor identifies third party coverage (Medicare or commercial health insurance), the Contractor shall notify DHH-OBH/BHSF within five (5) business days using the TPL Notification form DHH-OBH/BHSF will use this form to update the TPL Resource File on a daily basis. If DHH-OBH/BHSF identifies coverage for a Member the State will be notified through the monthly X12 834 roster process.

- i. The Contractor has one-hundred eighty (180) days to bill and receive payment, from the private or Medicare carrier, from date of discovery of other coverage. The Contractor will be required to include the collections in the invoice and/or encounter data submitted to DHH-OBH/BHSF. If the Contractor has not collected from the third party, within the one-hundred eighty (180) days, DHH-OBH/BHSF may pursue recovery. The Contractor will be responsible for all administrative costs associated with DHH-OBH/BHSF collection efforts.
- ii. The Contractor shall be required to provide all claim information for these individuals through encounter data, if it has not already submitted through the normal claims submission process. If the claim information is not provided through encounter data, a report may be generated with all of the data that would have been included in the encounter data. If a report is used, the additional cost associated with preparing the claims for billing, will be passed on to the Contractor.
- iii. In accordance with 42 CFR §433.138(e), the Contractor shall be responsible for identifying any accident or injury utilizing diagnosis and trauma related codes 800 through 999, excluding 994.6.
- iv. The Contractor 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 Contractor shall be required to seek amounts greater than five hundred dollars (\$500) as required by Louisiana State Plan and federal Medicaid guidelines. The amount of any subrogation recoveries collected by the Contractor shall be reported through adjusted invoice and/or encounter data.
- v. The Contractor has an affirmative duty to inform DHH-OBH/BHSF of any casualty insurance, tort claims and settlements or personal injury coverage. At the request of DHH-OBH/BHSF, the Contractor shall provide such information not included in encounter data submissions that may be necessary for the

administration of third party liability activity. The information shall be provided within thirty (30) calendar days of the 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.

- vi. T-XIX 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 Contractor are from T-XIX funds, the Contractor's T-XIX capitation payments would be secondary to all other third parties not listed above.
 - (a) DHH-OBH has adjusted the Contractor's capitation payment and monthly substance abuse treatment and administrative services equal to DHH-OBH TPL recoveries. In lieu of this offset to capitation or payment through DHH-OBH's collection of TPL, the Contractor shall retain its T-XIX TPL recoveries. For all adult capitated services, the Contractor will be permitted to keep any Third Party Liability/Coordination of Benefits received on behalf of enrolled Members.
 - (b) The Contractor is required to report any collections on behalf of non-risk services and offset any invoices to the State for the amount of the collections.
 - (c) The Contractor 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. The Contractor shall transfer to DHH-OBH any new TPL information on any Member that comes to their attention. DHH-OBH shall transfer to the Contractor any new TPL information for any Member that comes to their attention.
 - (d) DHH-OBH will retain responsibility for collecting medical subrogation. DHH-OBH will coordinate these activities with the Contractor. The Contractor is required to comply with any information requests regarding medical subrogation.

11. Implementation Planning

- a. Upon contract award, the Contractor shall immediately begin to collaborate with the DHH-OBH to work toward a timely implementation period. The implementation period shall be complete by January 1, 2012. The Contractor shall meet with the DHH-OBH to establish the following deliverables and to establish priorities and shall:
 - i. Meet within the first five (5) days of the contract award.
 - ii. Define the project management team, the communication paths and reporting standards between the DHH-OBH and the Contractor staff.
 - iii. Establish implementation plan, including the schedule for key activities and milestones.
 - iv. Define expectations for content and format of contract deliverables.

These issues shall be addressed collaboratively, but the ultimate decision regarding each shall be within the sole discretion of the DHH-OBH.

- b. The Contractor shall develop and submit a comprehensive written implementation plan which shall include timelines. This plan will be used to monitor progress throughout the Implementation period. The Implementation Plan is due on within

60 days of contract award and shall include time frames for critical milestones for implementation. The Plan shall clearly address all tasks that shall be necessary to meet the requirements of this RFP. It shall clearly specify the Contractor's expectations of work to be performed by DHH-OBH and include the following:

- i. Schedules and timetables for implementation.
 - ii. A detailed description of the implementation methods.
 - iii. Communication Plan that includes a plan to communicate with Members, providers and stakeholders, including Member service and provider service call centers and Member and provider handbooks.
 - iv. Website development plan.
 - v. Network development plan, including analysis and plans to effect a smooth transition, including a transition plan for state operated providers.
 - vi. Clinical transition and service continuation plan.
 - vii. A staffing plan identifying hiring expectations and staff associated with each task of the implementation period.
 - viii. Training plan for Contractor staff, State Agency staff, Members, WAA, providers, and stakeholders.
 - ix. Facilities, fiscal requirements and cost avoidance plans.
 - x. Quality Management Plan.
 - xi. Utilization Management Plan, including outlier management and care coordination plans.
 - xii. Grievances and appeals plan.
 - xiii. Overall MIS project plan, including reports and interface plans, claims processing and information management integration, hardware and equipment acquisition and installation, operating system and software installation, systems testing, etc.
 - xiv. Business Continuity, Disaster Recovery, and Risk Management Plan.
 - xv. Contract compliance/fraud and abuse plan.
 - xvi. Operational readiness plan.
- c. In addition to those items specifically enumerated above, the Contractor shall develop and execute plans that ensure completion of all necessary tasks, explicit or implicit, assigned to the Contractor by this RFP.
- d. The Contractor shall develop an implementation team that is designed to ensure the implementation plan progresses according to the required timelines.
- e. DHH-OBH shall designate a State Contract Monitor who shall have overall responsibility for the management of all aspects of this contract and this State Contract Manager shall be a Member of the implementation team. This person shall oversee the Contractor's progress, facilitate issue resolution, coordinate the review of deliverables, and manage the delivery of State resources to the project, consulting with the Contractor as needed. The State Contract Manager may designate other State staff to assume designated portions of the State Contract Manager's responsibility. The State Contract Manager shall be the central point of communications and any deliverables to the Department shall be delivered to the State Contract Manager and any communication or approval from DHH-OBH shall be communicated to the Contractor through the State Contract Manager.
- f. Should disagreements arise between Contractor staff and the State Project Team, those disagreements shall be escalated for resolution through each organization's

respective reporting structure. Should those disputes remain unresolved after that process, the DHH-OBH Contract Monitor has the authority to escalate to DHH-OBH Assistant Secretary who retains ultimate authority to decide the outstanding issue or question.

- g. The Contractor shall designate a full time Project Manager (PM) within one (1) week of the contract award. The PM shall have overall responsibility for successful completion of Contractor responsibilities, overseeing and monitoring Contractor staff on a day-to-day basis as they undertake project activities. The PM shall also work closely with the State Contract Monitor and assist in coordinating State resources. The PM or designated Contractor staff shall maintain the implementation plan.
- h. The PM and relevant staff shall meet with and provide project status to the State Contract Monitor and other State staff weekly. The purpose of the status meetings is for the Contractor to communicate actual progress, identify problems, recommend courses of action, and obtain approval for making modifications to the implementation plan. In conjunction with the project status meetings, the Contractor shall provide written status reports to the State Contract Monitor at least every two weeks during transition. This status report shall include:
 - i. Updated implementation plan and responsibility matrix.
 - ii. Tasks that are behind schedule.
 - iii. Dependant tasks for tasks behind schedule.
 - iv. Items requiring the State Project Manager's attention.
 - v. Anticipated staffing changes.
 - vi. Outstanding issues, current status and plans for resolution.
 - vii. Any issues that can affect schedules for project completion.
 - viii. Identification, time frames, critical path effects, resource requirements and materials for unplanned in scope items.
- i. The Contractor shall be responsible for documenting all meetings, including attendees, topics discussed, decisions recommended and/or made with follow-up details. Written minutes and summaries from all meetings are to be provided to the State Contract Monitor no later than three (3) business days after the date of the meeting.
- j. The Contractor shall also provide a written project communication plan, the purpose of which is to keep project management and staff informed about all information they need to complete assigned responsibilities, as well as to keep all system stakeholders proactively informed on the progress of the project.
- k. The Contractor shall prepare and submit, in its Beginning-of-Contract Transition Plan, its draft comprehensive set of flow diagrams that clearly depict the proposed final work operations, including but not limited to, client flow, workflow, data flow and authorization and provider payment process. These diagrams shall aid in the understanding of how the Contractor will perform work and support training. The level of detail in these diagrams shall be sufficient to communicate to the public and providers their role in the Children's System of Care process. With a goal to maximize clarity, the Contractor shall use graphical software that matches what DHH-OBH currently uses as its platform.

- l. Prior and subsequent to the contract start date, the Contractor shall demonstrate its readiness and ability to provide covered behavioral health services and to resolve previously identified operational deficiencies. DHH-OBH may conduct a readiness review to determine readiness. Upon DHH-OBH request and subject to its approval, the Contractor shall develop and implement a corrective action plan in response to deficiencies identified during any step of the implementation process.
- m. The Contractor shall commence operations only if all corrective action plan requirements are met to the satisfaction of DHH-OBH. At a minimum, the Contractor shall cooperate with the DHH-OBH to review the following areas:
 - i. Staffing adequacy.
 - ii. Call Center functionality.
 - iii. Member Services.
 - iv. Collaboration with all applicable State Agency systems.
 - v. A sufficient provider network and provider communication system.
 - vi. System users are trained and ready to input data into the system.
 - vii. Adequate staffing and policies and procedures related to the following:
 - viii. Care Management and Coordination.
 - ix. Utilization Management (UM).
 - x. Network Provider Services.
 - xi. Quality Management (QM).
 - xii. Financial management.
 - xiii. Information Technology and Claims.
 - xiv. Continuity of care plans for Members in services.
 - xv. Grievance, appeal, and Member service cases.
 - xvi. All major operational functions of the Contractor program are successfully tested.

12. Transition Planning Requirements (End of Contract)

- a. If the contract is cancelled or terminated, 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 Contractor by:
 - i. Deduction from an unpaid balance.
 - ii. Collection against the performance bond.
 - iii. Any combination of the above or any other remedies as provided by law.
- b. In the event the contract or any portion thereof is terminated for any reason, or expires, the Contractor shall assist the DHH-OBH in the transition of its Members to another Contractor at the Contractor's own expense.
- c. The Contractor shall cooperate with the DHH-OBH during the planning and transition of contract responsibilities from the Contractor to a replacement Contractor or the DHH-OBH. The Contractor shall ensure that Member services are not interrupted or delayed during the remainder of the contract and the transition planning by all parties shall be cognizant of this obligation. The Contractor shall:
 - i. Make provisions for continuing all management and administrative services and the provision of services to Members until the transition of all Members is completed and all other requirements of this contract are satisfied.
 - ii. Designate the program manager for the contract as the transition coordinator. The transition coordinator shall interact closely with the DHH-OBH and the staff from

- the new Contractor to ensure a safe and orderly transition and shall participate in all transition meetings.
- iii. Upon DHH-OBH request submit for approval a detailed plan for the transition of its Members, including the name of the transition coordinator.
 - iv. Provide all reports set forth in this contract and necessary for the transition process.
 - v. Notify providers, subcontracts and Members of the contract termination, as directed by DHH-OBH, including transfer of provider network participation to DHH-OBH or its designee.
 - vi. Complete payment of all outstanding obligations for covered services rendered to Members. The Contractor 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.
 - vii. Cooperate fully with a successor Contractor and DHH-OBH during Transition Period including, at a minimum, sharing and transferring behavioral health Member information and records, as required by the DHH-OBH.
 - viii. Transfer the toll-free call center line telephone numbers to DHH-OBH or the successor Contractor to allow for the continuous use of the number for Member services and provider services numbers.
 - ix. Return to the DHH-OBH within thirty (30) days of termination of the contract any funds advanced to the Contractor for coverage of Members for periods after the date of termination to the DHH-OBH within thirty (30) days of termination of the contract. Supply all information necessary for reimbursement of outstanding claims.
- d. 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 Contractor or the DHH-OBH and shall include the following:
- i. A realistic schedule and timeline to hand-off responsibilities to the replacement Contractor or the DHH-OBH.
 - ii. The 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 Contractor, the replacement Contractor and/or the DHH-OBH.
 - iii. The actions that shall be taken by the Contractor to cooperate with the replacement Contractor and/or the DHH-OBH to assure a smooth and timely transition.
 - iv. The Contractor shall develop a plan on how to best inform and keep Contractor employees during the transition.
 - v. A matrix listing each transition task, the functional unit and the person, agency or Contractor responsible for the task, the start and deadline dates to complete the planned task, and a place to record completion of the task.
 - vi. All information necessary for reimbursement of outstanding claims.
- e. The Contractor shall report, in writing, to the State Contract Monitor and within 48 hours, any problems and corrective actions taken regarding the plan for transition.
- f. The Contractor shall participate in a transition planning team as established by the DHH-OBH. The Contractor'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.

- g. The Contractor shall complete all work in progress and all tasks called for by the plan for transition prior to final payment to the Contractor. If it is not possible to resolve all issues during the end-of-contract transition period, the Contractor shall list all unidentified or held items that could not be resolved, including reasons why they could not be resolved, prior to termination 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 the performance bond. The Contractor shall specify a process to brief the DHH-OBH or replacement Contractor on issues before the hand-off of responsibilities.
- h. The expiration or termination or suspension shall not affect the obligation of the Contractor to indemnify the DHH-OBH for any claim by any third party against the State or the DHH-OBH arising from the Contractor's performance of this contract and for which the Contractor would otherwise be liable under this contract.
- i. The Contractor shall stop all work as of the effective date contained in the Notice of Termination and shall immediately notify all management subcontracts, in writing, to stop all work as of the effective date of the Notice of Termination. Upon receipt of the Notice of Termination, and until the effective date of the Notice of Termination, the Contractor shall perform work consistent with the requirements of this contract and in accordance with a written plan approved by the DHH-OBH for the orderly transition of Members to another Contractor. Unless otherwise directed by the DHH-OBH, the Contractor shall direct subcontracted providers to continue to provide services consistent with the Member's treatment plan or plan of care.

13. Administrative Organization

- a. The Contractor shall have organization, management and administrative systems capable of meeting all contract requirements. The Contractor shall operate the program through an entity authorized to do business in Louisiana and located in the City of Baton Rouge, within (10) miles of the DHH Office Building located at 628 N. 4th St. Baton Rouge, LA 70802, to assure rapid access for monitoring and communication purposes.
- b. The Contractor shall maintain a significant and sufficient local presence in the State to operate the SMO.
- c. The Contractor's organizational structure shall be of sufficient size and scope to efficiently and effectively manage the contract requirements. The Contractor shall require that all staff have the training, education, experience, orientation, and credentialing, as applicable, to perform assigned job duties. The Contractor shall maintain current organization charts and written job descriptions for each functional area consistent in format and style.
- d. The Contractor shall not knowingly have a relationship with any individual or company that has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activities or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 and 42 CFR §438.610(a) and (b). A relationship is defined as follows: a director, officer, or partner of the Contractor; a person with beneficial ownership of five percent or more of the Contractor's equity; or a person with an employment, consulting or other arrangement with the Contractor obligations under

its contract with the State. In addition, the Contractor may not contract with provider excluded by the State, Medicare, Medicaid or CHIP, except for emergency services.

- e. The Contractor shall employ the following Key Personnel to work full-time at sites located within Louisiana, the city of Baton Rouge, within (10) miles of the DHH Office Building located at 628 N. 4 St., Baton Rouge, LA 70802.
 - i. Chief Executive Officer (CEO) who shall have ultimate responsibility for the management of the Contractor and compliance with Federal and State laws and the requirements in this Contract, including all documents incorporated by reference. The Chief Executive Office shall have at least ten (10) years experience with management of behavioral health services of organizations similar in size and responsibility to the requirements of this RFP.
 - ii. Chief Financial Officer (CFO) shall be a certified public accountant with experience and demonstrated success in managed behavioral health care responsible for effective implementation and oversight of the budget, accounting systems, and all financial operations of the Contractor in compliance with Federal and State laws and the requirements set forth in this Contract, including all documents incorporated by reference.
 - iii. The Chief Medical Officer (CMO) shall have a Louisiana license as a physician, board-certified in psychiatry, and have responsibility for the effective implementation of all clinical-medical programs, the QM and UM program in compliance with Federal and State laws and the requirements set forth in this Contract, including the documents incorporated by reference. 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. These positions shall have the responsibility for effective implementation of the QM program and the UM of services and associated appeals as these functions relate to children and youth, and adults with SMI and/or addictive disorders. Additionally, the CMO shall be involved in:
 - (a) Development, implementation, and interpretation of clinical-medical policies and procedures.
 - (b) Physician recruitment and supervision.
 - (c) Decision making process for approval and denial of provider credentialing.
 - (d) Provider profile design and interpretation.
 - (e) Administration of all utilization management and quality management activities.
 - (f) Continuous assessment and improvement of the quality of care provided to Members.
 - (g) Development and implementation of the QM/UM plan and serve as the chairperson of the QM, UM, and Peer Review Committees with oversight of other medical/clinical committees.
 - (h) Provider education, in-service training and orientation.
 - (i) Attendance at regular (at least quarterly) DHH-OBH designated medical director meetings, including linkage with the CCN Medical Directors for primary care.
 - iv. Medical Administrator shall have a Louisiana license as a physician, board-certified in either general psychiatry or child psychiatry, complementary 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 significant experience providing services to children and youth.

- v. Chief Operations Officer shall meet the requirements for a LMHP and have at least seven (7) years experience in managing behavioral health care operations. The Chief Operations Officer shall have responsibility for clinical program development and oversight of personnel and services related to the delivery of covered mental health and addiction services to children/youth, adults with serious mental illness and/or with addictive disorders in compliance with Federal and State laws and the requirements set forth in this Contract, including all documents incorporated by reference. The Chief Operations Officer shall also assume the role of Adult System Administrator.
 - vi. The Chief Medical Officer and the Chief Operations Officer shall have joint responsibility to manage the Contractor's behavioral health service delivery system.
 - vii. The Contractor shall hire a Children's System Administrator who shall 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 in or at risk of out of home placement and involved with multiple child-serving agencies, such as but not limited to: child welfare, juvenile justice, schools, mental health and addictions. The ideal candidate will have at least three (3) years experience with delivering or managing EBP and best practices for children and youth, including experience with implementing the principles outlined for the CSOC in this RFP. The Children's System Administrator shall work closely with the CSOC Governance, DHH-OBH, and the WAA to implement 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.
- f. Contractor shall provide the DHH-OBH upon request with the opportunity to pre-approve Key Personnel prior to hire. The Contractor shall immediately verbally inform the DHH-OBH and provide written notice within seven (7) days after the date of a resignation or termination of any of the Key Personnel listed above, including the name of the interim contact person that will be performing the Key Personnel Member's duties. In addition, upon request, the Contractor shall submit a written plan for replacing Key Personnel, including expected time lines. If Key Personnel 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 Contractor shall notify the DHH-OBH within seven (7) days after the date of notification by the key personnel of the change in availability or change in full-time employment status.
- g. In addition to the Key Personnel described above, the Contractor shall have the following Required Personnel, to work full-time at sites located within Louisiana, the city of Baton Rouge, within (10) miles of the DHH Office Building located at 628 N. 4 St., Baton Rouge, LA 70802, including:
- i. Corporate Compliance Administrator: is responsible for oversight, administration and implementation of the Contractor's Compliance Program. The Compliance Administrator coordinates the Corporate Compliance

Committee, oversees all audits related to the Contract, regulatory and policy and procedure compliance and collaborates with the DHH Fraud and Abuse program. 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 Section 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.

- ii. 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, 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.
- iii. Quality Management Administrator: is a LMHP responsible for the development of the Contractor's QM/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. The Quality Management Administrator shall have significant experience and expertise in the oversight of effective quality improvement public sector programs and managed behavioral health care delivery systems.
- iv. Network Development Administrator: 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 Development Administrator shall be a LMHP with significant 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 for out of home placement), and 2) adults with SMI and/or addictive disorders. The Network Development Administrator shall be responsible for network development, contracting, credentialing and provider communications.
- v. Network Management Administrator: is a LMHP 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 review provider profiles and implements and monitors corrective action plans as needed; and assures accuracy of provider service delivery reports (e.g., encounter information verification). The Network Management Administrator shall have significant experience and expertise in the management of 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 addictive 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 addictive disorders.
- vi. Member Services Administrator: is responsible for the timely telephone access of eligible individuals to the managed behavioral healthcare delivery system and triage of all calls including information inquiries, services requests, crisis calls, grievances and appeals issues. 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.
 - vii. Information System Administrator: is responsible for oversight of the management information systems requirements, and compliance with Federal and State laws and the requirements in this Contract, including all documents incorporated by reference. The Information Systems Administrator shall have significant experience and expertise in behavioral health data systems and is responsible for all data interfaces and supporting the reporting requirements required by this Contract.
 - viii. Claims/Encounters Administrator: is responsible for oversight of timely and accurate claims and encounters processes. The Claims/Encounters Administrator shall have significant experience and expertise in process 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 (e.g., child welfare, juvenile justice, education).
 - ix. Grievances and Appeals Administrator: shall have experience pertinent to the resolution of grievances and appeals. The Grievances and Appeals Administrator is responsible for timely processing of grievances, appeals 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 QM/UM Committee. The Contractor shall not permit its in-house legal counsel, corporate attorney or risk management attorney to act as or supervise its Grievances and Appeals Administrator.
- h. In addition to the Key Personnel and Required Personnel, the Contractor shall have sufficient number of qualified supporting staff to meet the responsibilities of this Contract, including sufficient experience and expertise in working with the eligible Members served under this Contract: 1) all children and youth, including those served by multiple child-serving agencies (child-welfare, OJJ, schools, behavioral health) in, or at risk of out of home placements ; 2) adults with SMI, addictive disorders and co-occurring disorders of SMI and addictions. The Contractor shall have a sufficient number of the staff at a minimum in the following categories and shall provide DHH-OBH with the staffing formula:
- i. Care management and UM staff to review and authorize behavioral health care twenty-four (24) hours per day, seven (7) days per week and to coordinate inpatient certification/recertification of need, prior authorization, concurrent review and retrospective review; and provide ongoing care management and intensive care management for Members when medical necessity.

- ii. Behavioral health advisors, who meet the criteria for one of the following categories, to provide utilization review and consultation on Member treatment plans and CSoC Member plans of care:
 - a) Psychiatrists who are board certified in child and adolescent psychiatry and/or addiction psychiatry.
 - b) Primary care physicians who are board certified in addiction medicine.
 - c) Clinical and medical psychologists.
- iii. Quality management staff to oversee the implementation of the Contractor's QM/UM Plan and to track, review, and investigate critical incidents and accidents, morbidities, mortalities, and other quality of care issues.
- iv. Provider services staff to coordinate communications between the Contractor and its subcontracts and to ensure providers receive prompt resolution to their problems or inquiries and appropriate education about participation in the provider network.
- v. Provider network staff to train providers on 1) compliance with billing and documentation requirements; 2) evidence-based and best practices; 3) CSoC mission, goals and care coordination strategies; and 4) other areas identified in the Contractor's Quality Management and provider profiling program.
- vi. Member services staff to respond to telephonic requests for information and assist with resolution of grievances in a timely manner.
- vii. Grievance and appeals staff to timely and accurately process grievances by Members, appeals, and provider claims disputes and to be available to testify or present evidence at administrative hearings and other court proceedings.
- viii. Claims processing staff to ensure the timely, accurate, and complete processing of original claims, resubmissions of claims that were not accepted by the Contractor, and overall claim adjudication.
- ix. Encounter processing staff to ensure the timely, accurate and complete submission of encounter data to DHH-OBH and to correct and resubmit encounter data.
- x. A sufficient number of qualified staff to develop, implement, measure, and report on the performance and reporting requirements.
- xi. Data analysts to collect and analyze and assure the accuracy of encounter data from sub-contracted providers and other information regarding the Contractor's performance.
- xii. Human resources staff, to ensure ongoing hiring and recruitment of staff keep pace with personnel needs and to assure personnel disputes are handled fairly and quickly to avoid an unnecessary, negative impact on morale.
- xiii. Clerical and administrative support staff to facilitate the effectiveness of the Contractor's operations.
- xiv. At the minimum but not limited to, staff to provide the following liaison activities:
 - a) Medicaid eligibility.
 - b) DCFS, OJJ and DHH-OBH eligibility.
 - c) Health plan liaison.
 - d) 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.
 - e) Tribal liaison that is the single point of contact regarding delivery of covered services to Native Americans.
 - f) Consumer and family organizations for children, youth and adults.

- i. The Contractor shall provide a Human Resources and Staffing Plan that describes how the Contractor will maintain the staffing level to ensure the successful accomplishment of all duties outlined in the contract. The Key Personnel and Required Personnel listed in the RFP are required. The Contractor may propose a staffing plan that combines positions and functions outlined in the RFP for other positions as long as the Contractor describes how the Table of Organization and staff roles delineated in the RFP will be addressed.
- j. All personnel necessary to carry out the terms, conditions, and obligations of this contract are the responsibility of the Contractor. The Contractor shall recruit, hire, train, supervise and, if necessary, terminate such professional, paraprofessional and support personnel as are necessary to carry out the terms of this contract.
- k. The Contractor shall provide DHH-OBH staff currently performing managed behavioral health care functions preference for vacant Louisiana-based positions during the contract term.
- l. The Contractor shall be responsible for compliance with all Contract requirements, regardless of whether the Contractor enters into a subcontract to delegate performance of the Contract requirements. Prior to selecting a subcontract, the Contractor shall evaluate the prospective subcontract's ability to perform the activities to be delegated. The Contractor shall monitor and formally review a subcontract's performance on an ongoing basis.

C. Liquidated Damages

In the event the Contractor fails to meet the performance standards specified within the contract, the liquidated damages defined below may be assessed. If assessed, the liquidated damages will be used to reduce DHH-OBH's payments to the Contractor or if the liquidated damages exceed amounts due from DHH-OBH, the Contractor will be required to make cash payments for the amount in excess.

- a. Late submission of any required report required in this RFP - \$50 per working day, per report.
- b. Failure to fill vacant key staff positions required by this RFP within 60 days - \$250 per working day from the 61st day of vacancy until filled up or from the 91st day - \$500 per working day from 91st day of vacancy until filled with an employee approved by DHH-OBH.
- c. Other Performance guarantees as listed in Table 12 below. The percent of administrative fees at risk totals twenty percent (20%). Reconciliation of the performance guarantees will occur annually.

Table 12: Performance Guarantees

Item #	Percent of fees at risk: 20% of Administrative fees Reconciliation: Annually	Standard	Risk Allocation by Measure Expressed as a Percentage of Fees at Risk
	Measure		
	Claims administration		6%

Item #	Percent of fees at risk: 20% of Administrative fees Reconciliation: Annually Measure	Standard	Risk Allocation by Measure Expressed as a Percentage of Fees at Risk
1.	Financial payment (dollar) accuracy – 97% of audited claim dollars paid accurately <ul style="list-style-type: none"> - Percentage of audited claim dollars paid accurately. - Calculated as the total audited “paid” dollars minus the absolute value of over-and/or under- payments, divided by the total audited paid dollars. - Measurement using monthly system-generated reports. 	97%	1%
2.	Procedural accuracy - 99% of audited claims processed without procedural error; <ul style="list-style-type: none"> - Calculated as the total number of audited claims minus the number of claims processed with procedural error, divided by the total number of audited claims. - Measurement using monthly system generated reports. 	99%	1%
3.	Turn-around-time (TAT) – 95% of clean claims paid to all providers within 30 claim means 1) a bill for services; 2) a line item of services or 3) all services for one recipient within a bill <ul style="list-style-type: none"> - “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 Contractor’s claim 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. - Measurement is percent paid within time frame specified using monthly system-generated reports. - The date receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. 	95%	2%
4.	TAT – 99% of all provider claims paid within 45 days <ul style="list-style-type: none"> - “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 Contractor’s claim 	99%	2%

Item #	Percent of fees at risk: 20% of Administrative fees Reconciliation: Annually Measure	Standard	Risk Allocation by Measure Expressed as a Percentage of Fees at Risk
	<p>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.</p> <ul style="list-style-type: none"> - Measurement is percent paid within time frame specified using monthly system-generated reports. 		
Telephone responsiveness			2%
5.	<p>Call Abandonment Rate - Member/ Provider Services Line(s) less than 3 percent</p> <ul style="list-style-type: none"> - Percentage of calls that reach the 800 line and are placed in queue but are not answered because the caller hangs up before a representative answers the call. - Measured using monthly system-generated reports. 	< 3%	0.5%
6.	<p>Average Speed to Answer (ASA) – Member/Provider Services Line(s) all calls answered within 30 seconds</p> <ul style="list-style-type: none"> - Measured using monthly system-generated reports from first ring to live answer on 24/7 single point of entry 800 line. 	30 seconds	1.5%
Clinical			8%
7.	<p>Ambulatory follow up within 7 days of discharge from 24-hour facility</p> <ul style="list-style-type: none"> - Report percent of individuals discharged from a 24 hour facility with an ambulatory follow-up appointment within 7 days of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported quarterly as percent with follow-up within specified timeframe. 	Above HEDIS 50th percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	1.5%
8.	<p>Ambulatory follow up within 30 days of discharge from 24-hour facility</p> <ul style="list-style-type: none"> - Report percent of individuals discharged from a 24 hour facility with an ambulatory follow-up appointment within 30 days of discharge of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported quarterly as percent with 	Above HEDIS 50th percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	1.5%

Item #	Percent of fees at risk: 20% of Administrative fees Reconciliation: Annually Measure	Standard	Risk Allocation by Measure Expressed as a Percentage of Fees at Risk
	follow-up within specified timeframe.		
9.	Readmission Rate – less than 12 percent of Members readmitted within 30 days to same acute level of care <ul style="list-style-type: none"> - Measurement using system-generated reports. - Percentage of Members readmitted (to the same level of care) within 30 days of the discharge date from an acute level of care for any psychiatric or substance abuse diagnosis. 	< 12%	3%
10.	Percent of adult high service users (two or more IP admissions or four ER visits in a year) enrolled in an assertive community treatment program or psychosocial rehab. (Source: Schizophrenia PORT, 1998, McEwan & Goldner 2002; APA, 1999) <ul style="list-style-type: none"> - Measurement to be based on claims data, designed with input from Vendor. 	> 90%	2%
	Satisfaction		2%
11.	Annual Member Satisfaction Survey: 90% positive response rate <ul style="list-style-type: none"> - Members shall rate “satisfied” or better on the annual Member satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options. - Survey domains to include client/family involvement and choice in treatment planning. - The sampling methodology must yield a 95% confidence interval with +5% error rate, including response rate as a factor. 	90%	1%
12.	Annual Provider Satisfaction Survey: 85% positive response rate <ul style="list-style-type: none"> - Providers shall rate “satisfied” or better on the annual Provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options. - The sampling methodology must yield a 95% confidence interval with +5% error rate, including response rate as a factor. 	85%	1%
	Account Management		2%
13.	Timely completion of Implementation or Annual Plan Milestones:	90%	2%

Item #	Percent of fees at risk: 20% of Administrative fees Reconciliation: Annually Measure	Standard	Risk Allocation by Measure Expressed as a Percentage of Fees at Risk
	<ul style="list-style-type: none"> - Compliance measured as the number of milestones satisfactorily completed according to DHH by the date specified in the implementation schedule or annual project schedule as a percent of all milestones that were due under the implementation plan during the quarter. - Contractor to provide specific plans for review and approval by DHH. - Milestones not met in one quarter carry over into next quarter for evaluation. Milestones carried over. - Milestones missed due to factors beyond Contractor control will not be counted in measurement. 		

- a. The decision to impose liquidated damages may include consideration of some or all of the following factors:
 - i. The duration of the violation.
 - ii. Whether the violation (or one that is substantially similar) has previously occurred.
 - iii. The Contractor's history of compliance.
 - iv. The severity of the violation and whether it imposes an immediate threat to the health or safety of the consumers.
 - v. The "good faith" exercised by the Contractor in attempting to stay in compliance.

D. Fraud and Abuse

The Contractor shall confirm that its officers understand this Contract involves the receipt by the Contractor of State and federal funds. Further, the Contractor'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.

1. The Contractor shall submit its written Fraud and Abuse Compliance Plan to the DHH-OBH during the implementation period process for approval by the DHH-OBH and annually thereafter by June 30 each year. Requests for revision(s) to the Plan shall be submitted in writing to and approved in writing by the DHH-OBH at least thirty (30) days prior to implementation of such revision(s). The Fraud and Abuse Compliance Plan shall include the following:
 - a. 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.
 - b. 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.
 - c. 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 Contractor contracts.

- d. The designation of a compliance officer and a compliance committee that is accountable to senior management and requirements for an adequately staffed compliance office.
 - e. Effective education for the compliance officer, the organization's employees, Contractor providers and Members about fraud and abuse and how to report it.
 - f. Effective lines of communication between the compliance officer and the Contractor employees, Contractors, providers and the DHH-OBH and/or its designee. and
 - g. The Contractor shall ensure that the DHH-OBH's toll-free Provider Compliance Hotline number and accompanying explanatory statement is distributed to its Members and Providers through its Member and Provider handbooks.
2. The Contractor 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 in accordance with the requirements specified in this contract. These written policies, procedures; and standards of conduct that articulates the Contractor's commitment to comply with all applicable federal and state standards and regulations shall include the following:
- a. Enforcement of standards through well-publicized disciplinary guidelines (e.g., Member/provider manuals, trainings, or newsletters, bulletins).
 - b. Provisions for internal monitoring and auditing of the Contractor's providers, subcontractors, employees, and others.
 - c. Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this Contract.
 - d. Procedures for timely and consistent exchange of information and collaboration with DHH- Program Integrity , Attorney General Medicaid Fraud Control Unit (MFCU), and contracted EQRO regarding suspected fraud and abuse occurrences.
 - e. The Contractor 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). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers.
 - f. The Contractor shall establish a policy on referral of suspected Fraud and Abuse to the DHH Program Integrity. A standardized referral process will be developed to expedite information for appropriate disposition. At a minimum, the Contractor shall

report the number of complaints of fraud and abuse made to the state that warrant preliminary investigation. For each complaint which warrants investigation, supply the name and identification number, source of the complaint, type of provider, nature of complaint, approximate dollars involved, and legal and administrative disposition of the case.

- g. The Contractor's Fraud and Abuse policies and procedures shall provide and certify that the Contractor'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 the DHH-OBH for approval during the implementation period and then thirty (30) days prior to whenever material changes occur. The Contractor's submission of new or revised policies and procedures for review and approval by the DHH-OBH shall not act to void any existing policies and procedures which have been prior approved by the DHH-OBH for operation. Unless otherwise required by law, the Contractor may continue to operate under such existing policies and procedures until such time as the DHH-OBH approves the new or revised version thereof. The Contractor shall develop a certification process that demonstrates the policies and procedures were reviewed and approved by the Contractor's senior management. The Contractor shall, in order to remain in compliance with the Agreement, comply with its Fraud and Abuse policies and procedures.
- 3. The Contractor shall create and disseminate written materials for the purpose of educating employees, managers, providers, subcontracts and subcontracts' employees about health care Fraud laws, the Contractor's policies and procedures for preventing and detecting Fraud and Abuse and the rights of employees to act as whistleblowers. The Contractor's education shall comply with all requirements of 1902(a) (68) Employee Education About False Claims Recovery.
- 4. The False Claims Act ("FCA") provides, in pertinent part, that:
 - a. Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a Member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus three times the amount of damages, which the Government sustains because of the act of that person.
 - b. For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of

the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

5. 31 U.S.C. § 3729. While the FCA imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person, who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).
6. In sum, the FCA imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government Contractor who submits records that he knows, (or should know), is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.
7. In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as “qui tam relators,” may share in a percentage of the proceeds from an FCA action or settlement.
8. Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15% but not more than 25% of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d) (2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25% and not more than 30%.
9. The FCA provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees.
10. The Contractor will require that all providers and all subcontracts take such actions as are necessary to permit the Contractor to comply with the Fraud and Abuse requirements listed in this Contract. To the extent that the Contractor delegates

oversight responsibilities to a third party, the Contractor shall require that such third party complies with provisions above, of this Contract relating to Fraud and Abuse. Although all providers with whom the Contractor subcontracts are enrolled in the program and subject to regulations, the Contractor agrees to require, via contract, that such providers comply with regulations and any enforcement actions directly initiated by the DHH-OBH under its regulations, including but not limited to termination and restitution.

11. The Contractor and its employees shall cooperate fully with centralized oversight agencies responsible for Fraud and Abuse detection and prosecution activities. 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.
12. The Contractor shall immediately report to the 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 be fraudulent.
13. The DHH-OBH will seek all appropriate remedies for fraud, abuse and violation of law if it determines that a Contractor, provider, employee, or subcontract has committed "Fraud" or "Abuse" as defined in this Agreement or has otherwise violated applicable law.

E. Technical Requirements

1. Information management, analysis and reporting are essential to the effective and efficient operation of the Contractor and to fulfilling state and federal reporting requirements for Medicaid, SGF, and grants, including the mental health and substance abuse federal block grants. The Contractor's information system shall support the following key functions:
 - a. Twenty-four (24) hour, seven (7) days a week toll free telephone access line user and technical support.
 - b. Member services (including eligibility for all programs operated under the SMO).
 - c. Management of care.
 - d. Quality management.
 - e. Grievances and appeals.
 - f. Provider network management.
 - g. Member rights and responsibilities.
 - h. Financial reporting Claims payment for non-capitated services.
 - i. Encounter tracking and submissions for capitated services.
 - j. Implementation planning.
 - k. Business continuity, disaster recovery and emergency preparedness.
 - l. Performance measurement and accountability.
 - m. State and federal reporting requirements described below.
 - n. Secure electronic data interchange as needed to accomplish the above functions, operation of the DHH-OBH data warehouse, and state access to client-level data for DCFS, DOE, and OJJ.
 - o. Secure online web-based portal that allows providers and the State agencies (DCFS, DOE, DHH-OBH, and OJJ) to submit and receive responses to referrals and prior authorizations for services.

2. The Contractor shall have the capacity to collect, analyze, electronically and securely transfer, report, and utilize data from multiple service provider sources, and the capacity to adapt and upgrade these functions as necessary with future changes to the service and administrative operations of the CSoC and the BHS program for children and adults.
3. The Contractor 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, as well as other similar reports on Member pharmacy utilization for quality management purposes.
4. The Contractor shall have the capacity to monitor and analyze utilization data for individuals not enrolled as members of the SMO, but receive their behavioral health services from other sources (e.g., FQHC/RHC, CCN). DHH will provide utilization data to the Contractor. The Contractor shall work closely with DHH-OBH and DHH-BHSF to identify costs, utilization trends and quality of care issues.
5. The Contractor shall provide a comprehensive, integrated, secure Internet-based behavioral health information management system (IMS) which supports: 1) the functions of the public behavioral health system; 2) DHH-OBH as the operating agency of the CSoC; 3) interface with the other child-serving agencies financing the CSoC (DCF, DOE, OJJ); 4) the Louisiana Behavioral Health Services Medicaid program; 5) the CSoC; and 6) all subcontracting providers. The Proposer shall work closely with DHH, DHH-OBH, DHH-BHSF and stakeholders on an ongoing basis to assure implementation, operation, and maintenance of this critical information resource. The IMS shall provide the following 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 Medical Information System (MMIS) for Medicaid claims processing, reporting, and auditing.
 - a. The IMS shall support 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 Contractor shall utilize current state and federal standards and procedures (e.g., HL7; HIPAA; CMS; CPT; ICD-10) for this system and will maintain a uniform service and provider (credentials) taxonomy for billing and information management purposes. The Contractor shall provide technical assistance and consultation to providers on establishing the means for effective, ongoing electronic collection and transfer of required data.
 - b. The scope of coverage of the IMS will be for all programs and services provided through the Contractor.
 - c. 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); service 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 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 (i.e., SAMHSA) for data content.
- d. The Contractor will be expected to at least bi-weekly update and transfer this dataset 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. The Contractor will be expected to provide DHH-OBH current documentation of the data set, process, and procedures.
 - e. The Contractor shall be responsible for maintaining standardized data collection process and procedures and provide training and support of all provider staff.
 - f. The Contractor 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.
 - g. The Contractor shall maintain disaster recovery and business continuity of this system, as well as the provisions for the state to have continued access to and use of these data in the event of a separation of service with the contracted Contractor.
6. The Contractor shall provide a secure electronic data interface for the OBH behavioral health data warehouse of client-level, standardized data, for purposes of state and federal reporting (e.g., SAMHSA Uniform Reporting System (URS)/National Outcome Measures (NOMS), 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 (as outlined in the Quality Management Strategy). The Contractor shall provide data to meet federal reporting requirements for the Community Mental Health (CMHS) and Substance Abuse Prevention and Treatment (SAPT) federal 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 OBH and its contractor and stakeholders to assure effective design, implementation, and ongoing operation of the OBH data warehouse.
- a. The client level data electronically transferred to the OBH behavioral health data warehouse shall be well-documented (data dictionary; data structure schema and foreign keys). Documentation will be kept current and accurate.
 - b. The Contractor shall be responsible for training and support regarding the content and access to the client data.
 - c. 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) and will be in keeping with DHH-OBH and national (SAMHSA) standards.
 - d. The Contractor shall provide an integrated behavioral health reporting store that supports the capacity for ad hoc as well as production-type reporting. The Contractor shall have the capacity to provide documented client level data sets, as needed, by the State for its own analyses and reporting. The types of reports the Contractor shall provide include but not limited to:
 - i. 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:

- ii. Utilization/cost outliers that trigger notice for follow-up action.
 - iii. 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 levels of care.
 - iv. Services rendered and appropriately paid, based upon linkage of raw claims data to authorizations.
 - v. Dashboard-type quality management and performance reporting, as well as standard tabular and graphical reporting.
 - vi. Data Certifications: Data submitted by the Contractor including, but not limited to, all documents specified by DHH, encounter 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 Contractor shall submit the certification concurrently with the certified data and documents. All data and documents requiring certification the Contractor submits to DHH-OBH shall be certified by one of the following:
 - (a) Contractor's Chief Executive Officer.
 - (b) Contractor's Chief Financial Officer.
 - (c) An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.
7. The Contractor shall track and report to DHH-OBH all Medicaid payments and service encounters distinguished from other payment sources. At a minimum the Medicaid data must differentiate between State Medicaid Plan services, 1915(b) waiver services, and 1915(c) waiver services.
8. The Contractor shall provide an integrated behavior 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: CSOC 1915(c) performance measures, Client quality-of-care surveys (e.g., the MHSIP adult and YSS-F parent surveys required by SAMHSA and now used by the state), client self-assessment outcome measures (e.g., the Telesage Outcome Measurement System (TOMS); Client Behavior Checklist (CBCL), both used by the state), and clinical/functional provider assessment instruments (e.g., Addiction Severity Index (ASI); Level of Utilization System (LOCUS/ CALOCUS/CANS), as now utilized by the state; the Comprehensive Adolescent Severity Inventory (CASI), which is the adolescent addiction assessment tool; and The American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC) which is the Addiction equivalent to the LOCUS and CALOCUS. In addition to the care management record, these measurement data shall be stored in client-level form in the above referenced data warehouse.
9. The Contractor shall provide an integrated claims processing and payment system for Medicaid and all other funding sources providing services within the CSOC. This system will have the capability to perform eligibility, billing, accounts receivables, accounts payable, remittance advices, prior authorization, fiscal management, provider enrollment, etc. for Medicaid and all state funding sources.
10. The Contractor shall maintain a SMO website, with both public and secure access

multi-level portals (such as providers, managers and recipients), for providing data/measure manuals, web-based training, standard reports, CANS tool, and data access as needed for the effective management and evaluation of the performance of the Contractor and the service delivery system including the Wraparound Agencies. The website may be combined with the Member Services website required under the Member Services requirements of this Contract.

11. The Contractor shall conform to HIPAA-compliant standards. Transaction types are subject to change and the Contractor shall timely comply with applicable federal and HIPAA standards and regulations as they occur.
12. The Contractor shall plan for changes such as, but not limited to the new ANSI 5010 formats and implementation of ICD10 diagnosis and inpatient procedure codes.
13. The Contractor 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-OBH 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).
14. The Contractor shall not revise or modify the standardized forms or formats without agreement of all parties.
15. The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms.
16. The Contractor shall ensure that ninety percent (90%) of clean claims for payment of services delivered to a Member are paid by the Contractor to the provider within thirty (30) calendar days of the receipt of such claims. Process and if appropriate, pay within ninety (90) calendar days, ninety-nine percent (99%) of all provider claims for covered services delivered to a Member.
 - a. If a claim is partially or totally denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation.
 - b. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the timeframe for claims processing.
17. On every claim processing day, the Contractor shall utilize a randomly selected sample of all processed, adjusted, and paid or denied claims. A minimum sample of two percent of those daily claims shall be audited. Results from the audits shall be collected and reported to DHH-OBH monthly. The minimum attributes to be tested for each claim selected shall include:
 - a. Claim data correctly entered into the claims processing system with an assigned transaction number.
 - b. Claim is associated with the correct provider.
 - c. Service obtained the proper authorization.
 - d. Authorization limits are not exceeded.
 - e. Member eligibility at processing date correctly applied.
 - f. Allowed payment amount agrees with contracted rate.

- g. Duplicate payment of the same claim has not occurred.
 - h. Denial reason applied appropriately.
 - i. Co-payment application considered and applied.
 - j. Effect of modifier codes correctly applied.
 - k. Proper coding consistent with the provider's credentials.
 - l. Adjustments to claims are properly made with supporting documentation.
 - m. Payment is coordinated properly when other insurance is applicable.
18. The results of testing, at a minimum, should be documented to include:
- a. Results for each attribute tested for each claim selected.
 - b. Amount of overpayment or underpayment for each claim processed, adjusted or paid in error.
 - c. Explanation of the erroneous processing for each claim processed, adjusted or paid in error.
 - d. 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.
 - e. Claims processed, adjusted or paid in error have been corrected.
19. The Contractor shall perform front end system edits, including, but not limited to:
- a. Confirming eligibility on each Member as claims are submitted on the basis of the eligibility information provided by DHH-OBH, DCFS, DOE, and OJJ that applies to the period during which the charges were incurred.
 - b. Medical necessity – the system shall validate that medical necessity was determined.
 - c. Prior approval – the system shall determine whether a covered service required prior approval and if so, whether the Contractor granted such approval.
 - d. Duplicate claims – the system shall in an automated manner, flag a claim as being exactly the same as a previously submitted paid claim or a possible duplicate and either deny or pend the claim as needed.
 - e. Covered services - ensure that the system can verify that a service is a covered service and is eligible for payment.
 - f. 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.
 - g. Quantity of service - ensure that the system shall evaluate claims for services provided to Members to ensure that any applicable benefit limits are applied.
 - h. System edits for valid dates of service, and assures that dates of services are valid dates such as not in the future or outside of a Member's Medicaid eligibility span.

The Location of claims processing staff shall be indicated and shall be at minimum located in the continental United States.

F. Subcontracting

The Contractor shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of the DHH-OBH. The Contractor shall not substitute any subcontract without the prior

written approval of the DHH-OBH.

The Contractor shall oversee and hold subcontracts accountable for any functions and responsibilities that it delegates. The Contractor shall have credentialing and re-credentialing policies consistent with federal and state regulations. The Contractor shall evaluate the prospective subcontract's ability to perform the activities to be delegated.

The Contractor is not obligated to contract with any provider unable to meet contractual standards. In addition, the Contractor is not obligated to continue to contract with a provider who does not provide high quality services or who demonstrates utilization of services that are an outlier compared to peer providers with similarly acute populations and/or compared to the expectations of the Contractor and State. The Contractor's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

The Contractor shall have a written contract that specifies the activities and report responsibilities delegated to the subcontract; and provides for revoking delegation, terminating contracts, or imposing other sanctions if the subcontract's performance is inadequate. The Contractor shall monitor all subcontracts' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The Contractor shall identify deficiencies or areas for improvement, and the subcontract shall take corrective action.

For subcontract(s), before commencing work, the Contractor will provide letters of agreement, contracts or other forms of commitment which demonstrates that all requirements pertaining to the Contractor will be satisfied by all subcontracts through the following:

1. The subcontract(s) will provide a written commitment to accept all contract provisions.
2. The subcontract(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.
3. All subcontracts shall fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.

G. Insurance Requirements and Risk Liability

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.

1. The Contractor 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 Contractor, 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 Contractor from liabilities that might arise out of the performance of the work under this contract by the Contractor, its agents, representatives,

employees, or subcontracts, and Contractor is free to purchase additional insurance.

2. The Contractor 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 the DHH-OBH for approval. The Contractor shall not allow any subcontract to commence work on subcontract until all similar insurance required for the subcontract has been obtained and approved. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the DHH-OBH before work is commenced. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days notice in advance to the DHH-OBH and consented to by the DHH-OBH in writing and the policies shall so provide.
3. Before any work is commenced, the Contractor shall obtain and maintain during the life of the contract, Workers' Compensation Insurance for all of the Contractor's employees employed to provide services under the contract. In case any work is sublet, the Contractor shall require the subcontract similarly to provide Workers' Compensation Insurance for all the latter's employees, unless such employees are covered by the protection afforded by the Contractor. In case any class of employees engaged in work under the contract at the site of the project is not protected under the Workers' Compensation Statute, the Contractor shall provide for any such employees, and shall further provide or cause any and all subcontracts to provide Employer's Liability Insurance for the protection of such employees not protected by the Workers' Compensation Statute.
4. The Contractor shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect Contractor, the DHH-OBH, and any subcontract during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from operations under the contract, whether such operations be by the Contractor or by a subcontract, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to the DHH-OBH. Such insurance shall name the DHH-OBH as additional insured for claims arising from or as the result of the operations of the Contractor or its subcontracts. In the absence of specific regulations, the amount of coverage shall be as follows: Commercial General Liability Insurance, including bodily injury, property damage and contractual liability, with combined single limits of \$1,000,000.
5. Insurance Covering Special Hazards. Special hazards as determined by the DHH-OBH shall be covered by rider or riders in the Commercial General Liability Insurance Policy or policies herein elsewhere required to be furnished by the Contractor, or by separate policies of insurance in the amounts as defined in any Special Conditions of the contract included therewith.
6. Licensed and Non-Licensed Motor Vehicles. The Contractor shall maintain during the life of the contract, Automobile Liability Insurance in an amount not less than combined single limits of \$1,000,000 per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the contract on the site of the work to be

performed there under, unless such coverage is included in insurance elsewhere specified.

7. Subcontract's Insurance. The Contractor shall require that any and all subcontracts, which are not protected under the Contractor's own insurance policies, take and maintain insurance of the same nature and in the same amounts as required of the Contractor.
8. The Contractor shall implement processes for verifying the accuracy and timeliness of reported data, screen the data for completeness, logic, and consistency, and collect service information in standardized formats. The Contractor shall submit timely, accurate, and complete data or shall be subject to corrective action, notice to cure, sanction, or other remedies available under this Contract.
9. The Contractor, by execution of this Contract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this Contract and that all services shall be performed in conformity with the requirements of this Contract by qualified personnel in accordance with standards required by Federal or State law, rules and regulations.

H. Resources Available to Contractor

The Agency/Program name will have an assigned staff Member who will be responsible for primary oversight of the contract. This individual will schedule meetings to discuss progress of activities and problems identified.

I. Contact Personnel

All work performed by the contract will be monitored by the contract monitor:

Joseph E. Comaty, PhD, M.P.
Chief Psychologist/Medical Psychologist
Director-Quality Management Division
Development Section
Office of Behavioral Health
Louisiana Department of Health & Hospitals
P.O. Box 4049 (Bin 12)
628 N. 4th Street
Baton Rouge, LA 70821-4049
Phone: 225-342-8675
Email: BHMANAGE@LA.GOV

J. Term of Contract

The contract shall commence on or near the date approximated in the Schedule of Events. The term of this contract is for a period of 24 months. DHH-OBH reserves the right to renew or extend the contract for up to a maximum of 36 months with the same rates and conditions.

1. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract. Payments made by the State pursuant to this Contract are conditioned upon the availability of funds authorized for expenditure in the manner and for the purposes provided herein.

K. Payment terms

The Contractor shall submit deliverables in accordance with established timelines and shall submit required information for payment as described in the terms below.

1. Non-risk and risk payment for Medicaid Members. In general the Contractor will be paid on a risk basis for adult Medicaid services and on a non-risk basis for all children's Medicaid services. The Contractor is required to pay the fee-for-service fee schedule for all non-risk services. The Contractor shall pay the block grant fee schedules for all non-Medicaid services.
2. Payment for Medicaid-eligible adults. In full consideration of the Contract services rendered by the Contractor, DHH-OBH agrees to pay the Contractor monthly payments based on the number of enrolled Adult Members and other relevant cohort distinctions (age, gender, geographic location, eligibility category, etc.). The Contractor will receive a roster listing Medicaid eligible adults at the beginning of each month and daily files for updates. The Contractor will also receive a capitation payment at the beginning of each month for each Medicaid eligible adult that is not retroactively or spend-down eligible. Actuarially sound capitation rate ranges for the T-XIX Members shall be set by DHH-OBH's actuarial Contractor, using the methodology described in the Overview of Rate Setting Methodology contained in the Procurement Library. The historical data used to set rates can be found in the Data Book in the Procurement Library. The final rates agreed upon by DHH-OBH and the Contractor shall be within these actuarially sound rate ranges.
3. DHH annually enlists an independent actuarial consulting firm to evaluate rates. The capitation rate may be adjusted based on applicable program changes, trend or other actuarial factors that impact rates. The Contractor will be offered a capitation rate at least sixty 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. "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. Actuarially sound capitation rate ranges will be developed for each year of the contract, including in renewal years.
 - a. The Contractor shall perform a cost-benefit analysis for any new adult service it proposes to develop under the capitated rate as cost-effective services per 42 CFR 438.6(e), as directed by DHH-OBH, including whether the proposed service would have an impact on the T-XIX capitation rates or on the non-T-XIX payments.
 - b. The Contractor shall implement those new special services and programs approved by DHH-OBH and CMS (as necessary).

4. 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, or (b) unless the change is necessary to continue to receive federal funds or due to action of a court of law. The Contractor shall receive thirty calendar days notice prior to such changes and the capitation payment shall be adjusted accordingly.
5. Adult Capitation Rates for T-XIX Payment – Schedule.

Payment to the Contractor shall be based on T-XIX enrollment data each month during the term of the Contract. Except for Members with spend-down requirements, Payment for T-XIX 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. Individuals who lose eligibility for T-XIX due to failure to provide eligibility reports on a timely basis, but whose eligibility is consequently re-established prior to the end of the month, will receive a full month of eligibility, and will be reported on the daily eligibility files sent to the Contractor. Payment for these Members will be made with the capitation payments for the next benefit month. Contractors will be given notice if this payment schedule changes.

 - a. Payment will be made based on the number of Members.
 - b. Except for Members with spend-down requirements, all payments to the Contractor for T-XIX will be made for a full month and no pro-rations shall be used.
 - c. T-XIX Members with spend-down requirements and retroactive eligibility will be provisionally eligible for services. The Contractor will receive a roster with those individuals noted at the beginning of each month and daily files for updates. The Contractor shall pay services for spend down individuals and individuals with retroactive eligibility utilizing the State's FFS fee schedule. At the end of each month, the Contractor will submit encounter data and an invoice for the services provided to each spend-down and retroactive eligible beneficiary. The DHH-OBH will reimburse for services provided to these individuals as documented in both the invoice and encounter data on a non-risk basis subject to the non-risk upper payment limit in 42 CFR 447.362. The Contractor may recoup any payments from Members made on behalf of provisional spend-down Members where the Member did not meet spend-down requirements.
 - d. A capitated per Member per month rate for adult Medicaid services shall be based on adult T-XIX enrollment data each month during the term of the Contract. Adult Medicaid per Member per month payment will be made based on the number of adult Members. For all beneficiaries with retroactive eligibility and spend-down requirements retrospective invoicing and settlement for services will occur on a quarterly basis for eligible beneficiaries not receiving a PMPM payment. If quarterly reconciliation for these beneficiaries has a negative impact on the Contractor, DHH-OBH will consider more frequent reconciliations on an ad hoc basis.
6. Recovery of Capitation Rates for T-XIX Services.

DHH-OBH may recover inappropriate Contractor monthly payments when the Contractor actually provided service, if the Member is subsequently determined to be ineligible for the month in question. Consideration may be given in instances where the Contractor has paid for services.

7. Renegotiation of Capitation Rates for T-XIX Services.
 - a. In the event of a reduction in the appropriation from the State budget, DHH-OBH may either renegotiate this Contract or terminate with thirty calendar days written notice. DHH-OBH will confirm current or establish new capitation rates at least sixty calendar days prior to the expiration of the initial term of this agreement and sixty calendar days prior to the expiration of any Contract extensions.
 - b. The Contractor shall have the right to not extend the Contract beyond the initial Contract term if the new or confirmed rates established are deemed to be insufficient notwithstanding any other provision of this RFP and resultant Contract. The Contractor shall notify DHH-OBH regarding its desire to extend the Contract within fifteen calendar days of receipt of the new capitation rates.
8. Payment for Medicaid Children's Services.
 - a. Payment for T-XIX Services for Children. The Contractor agrees to provide all children's Medicaid behavioral health services outlined in the contract for the cost of the actual utilization of Medicaid State Plan services priced at the Medicaid fee-for-service fee schedule paid in that quarter subject to the upper payment limit found at 42 CFR 447.362, plus the actual utilization of 1915(c) services priced at the 1915(c) waiver fee schedule, plus the actual utilization of 1915(b)(3) waiver services priced at the 1915(b)(3) waiver fee schedule. The Contractor will receive a PMPM administrative rate negotiated with the State based on the proposal by the Contractor using Medicare cost plan principles.
 - b. The Contractor will receive a roster listing Medicaid eligible children at the beginning of each month and daily files for updates. The Contractor shall pay services for children utilizing the State's FFS fee schedule. At the end of each month, the Contractor will submit encounter data and an invoice for the services provided to each child. The DHH-OBH will reimburse for services provided to these individuals as documented in both the invoice and encounter data on a non-risk basis subject to the non-risk upper payment limit in 42 CFR 447.362. The Contractor should ensure that the claim is denied reimbursement until the Contractor coordinates all available benefits the Member may have through other insurance.
 - c. In the event that Contractor does not provide the services listed under this Contract, or only provides a portion of the services, DHH-OBH reserves the right to withhold payments until such time as Contractor demonstrates that the services have been provided.
 - d. Services provided by a provider or subcontractor of the Contractor providing services under the program shall be billed to the Contractor. The Contractor through a contract will make payment to subcontractors for the provision of services under this program including the 1915(c) Waiver. This will include a separate pass through payment to the SMO for the Wraparound Agency to cover treatment planning and Wraparound facilitation functions.
 - e. In full consideration of the Contract services rendered by the Contractor, DHH-OBH agrees to pay the Contractor monthly administration fees per Member per month based on the administrative payments contained in the cost proposal negotiated with OBH based on Medicare cost plan principles.
 - f. Non-risk service payments will be paid based on actual utilization priced at the Medicaid fee-for-service fee schedule on invoices and documented through encounter data. Monthly, the Contractor shall provide actual utilization and

costs by service consistent with required State encounter data and, using the Cost Template provided in Attachment IV to the contract, administrative costs incurred in that month. No payment will be provided to the Contractor for services without complete encounter data submittals.

- g. DHH-OBH has included the administrative payments per Member per month payment in the cost-effectiveness portion of the 1915(b) waiver. The negotiated amount must be less than the amount in the 1915 (b) waiver. The PMPM payment rate may be adjusted after annual reconciliations based on applicable program changes, trend, and other actuarial data.
 - h. The final payment for Medicaid State Plan services cannot exceed what would have been paid had the same services been provided under the fee-for-service fee schedule (42 CFR 447.362). The final payment for 1915(c) services cannot exceed what would have been paid had the same services been provided under the 1915(c) SED waiver in a fee-for-service environment. The final payment for 1915(b)(3) waiver services cannot exceed the aggregate limits established in the 1915(b) waiver or the 1915(b)(3) services priced at the appropriate 1915(b)(3) fee schedule.
 - i. 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, or (b) unless the change is necessary to continue to receive federal funds or due to action of a court of law. The Contractor shall receive thirty calendar days notice prior to such changes and the lump sum payment shall be adjusted accordingly. The method of retrospective reconciliation will not be altered by any changes in the payments.
- 9. Payment Per Member Per Month Rates Payment Schedule – Title XIX Children.
 - a. An administrative only per Member per month payment for administering Medicaid payments for all children's Members will be paid to the Contractor based on T-XIX enrollment data each month during the term of the Contract. Administrative payments per Member per month payment will be made based on the number of Members.
 - b. Upon receipt of Contractor's invoice, payment for goods and services provided to all children shall be provisionally paid on a monthly basis using the Medicaid fee-for-service fee schedule with a final annual settlement as noted above in section 2.1.
- 10. Payment procedures for all Members.
 - a. For all beneficiaries with retroactive eligibility and spend-down requirements retrospective invoicing and settlement for services will occur on a quarterly basis for eligible beneficiaries not receiving a PMPM payment. If quarterly reconciliation for these beneficiaries has a negative impact on the Contractor, DHH-OBH will consider more frequent reconciliations on an ad hoc basis.
 - b. The invoiced payments will be reconciled and settled annually to ensure that the fee-for-service fee schedule was utilized by the Contractor and that the non-risk upper payment limit is not exceeded.
- 11. Recovery of PMPM payments for T-XIX Services.
 - a. DHH-OBH may recover inappropriate Contractor PMPM and invoiced services payments when the Contractor actually provided service, if the Member is subsequently determined to be ineligible for the month in question.

Consideration may be given in instances where the Contractor has paid for services.

- b. DHH-OBH reserves the right to recover inappropriate payments.

12. Renegotiation of Administrative Per Member Per Month Rates and Adult Capitation Rates for T-XIX Services.

- a. In the event of a reduction in the appropriation from the State budget, DHH-OBH may either renegotiate this Contract or terminate with thirty calendar days written notice.
- b. DHH-OBH will confirm current or establish new administrative per Member per month rates and adult substance abuse capitation rates at least sixty calendar days prior to the expiration of the initial term of this contract and sixty calendar days prior to the expiration of any Contract extensions. Nothing in this contract shall be construed to mean that the administrative per Member per month rate will be increased.
- c. The Contractor shall have the right to not extend the Contract beyond the initial Contract term if the new or confirmed rates established are deemed to be insufficient notwithstanding any other provision of this Contract. The Contractor shall notify DHH-OBH regarding its desire to extend the Contract within fifteen calendar days of receipt of the new administration and capitation rates.

13. Non-Medicaid DHH-OBH Payments for non-T-XIX (SGF, SAPT and MH Block Grant) Services (Adults and Children).

- a. DHH-OBH will provide payments to providers for Non-Medicaid eligible services provided by the DHH-OBH funded clinics and specific contracted services until such time as determined by DHH-OBH and the Contractor to transfer provider claims payment functions to the Contractor. (Please refer to the Procurement Library for a list of the clinic and contracted services included in this arrangement.)
- b. For the first year of the contract and until otherwise determined by DHH-OBH in collaboration with the Contractor, the Contractor will submit client level data electronically to DHH-OBH to verify administrative services rendered by the contractor at the end of each month for Non-Medicaid eligible members. This electronic delivery of information shall include and not be limited to client level data and summary reporting regarding telephonic contact/screening, assessment, treatment planning, level of care decisions, concurrent reviews, appeals and their results, and access to non-Medicaid benefit services data in order to access the effectiveness/outcomes associated with services authorized for this population.
- c. Over the three year time frame addressed by this RFP, the goal is to transition payment for services provided to all adult Non-Medicaid eligible members from OBH to the SMO's claims payment process. Once this is accomplished, the Contractor shall utilize:
 - i. 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.
 - ii. The DHH-OBH-approved Block Grant fee schedules to reimburse providers.
- d. In the remaining years of the Contract, the payment for treatment services and payment for administrative services of the SAPT Block Grant will be reviewed

based on funding received from the federal government and state dollars available as part of the required Maintenance of Effort in support of the SAPT Block Grant. Nothing in this RFP shall be construed to mean that the services or administration amount paid to the Contractor will be increased.

- e. 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, or (b) unless the change is necessary to continue to receive federal funds or due to action of a court of law. The Contractor shall receive thirty calendar days notice prior to such changes and the monthly services and/or administration payment shall be adjusted. Payments for non-T-XIX (Block Grant) Services — Schedule Payments for both treatment and administrative services will be made on or before seven calendar days following to the month for which the payments cover. Recovery of Monthly Payments non-T-XIX (Block Grant) Services. DHH-OBH reserves the right to recover inappropriate monthly administrative payments and inappropriate payments to the Contractor for services rendered.

14. Non-Medicaid DCFS and OJJ Payments for non-T-XIX (Children).

- a. At the end of each month, the Contractor will submit client level data and an invoice for the services provided to beneficiaries 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. In full consideration of Contractor services rendered by the Contractor, on a monthly basis, DCFS and OJJ shall pay the Contractor for services rendered to individuals eligible for DCFS/OJJ services and individuals as documented in both the client level data and invoice.
- b. The Contractor 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.
- c. The Contractor will utilize the DCFS and OJJ fee schedules to reimburse providers.
- d. In the remaining years of the Contract, the payment for treatment services and payment for administrative services of the DCFS/OJJ will be reviewed based on funding received from the federal government and state dollars available as part of the required Maintenance of Effort for Block Grants such as the TANF BG. Nothing in this RFP shall be construed to mean that the services or administration amount paid to the Contractor will be increased.
- e. 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, or (b) unless the change is necessary to continue to receive federal funds or due to action of a court of law. The Contractor shall receive thirty calendar days notice prior to such changes and the monthly services and/or administration payment shall be adjusted. Payments for non-T-XIX (Block Grant and SGF) Services — Schedule Payments for both treatment and administrative services will be made on or before seven calendar days following to the month for which the payments cover. Recovery of Monthly Payments non-T-XIX (Block Grant and SGF) Services. OJJ/DCFS reserves the right to recover inappropriate monthly

administrative payments and inappropriate payments to the Contractor for services rendered.

15. Renegotiation of Monthly Payments for non- T-XIX (Block Grant, TANF Block Grant, and SGF) Services. In the event of a reduction in the appropriation from the State budget for the required Maintenance of Effort in the support of the Block Grant, or a reduction by the federal government to the Block Grant, DHH-OBH may either renegotiate this Contract or terminate with thirty calendar days written notice. DHH-OBH will confirm current or establish new monthly payment rates for treatment services and administrative services at least 60 calendar days prior to the expiration of the initial term of this agreement and 60 calendar days prior to the expiration of any Contract extensions.
16. The Contractor shall have the right to not extend the Contract beyond the initial Contract term if the new or confirmed payments established are deemed to be insufficient notwithstanding any other provision of this RFP and resultant Contract. The Contractor shall notify DHH-OBH regarding its desire to extend the Contract within 15 calendar days of receipt of the new monthly payment rates.
17. DHH-OBH shall have the right, at its sole option, to renew the Contract for one-year period, or any portion thereof, after the initial two-year Contract. 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:
 - a. DHH-OBH will contract with an actuarial firm to calculate actuarially sound capitation rate ranges for each year of the contract.
 - b. DHH-OBH will develop a rate adjustment that incorporates actual applicable trends occurring in the health care market, subject to available appropriations.
 - c. If the State of Louisiana elects to renew the Contract, the Contractor 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-OBH's actuarial Contractor.

III. PROPOSALS

A. General Information

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

B. Contact After Solicitation Deadline

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

C. Code of Ethics

Proposers are responsible for determining that there will be no conflict or violation of the Ethics Code if their company is awarded the contract. The Louisiana Board of Ethics is the only entity which can officially rule on ethics issues.

D. Rejection and Cancellation

Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts. DHH-OBH reserves the right to reject any or all proposals received in response to this solicitation.

In accordance with the provisions of R.S. 39:2182, in awarding contracts after August 15, 2010, any public entity is authorized to reject a proposal or bid from, or not award the contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or proposal awarded under the laws governing public contracts under the provisions of Chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950, professional, personal, consulting, and social services procurement under the provisions of Chapter 16 of this Title, or the Louisiana Procurement Code under the provisions of Chapter 17 of this Title.

E. Award Without Discussion

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

F. Assignments

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

G. Proposal Cost

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, and shall not include this cost or any portion thereof in the proposed contract price.

H. Errors and Omissions

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

I. Ownership of Proposal

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

J. Procurement Library/Resources Available To Proposer

Relevant material related to this RFP will be posted at the following Web link:

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

K. Proposal Submission

1. All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each Proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.
2. Proposer **shall** submit one (1) original hard copy (The Certification Statement must have original signature signed in ink) and should submit one (1) electronic copy in PDF format (CD or flash drive) and twelve (12) hard copies of each proposal. No facsimile or emailed proposals will be accepted. The proposer shall provide proposed rates in its separate cost proposal using the Proposal Cost Template provided in Attachment IV to this RFP. The cost proposal and financial statements should be submitted separately from the technical proposal; however, for mailing purposes, all packages may be shipped in one container.
3. Proposals must be submitted via US mail, courier or hand delivered to:

If courier mail or hand delivered:

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

If delivered via US mail:

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

L. Proprietary and/or Confidential Information

1. The designation of certain information as trade secrets and/or privileged or confidential proprietary information shall only apply to the technical portion of the proposal. The cost proposal will not be considered confidential under any circumstances. Any proposal copyrighted or marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.
2. For the purposes of this RFP, the provisions of the Louisiana Public Records Act (La. R.S. 44.1 et. seq.) will be in effect. Pursuant to this Act, all proceedings, records, contracts, and other public documents relating to this RFP shall be open to public inspection. Proposers are reminded that while trade secrets and other proprietary information submitted in conjunction with this RFP may not be subject to public disclosure, protections must be claimed by the Proposer at the time of submission of its Technical Proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.
3. The Proposer must clearly designate the part of the proposal that contains a trade secret and/or privileged or confidential proprietary information as "confidential" in order to claim protection, if any, from disclosure. The Proposer shall mark the cover sheet of the

proposal with the following legend, specifying the specific section(s) of the proposal sought to be restricted in accordance with the conditions of the legend:

"The data contained in pages _____ of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions."

4. Further, to protect such data, each page containing such data shall be specifically identified and marked "CONFIDENTIAL".
5. Proposers must be prepared to defend the reasons why the material should be held confidential. If a competing Proposer or other person seeks review or copies of another Proposer's confidential data, DHH will notify the owner of the asserted data of the request. If the owner of the asserted data does not want the information disclosed, it must take legal action as necessary to restrain DHH from releasing information DHH believes to be public record.
6. **If the proposal contains confidential information, a redacted copy of the proposal must be submitted.** If a redacted copy is not submitted, DHH may consider the entire proposal to be public record. When submitting the redacted copy, it should be clearly marked on the cover as - "REDACTED COPY". The redacted copy should also state which sections or information has been removed.
7. Any proposal marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

M. Proposal Format

1. An item-by-item response to the RFP is requested and should be organized according to the Proposal Outline listed below in Section III. L. Requested Proposal Outline and Section III. M. Proposal Content.
2. Suggested page numbers are included. The suggested page numbers are not page limits. Emphasis should be on simple, straightforward and concise statements of the Proposer's ability to satisfy the requirements of the RFP.

N. Requested Proposal Outline:

1. Introduction/Administrative Data
2. Work Plan/Project Execution:
 - a. Access and Member Services
 - b. Management of care
 - c. Utilization Management (UM)
 - d. Quality management (QM)
 - e. Complaints
 - f. Appeals
 - g. Provider network management
 - h. Member rights and protections
 - i. Financial oversight
 - j. Claims payment for non-capitated services

- k. Encounter tracking and submissions for capitated services
- l. Reporting and monitoring
- m. Technical requirements
- n. Implementation planning
- o. Transition planning
- 3. Relevant Corporate Experience
- 4. Personnel Qualifications
- 5. Additional Information
- 6. Corporate Financial Condition
- 7. Cost and Pricing Analysis
- 8. CMS Certifications

O. Proposal Content

Proposals should include information that will assist DHH-OBH in determining the level of quality and timeliness that may be expected. DHH-OBH shall determine, at its sole discretion, whether or not the RFP provisions have been reasonably met. The proposal should describe the background and capabilities of the Proposer, give details on how the services will be provided, and shall include a breakdown of proposed costs. Work samples may be included as part of the proposal.

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.

Proposals should define Proposer's functional approach in providing services and identify the tasks necessary to meet the RFP requirements of the provision of services, as outlined in Section II.

1. Introduction/Administrative Data

- a. The introductory section should contain summary information about the Proposer's organization. This section should state Proposer's knowledge and understanding of the needs and objectives of the Louisiana BH services program for children and adults and the CSoC for children, as related to the scope of this RFP. It should further cite its ability to satisfy provisions of the RFP. This section should discuss how the Proposer will define success at the end of years 1 and 2 of the contract by describing milestones it expects to achieve, specifically addressing milestones for network development. The Proposer should address separately milestones for (1) the CSoC, (2) management of services for other children not eligible for the CSoC, and (3) adults with SMI and/or addictive disorders.
- b. This introductory section should include a description of how the Proposer's organizational components communicate and work together in both an administrative and functional capacity from the top down. This section should contain a brief summary setting out the Proposer's management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication Systems. This section should include an organizational chart displaying the Proposer's overall structure including advisory and other related committees the Proposer will establish for this project. Suggested number of pages: 3 exclusive of organizational chart
- c. This section should also include the following information:
 - i. Location of Active Office with Full-Time Personnel, include all office locations (address) with full time personnel;

- ii. Name and address of principal officer;
 - iii. Name and address for purpose of issuing checks and/or drafts;
 - iv. For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation;
 - v. If out-of-state Proposer, give name and address of local representative; if none, so state;
 - vi. If any of the Proposer's personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number;
 - vii. If the Proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state;
 - viii. Proposed location and functions of the required Louisiana-based operations in the Baton Rouge area; and
 - ix. Proposer's state and federal tax identification numbers.
- d. The following information must be included in the proposal:
- i. Certification Statement: The Proposer must sign and submit (original signature must be signed in ink) the attached Certification Statement (See Attachment I).

2. Work Plan/Project Execution

The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:

a. Member Services

- i. 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. Suggested number of pages: 2 exclusive of organizational chart.
- ii. 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 Louisiana within the continental United States. Also describe the system back-up plan to cover calls to the toll-free line.
- iii. Describe the capabilities of the telephone system with respect to warm line transfer, live call monitoring and other relevant features. Suggested number of pages: 2
- iv. Describe the Proposers plan to train member services staff.
Suggested number of pages: 2
- v. 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. Suggested number of pages: 3
- vi. Describe the member experience when calling the member services line and the transition to care managers:

- (a) Provide a description of the process for transitioning an adult caller from member services to care management, including the process for determining and addressing a psychiatric crisis.
 - (b) Provide a description of the process for transitioning a family member/parent of a child/youth from member services to care management, including the process for determining and addressing a psychiatric crisis.

Suggested number of pages for both examples: 2
- vii. Describe the Proposer's plan to manage and respond to complaints, including the process for logging, tracking and trending complaints, call resolution or transfer, and staff training.
Suggested number of pages: 2
- viii. Describe 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. Suggested number of pages: 2
- ix. Describe how the Proposer's information management system will support utilization management activities. Suggested number of pages: 1
- x. Member Services Website.
Propose a plan for implementing a website to be utilized by members and family members, providers, stakeholders and State agencies that provides a provider directory, education and advocacy information as described in the RFP. Discuss the proposed content of the website with respect to promoting holistic health and wellness. Provide an example of an active web based site that has been developed for a State agency and include information to permit access to the site. Describe the development tools that will be utilized to create the Louisiana website as well as the proposed security protocols that will be used.
Suggested number of pages: 8
- xi. Member Handbook.
Describe the Proposer's experience demonstrating compliance with annual notification to members of member rights and other required information given confidentiality concerns and the transient lifestyle of some members.
Suggested number of pages: 2
- xii. Member Communications.
 - (a) Describe how the Proposer will ensure a comprehensive communication program to provide all eligible individuals, not just those members accessing services, with appropriate information about services, their rights, network providers available, and education related to benefits and accessing BH services. Include a description of the standard materials to be included in the communications program at no additional cost to the State. Suggested number of pages: 3
 - (b) Illustrate an example of the Proposer's most successful member communication effort that best embodies the system principles outlines in the RFP. Suggested number of pages: 2

b. Care Management

- i. Describe how the Proposer will conduct CM and UM of BH services. Describe how CM and UM will be integrated and organized for all covered populations, including workflow. Suggested number of pages: 6 exclusive of workflow
- ii. Provide an organizational chart for the CM/UM department(s) that includes position titles, numbers of positions, and reporting relationships. Describe the required qualifications for each position, (with the exception of Psychiatrist/Psychologist Advisors that will participate in the CM/UM program, which are addressed later in this section).
 - (a) 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. Suggested number of pages: 4
 - (b) Describe how the Proposer's information management system will support the CM program. Suggested number of pages: 4
 - (c) Describe how the Proposer will provide an outreach program to ensure that high-risk members understand the benefits and services available to them. Include how the Proposer defines and identifies high-risk members. Provide an example of a successful outreach program. Suggested number of pages: 3
 - (d) Describe how the Proposer will assist the WAA in developing POC for the 650-750 CSoC children/youth currently living in out-of-home placements to facilitate their transition to family- and community- based services. Address the following components:
 - (i) Involvement of youth, families and caretakers enrolled and not enrolled in a WAA, including WF for enrolled children;
 - (ii) Collaboration with the CSoC child serving agencies on service planning;
 - (iii) Needs identification and collaboration with the Proposer's network management and development staff; and
 - (iv) Strategies the Proposer has found useful in other programs. Suggested number of pages: 3
- iii. Describe strategies the Proposer has used to collaborate with wraparound facilitation staff/child and family teams and families, including family support type organizations in another client state. Discuss the Proposer's successes and challenges and provide a reference that can validate the Proposer's approach. Suggested number of pages: 3
- iv. Describe how the Proposer will develop treatment planning for adults in the 1915(i) State Plan and adults eligible for treatment planning under the 1915(b) waiver, adults eligible for the 1915(i) HCBS services, IV drug users, pregnant substance abuse users, substance abusing women with dependent children or dual diagnosis, including from the point of access to the point of either case closing or reduction in CM activity to the point of care monitoring:
 - (a) Involvement of individuals, certified peer specialists and families, when desired by the individual;
 - (b) Collaboration with community providers on assessment and treatment planning;
 - (c) Needs identification and collaboration with the Proposer's network management and development staff;

- (d) Approaches to treatment planning for individuals with co-occurring disorders;
 - (e) Experience with managing care for individuals living in permanent supportive housing; and
 - (f) Strategies the Proposer has found useful in other programs.
- Suggested number of pages: 7

c. Utilization Management

- i. Address how the Proposer will perform the following UM activities:
 - (a) How the authorization process will differ for acute and ambulatory levels of care for adults, CSoC and non-CSoC children;
 - (b) Describe the UM workflow and processes for denial of care;
 - (c) Describe appeals process, including the Proposer's standard and expedited appeals procedures, including the impact on the member and involved providers during the appeal process; and
 - (d) Describe the methodology and criteria for identifying over- and under-utilization of services. Provide sample reports and how the information in those reports would be used.

Suggested number of pages for all above items: 7 exclusive of report samples
- ii. Describe how the Proposer's information management system will support UM activities. Suggested number of pages: 1
- iii. Describe the medical necessity criteria and level of care guidelines utilized by the Proposer's organization in managing care, include the source of the criteria/guidelines with which the Proposer has experience and the Proposer's experience in utilizing guidelines provided by contracting agencies. Suggested number of pages: 3
- iv. Describe the specialties/expertise areas of the Psychiatrist/ Psychologist Advisors that will be assigned to this contract. Suggested number of pages: 2
- v. Practice Guidelines. Describe the Practice Guidelines for utilization of care proposed for the program. Suggested number of pages: 2
- vi. Describe how the Proposer will address the high utilization of inpatient services 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. Suggested number of pages: 2
- vii. Assuming that pharmacy data for members will be provided to the Proposer by DHH, describe how the Proposer will review, monitor and analyze pharmacy data for medication side effects, adverse drug interactions, and member adherence. Describe strategies to detect under-and over-utilization and potential inappropriate utilization of medications by members and by providers. Suggested number of pages: 2
- viii. Assuming that DHH will provide utilization data for individuals who are not enrolled as members of the SMO, but receive their BH services from other sources (e.g., Federally Qualified Health Centers (FQHCs)/Rural Health Clinics

(RHCs), Louisiana's Community Care Network), describe how the Proposer will review and monitor this data for utilization, trends and other QM purposes.

Suggested number of pages: 1

d. Quality Management

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. Suggested number of pages: 2, exclusive of organizational chart

- i. Describe the essential elements of the Quality Assurance/ Quality Improvement Plan the Proposer would develop for the program and how the Proposer will assure it is a dynamic document that focuses on continuous QI activities; include:
 - (a) Covered BH services and administrative and clinical processes and functions to be addressed;
 - (b) Committee structure, responsibility and membership
 - (c) Necessary data sources;
 - (d) Proposed outcomes measures and instruments;
 - (e) Monitoring activities (e.g., surveys, audits, studies, profiling, etc.); and
 - (f) Feedback loops.

Suggested number of pages: 5

- ii. Describe how the Proposer's information management system will support continuous QI. Suggested number of pages: 1
- iii. Describe how the Proposer will resolve quality of care concerns and how information related to the concerns will be used to improve the quality of care provided to members at the individual and BH system level. Suggested number of pages: 2
- iv. Describe the methods the Proposer will use to ensure its own and its provider's compliance with QM initiatives and requirements. Suggested number of pages: 2
- v. Describe how members, families/caretakers, providers, advocates and stakeholders will be involved in the design and implementation, and evaluation of QM information. Suggested number of pages: 1
- vi. Describe how the Proposer will involve members, family members, the Proposer's personnel, subcontracted providers and other stakeholders in the development and ongoing work of the QM system and share results of QI initiatives. Suggested number of pages: 1
- vii. Provide the following information regarding the two most recent member satisfaction surveys with members of government/public sector managed BH care programs:
 - (a) Time period;
 - (b) Overall response rate to satisfaction survey;
 - (c) Percent of respondents satisfied overall; and
 - (d) Lowest rated item and percent satisfied.Suggested number of pages: 1

e. Network Management

- i. Describe how Network Management (NM) and development functions will be organized, including staff that will be located in Louisiana and staff support available at the Proposer's corporate or other operations. Suggested number of pages: 3, exclusive of organizational chart
- ii. Provide an organizational chart for NM that includes position titles, numbers of positions, qualifications and reporting relationships. Discuss how provider relations, network development and network monitoring will be addressed. Suggested number of pages: 3 exclusive of organizational chart
- iii. Describe how the Proposer's information management system will support NM and development. Suggested number of pages: 2
- iv. 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 or Grants (i.e., not Medicaid-reimbursable services). Suggested number of pages: 3
- v. Provide an example of how the Proposer has developed, organized, or implemented another public sector mental health and substance abuse provider network to successfully achieve system goals similar to those outlined in the RFP. Provide a contact from a contracting agency that can verify the Proposer's experience. Suggested number of pages: 3
- vi. Describe the Proposer's approach to contracting with the current provider delivery system in a new client state to assure continuity of care during the program start-up and implementation period. Describe how the Proposer will transition providers that do not meet credentialing requirements or do not offer services covered by Medicaid or other funding sources identified by DCFS, DHH-OBH, DHH-OCDD, DOE, and OJJ. Suggested number of pages: 5
- vii. Describe how the Proposer will secure sufficient numbers of providers to assure service access on Contract Start Date. What barriers are anticipated with having sufficient 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. Suggested number of pages: 4
- viii. Describe the Proposer's plan for expanding the network to include family-based and community services for the 650-750 children/youth currently in out-of-home placements. Discuss the approach to developing alternative services including:
 - (a) Input from the Proposer's CM and UM staff;
 - (b) Input of youth/families, adults and system stakeholders;
 - (c) Establishment of priorities for network development;
 - (d) Assessment of current provider capabilities; and
 - (e) Collaboration with WAA and the adult and child-serving State agencies in plan development.Suggested number of pages: 5

- ix. Describe the resources for providers to obtain information about covered services, billing requirements, payments, and training, or other resources. Suggested number of pages: 3
- x. Describe how the Proposer will develop service alternatives to unnecessary inpatient utilization for children and adults, including those with addictive disorders. Discuss strategies the Proposer has used to develop services that divert individuals from non-medically necessary inpatient care, decrease length of stay, and prevent readmissions. Discuss the approach for developing service alternatives including:
 - (a) Input from the Proposer's CM and UM staff;
 - (b) Input of individuals, families and system stakeholders;
 - (c) Establishment of priorities for network development;
 - (d) Assessment of current provider capabilities; and
 - (e) Collaboration with DHH-OBH in plan development.Suggested number of pages: 5
- xi. Describe how the Proposer will develop and maintain sufficient qualified service providers to ensure culturally-appropriate services, including outreach, engagement, and re-engagement of the Latino, African American, Vietnamese, Native American and other minority populations and delivery of a service array and mix comparable to the majority population within each region. Suggested number of pages: 3
- xii. Describe the Proposer's plan for implementing a statewide network of crisis response providers to serve people of all ages. Provide an example of the Proposer's success in developing, implementing and managing crisis response network providers. Suggested number of pages: 4
- xiii. Describe the Proposer's provider profiling system proposed for this Contract. List the elements the Proposer will use to profile providers:
 - (a) Indicate if the profiling elements will differ by provider;
 - (b) Describe the process for collecting accurate baseline data that engenders provider confidence and the time table for development of accurate baseline data; and
 - (c) Include a description of the parties who will have access to the provider profile and how the information will be utilized. Describe how the Proposer has used provider profiles for other public sector BH managed care contracts.Suggested number of pages: 5
- xiv. Describe at least one (1) goal, measureable outcome and strategy from another client state where improvements in the availability of and member engagement in culturally appropriate services occurred. Also, describe one (1) strategy that did not result in positive change and the Proposer's understanding of why this strategy was not successful. Suggested number of pages: 3
- xv. Describe the strategies the Proposer will use to facilitate BH provider, PCP, DCFS, OJJ, DOE 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. Suggested number of pages: 3

f. Member Rights and Responsibilities

Describe how the Proposer will assure Members understand and know how to exercise their rights. Include a description of how the Proposer will assure members' rights are recognized and supported by employees and providers. Suggested number of pages: 2

g. Technical Requirements

- i. Describe the Proposer's telephone system capabilities, call center software and operating systems. Suggested number of pages: 1
- ii. 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, and reporting relationships. Describe the qualification of staff. Suggested number of pages: 4 exclusive of organizational chart
- iii. Describe training for IT and claims staff, including any subcontractors. Suggested number of pages: 5
- iv. 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 as indicated in the Implementation Planning section of the RFP. Suggested number of pages: 6
- v. Describe how the BH MIS will electronically and securely interface with the DHH Medicaid Medical Information System (MMIS) system, the WAAs, the DHH-OBH data warehouse, including the capability of interagency electronic transfer to and from the participating state agencies (DHH, DHH-OBH, DCFS, DOE, & OJJ) as needed to support operations. Suggested number of pages 3
- vi. Describe Proposer's web-based capabilities to receive and respond to providers and State agencies for referrals and prior authorizations for services. Suggested number of pages 2
- vii. Describe how the Proposer's BH MIS will meet the requirements for regular (e.g., bi-weekly) electronically transfer client/episode-level recipient, assessment, service, and provider data to the DBH-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 as outlined in the Quality Management Strategy). Suggested number of pages: 4
- viii. 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. Suggested number of pages: 4
- ix. Describe the Proposer's system's ability to provide an electronic data interface to allow transfer of Health Insurance Portability and Accountability Act- (HIPAA) compliant information from and to WAA, DOE or other agencies. Include the

transfer of eligibility and encounter data in the Proposer's response. Suggested number of pages: 2

- x. Describe the Proposer's experience and capabilities in using, creating, and sharing data and maintaining electronic health records. Suggested number of pages: 2
- xi. 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. Suggested number of pages: 3
- xii. 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 who can perform them. Provide a listing of system reports and their frequency. Suggested number of pages: 5
- xiii. Provide a detailed description of scheduled and unscheduled system downtime for the past 12 months for all government contracts. Suggested number of pages: 2
- xiv. Describe the Proposer's system data archive and retrieval system including disaster recovery procedures, including loss of the Proposer's main site or computer systems. Indicate when the disaster recovery was last used or tested and describe the outcome. Suggested number of pages: 4
- xv. Describe the Proposer's technical support or "help desk" services available to front-end users of your information systems. Suggested number of pages: 2
- xvi. Describe the Proposer's ability to access the system for end users not working in the office. Suggested number of pages: 2
- xvii. Describe the Proposer's experience with the 270/271 Eligibility Request/Response transactions as well as submitting and receiving 834 Enrollment/Disenrollment transaction sets. Suggested number of pages: 3
- xviii. Describe the Proposer's experience with the HIPAA 835 and electronic funds transfer. Suggested number of pages: 2
- xix. Describe the Proposer's system's ability to send and receive data from other agencies such as eligibility (HIPAA 834) and member's plan of care data consistent with the collaboration requirement in the Scope of Work. Suggested number of pages: 3
- xx. Describe The Proposer's current status of implementing the HIPAA ANSI 5010 formats and preparation for the ICD-10 implementation. Suggested number of pages: 3
- xxi. Provide claim submission statistics as directed below for the most recently completed month overall for your current clients, for electronic and paper submissions. All formats, including proprietary formats, should be included.

Claim Type	Number Received
CMS UB 04 (paper)	_____
CMS 1500 (paper)	_____
HIPAA 837I (Institutional)	_____
HIPAA 837P (Professional)	_____
NCPDP	_____
Other (please list)	_____

- xxii. Describe the Proposer's process for receipt, storage, and data entry of provider paper format billings. Suggested number of pages: 2
- xxiii. Describe the Proposer's internal claims audit including percent of claims audited. Provide a sample of the reports used in this process. Suggested number of pages: 5

- xxiv. Explain the Proposer's high-level testing process to fulfill the claims testing processes requirements.
- xxv. Describe the Proposer's process of paying claims and ensuring prior authorization has been obtained. Include the process or system functions that ensure only the number of services authorized are paid. Suggested number of pages: 3
- xxvi. Describe the fields utilized in the exact duplicate match. Suggested number of pages: 1
- xxvii. Describe the process for determining covered service payments that may not require an authorization. Suggested number of pages: 2
- xxviii. Describe the process of ensuring that paid claims are for providers that are credentialed to perform the specific service rendered. Suggested number of pages: 2
- xxix. Describe the Proposer's storage of and use of national provider identification (NPI) numbers. Suggested number of pages: 2
- xxx. Describe the process for capturing DOE data as encounters. Suggested number of pages: 2
- xxxi. Provide a list of the system edits and their description to be used when processing the medical claims. Suggested number of pages: 8
- xxxii. Provide the policy and procedure for fraud detection in claims submissions.
- xxxiii. Describe the Proposer's coordination of benefits (COB) experience for determining payment. Suggested number of pages: 5
- xxxiv. Describe the Proposer's third party liability and COB process for identifying other health insurance. Include the capture and storing of other health insurance information. Include any system edits invoked during claims processing. Suggested number of pages: 3
- xxxv. Describe the Proposer's hardware and platform on which the software runs. Describe the environment in which the processor is or will be located. Suggested number of pages: 3
- xxxvi. Describe the Proposer's operating system/network infrastructure on which the software runs. Describe the programming language utilized and the software used to develop it. Describe how the source code can be purchased and if the Proposer can customize the software. Describe the Proposer's policy and procedure on software upgrades. Suggested number of pages: 5

h. Business continuity, disaster recovery and emergency preparedness.

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 Governor or designee. Suggested number of pages: 2

- i. Implementation Plan.** Provide an Implementation Plan that addresses the requirements of this RFP, including but not limited to establishing a Louisiana site, recruitment, hiring and training personnel, network development, and IT. The Implementation Plan should include tasks, milestones, due dates, and parties responsible. Provide a narrative that describes the Proposer's approach to implementation, highlighting tasks identified in the implementation plan.
- j. Subcontracting.** Describe the Proposer's plan to mandate subcontractors' acceptance of all contract requirements and monitoring protocol to ensure that

subcontractors' accounting and financial controls are adequate to permit the effective administration of the contract. Suggested number of pages: 2

k. Insurance Requirements and Risk and Liability

- i. Describe the Proposer's corporate policy regarding risk and liability insurance coverage. Provide declaration page for each policy that illustrates compliance with the risk and liability insurance requirements of the RFP (not included in suggested number of pages). Suggested number of pages: 2
- ii. If there is no current coverage or coverage does not cover all RFP requirements, provide an explanation on how the Proposer will meet the risk and liability insurance requirements of this RFP. Suggested number of pages: 2

- l. Transition planning.** Describe a Contract that either the Proposer of a government client cancelled or terminated and the Proposer's approach to transition planning particularly in relation to assuring that member services were not interrupted. Provide a client reference to verify this experience. Suggested number of pages: 2

3. Relevant Corporate Experience

- a. The Proposer should describe how its corporate experience will assist DHH-OBH with implementation and management of the BH services program and the CSOC. Suggested number of pages: 2
- b. Provide the number of government/public sector customers for which the Proposer has managed BH care services of persons eligible for Medicaid in the most recent five (5) calendar years (i.e., 2006, 2007, 2008, 2009, 2010), including the following information:
 - i. Customer Name;
 - ii. Number of eligibles;
 - iii. Approximate revenue in most recent year of the contract;
 - iv. Payment type (e.g., administrative services only fee, full capitation, etc.);
 - v. Direct contract with Agency or via health plan;
 - vi. Populations served (e.g., Title XIX, XXI, State only, CHIP, SAPT, CMHS block grants);
 - vii. Number of years Proposer has held contract; and
 - viii. Contract active or terminated.
- c. Provide the percentage of the Proposers managed BH care revenue attributed to government/public sector customers in fiscal years 2006, 2007, 2008, 2009, and the third quarter of 2010.
- d. For all current government/public sector customers for whom the Proposer currently manages Medicaid BH care services provide the following information for a state contact:
 - i. Name;
 - ii. Address;
 - iii. City, State, Zip;
 - iv. Telephone number; and
 - v. Email address.
- e. For current customers listed in letter d above, provide the number of complaints per 1,000 members received during the past two (2) calendar years. Also provide the most common types of complaints ranked by order of frequency.

- f. Provide three (3) references from governmental/public sector clients, at least of which two (2) are from government/public sector clients with whom the Proposer currently holds contracts for management of behavioral health services. Include the following information:
 - i. Name;
 - ii. Address;
 - iii. City, State, Zip;
 - iv. Telephone number; and
 - v. Email address.

4. Personnel Qualifications

The Proposer should describe the qualifications of key personnel and required personnel by providing the materials listed below. Key personnel include: Chief Executive Officer, Chief Financial Officer, Chief Medical Officer, the Chief Operations Officer and the Children's System Administrator. Required Personnel include: Corporate Compliance Administrator, Utilization Review Administrator, Quality Management Administrator, Network Development Administrator, and the Network Management Administrator, Member Services Administrator, Information System Administrator, the Claims/Encounters Administrator, and the Grievances and Appeals Administrator.

- a. Job descriptions of key and required personnel including the percentage of time allocated to the project, minimum education, training, experience, special skills and other qualifications for each position as well as specific job duties identified in the proposal.
- b. Resumes of all known key and required personnel should be included. Resumes should include, but not be limited to:
 - i. Experience with Proposer;
 - ii. Previous experience in projects of similar scope and size; and
 - iii. Educational background, certifications, licenses, special skills, etc.
- c. 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.

5. Additional Information

As an appendix to its proposal, if available, a Proposer may provide samples of specific policies and procedures that would highlight its expertise in serving the populations identified in the RFP, inclusive of organizational standards, employee expectations, member rights, UM guidelines and ethical standards. Full copies of manuals are not desired. This appendix should also include a copy of Proposer's All Hazards Response Plan, if available.

6. Corporate Financial Operations and Conditions

The organization's financial solvency will be evaluated. The Proposer's ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be evaluated.

- a. **Maintaining Records for Governmental Contracts.** Describe the Proposer's experience in maintaining records for governmental contracts and submitting financial statements to governmental agencies and compliance with the

requirements of subsection 6 b. below -Federal Financial Participation. Suggested number of pages: 2

b. Federal Financial Participation and Access to Records, Books, and Documents.

- i. 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. Suggested number of pages: 3
- ii. Describe the Proposer's experience with audits from governmental agencies. Provide two examples of actual audit reports and the resulting corrective action plan. Suggested number of pages: 2

c. Financial Reporting. Submit the Proposer's audited financial statements that cover the two (2) most recent years and the most recent unaudited quarterly financial statements (year-to-date). If the Proposer is a newly formed corporation and does not have any audited financial statements submit the most recent annual audited (to cover the most recent two (2) years) and quarterly unaudited financial statements of the corporation that intends to provide funding or support to the newly-formed corporation. Disclose the relationships of the corporation providing funding to the Proposer. Suggested number of pages: 1 excluding the audited financial statements

- i. Describe the Proposer's experience in developing and submitting financial statements to governmental agencies and tracking revenue and expenditures by funding source. Suggested number of pages: 2 pages, and include three examples of actual reports submitted to governmental agencies. Identify customer(s) who can verify the experience.
- ii. Describe the Proposer's experience in working with governmental agencies in developing and submitting financial and utilization data to assist in the monitoring of contractual performance and operations. Suggested number of pages: 2 and include three examples of actual reports submitted to governmental agencies. Identify customer(s) who can verify the experience.

d. Budget Tracking System (Early Warning System). Describe the Proposer's experience in working with governmental agencies in developing and submitting budget tracking systems (early warning systems) to track expenditures, utilization, cost per service and recipients in service by funding source. Suggested number of pages: 2 and include one example of actual reports submitted to governmental agencies. Identify customer(s) who can verify the experience.

e. Protection Against Liability and Insolvency. Describe how the Proposer will ensure that members are not held liable for services from providers and maintain compliance with 42 CFR §438.106 and Section 1932(b)(6), Social Security Act (as enacted by section 4704 of the Balanced Budget Act of 1997). In addition, provide the Proposer's experience with the regulations contained within this requirement. Suggested number of pages: 2

f. Solvency and Corporate Financial Condition

- i. The Proposer agrees to have in place within thirty (30) days of the Contract award date, capitalization requirements as will be established for this contract in the amount of funds equal to sixty (60) days of estimated payments to the

Contractor, which is met with no encumbrances, such as loans subject to repayment. Describe in detail how this requirement will be met. If the Proposer is relying on another organization to meet the capitalization requirement, submit the most recent audited financial statements of the other organization. In addition, in this case, submit a written certification, signed and dated by the President/Chief Executive Officer of the parent organization, indicating the parent organization's plan to provide the initial minimum capitalization to the Proposer, without restrictions, within the time frame contained in the RFP. Suggested number of pages: 3

- ii. Describe the Proposer's business plan to fund any potential losses to ensure continued compliance with the capitalization requirements. Suggested number of pages: 1
- g. **Non-Allowable Costs.** Describe the Proposer's experience with following the guidelines of OMB Circular A-87 and maintaining compliance with those requirements. Suggested number of pages: 2 and include one example of A-87 Audit Report. Identify customer(s) who can verify the experience.
- h. **Performance Bond/Retainage.** Describe how the Proposer will meet the performance bonding requirement outlined in the RFP. For purposes of this response assume that the initial performance bonding/retainage requirement is approximately ten percent of the total annual contract. Suggested number of pages: 2
- i. **Liquidated Damages.** Describe the Proposer's experience in performing contracts with liquidated damages provisions and acknowledge the Proposer's acceptance of the liquidated damages provisions of this RFP. Suggested number of pages: 2
- j. **Fraud and Abuse.** The Proposer shall describe its approach for meeting program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss Proposer's approach for meeting the requirements for coordination with DHH and other State funding agencies. Include a description of the internal controls and policies and procedures, the Proposer will implement to detect fraud and abuse within its own organization, and for providers and Members. Describe the Proposer's experience with implementing a comprehensive fraud and abuse monitoring program. Include key personnel and departmental structure involved in Proposer's fraud and abuse program. Provide three (3) examples of fraud or abuse the Proposer has detected and what Proposer did upon detection. Identify a customer that can verify the experience. Suggested number of pages: 4

7. Cost and Pricing Analysis

- a. The Proposer shall specify costs for performance of tasks. The Proposal shall include all anticipated costs of successful implementation of all deliverables outlined. An item by item breakdown of costs shall be included in the proposal, including per member per month costs associated with the covered populations.
- b. Proposers shall submit the breakdown as described in Attachment IV.

8. CMS Certifications

The Proposer shall complete the CMS required certifications listed in the Attachments section of this RFP.

P. Evaluation Criteria

The following process and criteria will be used to evaluate proposals:

1. Evaluations will be conducted by a Proposal Review Committee.
2. Evaluations of the financial statements will be conducted by a member of the DHH Fiscal Division.
3. Scoring will be based on a possible total of 500 points and the proposal with the highest total score will be recommended for award.
4. The proposal will be evaluated based upon the following criteria:
 - a. Responsiveness and completeness of the Proposal Section 1 Introduction and Administrative Data, based upon the organization and administrative requirements outlined in the RFP, and the Proposers understanding of the program described in Section I of the RFP.
 - b. Work Plan/Project Execution based upon the standards described in Section II, Scope of Work of the RFP.
 - c. Relevant Corporate Experience based upon the standards described in Section B. Proposer Requirements, including a minimum of five (5) years of public sector BH managed care experience and demonstrated success in the provision of complex public sector managed BH care services
 - d. Personnel Qualifications based upon standards described in Section II, Scope of Work of the RFP.
 - e. Corporate Financial Condition, based upon financial statements.
 - f. Completion of required certifications.
5. Cost Evaluation:
 - a. The administrative and care management \$PMPM proposal for Children's Title XIX administration and care management services in Table 13 must only include the costs to perform administrative and care management services. The \$PMPM value does not include medical services.
 - b. The at-risk \$PMPM proposal for Adult rate cells in Table 14 must include both the cost of medical services and the administration and care management of the Adult rate cells covered. The at-risk \$PMPM proposal for Adult rate cells is for year 1 only. The year 2 rate will be recalculated based upon actuarial analysis.
 - c. The Proposer with the lowest total \$PMPM costs in for a specific category (for example, Aged Adults, Ages 65+) shall receive the maximum points for that specific category.
 - d. Calculating the lowest score
 - i. The cost proposal will receive a maximum total of 100 points.
 - ii. The 100 points are allocated to each specific category as follows in the tables below:

Table 13: Children's Year 1 and Year 2 Administrative and Care Management \$PMPM Proposal

Title XIX Category	Year 1 Administrative and Care Management \$PMPM proposal	Year 2 Administrative and Care Management \$PMPM proposal	Category Point Values (CPV)
Children in 1915(b) Medicaid waiver only			20
Children in CSoC			5

program regardless of funding source			
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Table 14: Adults Year 1 At-risk \$PMPM Proposal

Adult Rate Cell	Year 1 At-risk \$PMPM proposal	Category Point Values (CPV)
Non-Disabled Adults, Ages 21-64		10
Disabled Adults, Ages 21-64		50
Aged Adults, Ages 65+		5

Table 15: OBH Non-Title XIX Eligible/Non CSoC Children and Non-Title XIX Adults Administrative and Care Management Fee Proposal*

Administrative Fee for OBH Non-Medicaid Eligibles	Percentage of Cost of Services Authorized proposal	Category Point Values (CPV)
Non-Title XIX/Non CSoC Children		5
Non-Title XIX Adults, Ages 21 +		5

*Does not include the requirement to pay claims for OBH Non-Title XIX Eligibles.

- e. Other Proposers shall receive points for a specific category based upon the following formula:

$$CPS = (LPC/PC) * CPV$$

CPS = Cost Proposal Score

LPC = Lowest Proposal Cost of all proposers

PC = Individual Proposal Cost

CPV = Category Point Value

The total points awarded will be a summation of the points received for each category based upon the formula above.

Please note that based upon this approach, a Proposer can receive the highest points in one category but the lowest in another. In addition, it is possible that no Proposer will receive 100 points for the cost proposal based upon this methodology.

- f. The assignment of the points based on the above formulas will be calculated by a member of the DHH Contracts Office staff.
- g. Additionally, a maximum of 25 points may be awarded for the cost criteria based on evaluation of reasonableness of cost based on economies of scale, adequate budget detail, and justification that all cost is consistent with the purpose, objectives, and deliverables of the RFP.
- h. The DHH Deputy Undersecretary may provide information to the Proposal Review Committee in its evaluation of the additional points.

6. **Evaluation Criteria and Assigned Weights:** In calculating points during the scoring process, scores will be calculated to the 4th decimal point (for example 1.2345). If the 5th number after the decimal point is 5 or higher, the 4th number after the decimal point will be rounded up to the next highest number (example: 1.23457 would be 1.2346). If the 5th number after the decimal point is 4 or lower, the 4th number after the decimal point will not be changed (example: 1.23454 would be 1.2345). In the event of a tie score, the Department will select the Proposer with the lowest overall cost to the State (i.e. the Proposer that received the overall highest score in the cost proposal evaluation). The table below lists the Evaluation Criteria.

Table 16: Evaluation Criteria

Evaluation Criteria	Assigned Weight in Points
Introduction/Understanding of RFP	40
Work Plan/Project Execution	200
Corporate Experience	60
Qualification of Personnel	40
Corporate Financial Statements	35
Cost of proposal (100 points) Reasonableness (25 points)	125
Total	500

Q. Announcement of Award

DHH-OBH will award the contract to the Proposer with the highest graded proposal and deemed to be in the best interest of DHH-OBH. All Proposers will be notified of the contract award. DHH-OBH will notify the successful Proposer and proceed to negotiate contract terms.

IV. CONTRACTUAL INFORMATION

- A. The contract between DHH and the Contractor shall include the standard DHH contract form (CF-1/attached) including a negotiated scope of work, the RFP and its amendments and addenda, and the Contractor's proposal. The attached CF-1 contains basic information and general terms and conditions of the contract to be awarded.
- B. **Mutual Obligations and Responsibilities:** The state requires that the mutual obligations and responsibilities of DHH and the successful Proposer be recorded in a written contract. While final wording will be resolved at contract time, the intent of the provisions will not be altered and will include all provisions as specified in the attached CF-1.
- C. **Performance Bond-**For all contractors (for profit or not for profit) awarded contracts through the RFP; DHH-OBH shall require the contractor, within 10 days of signing the contract, to procure, submit, and maintain a Performance Bond in the amount of 10% of the annual contract amount.
OR
Performance Bond/Retainage - As an alternative to a performance bond requirement above, DHH-OBH, at the request of the contractor and acceptance by DHH-OBH, may secure a retainage of 10% from all billings under the contract as surety for performance.

On successful completion of contract deliverables, the retainage amount may be released on an annual basis.

D. In addition, to terms of the CF-1 and supplements, the following will be incorporated into the contract awarded through this RFP:

1. Personnel Assignments: The Contractor's key personnel assigned to this contract may not be replaced without the written consent of DHH-OBH. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. Key personnel for these purposes will be determined during contract negotiation, but include at a minimum the Chief Executive Officer, the Chief Medical Officer, the Chief Financial Officer, the Chief Operations Officer and the Children's System Administrator.
2. Force Majeure: The contractor and DHH-OBH are excused from performance under contract for any period they may be prevented from performance by an Act of God, strike, war, civil disturbance, epidemic or court order.
3. Order of Precedence: The contract shall, to the extent possible, be construed to give effect to all provisions contained therein; however, where provisions conflict, the intent of the parties shall be determined by giving a first priority to provisions of the contract excluding the RFP and the proposal; second priority to the provisions of the RFP; and third priority to the provisions of the proposal.
4. Entire Agreement: This contract, together with the RFP and addenda issued thereto by DHH-OBH, the proposal submitted by the contractor in response to DHH-OBH's RFP, and any exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect to the subject matter.
5. Board Resolution/Signature Authority: The contractor, if a corporation, shall secure and attach to the contract a formal Board Resolution indicating the signatory to the contract is a corporate representative and authorized to sign said contract.
6. Warranty to Comply with State and Federal Regulations: The contractor shall warrant that it shall comply with all state and federal regulations as they exist at the time of the contract or as subsequently amended.
7. Warranty of Removal of Conflict of Interest: The contractor shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The Contractor shall disclose any dual relationships that pose any evident or potential conflicts of interest. The contractor shall periodically inquire of its officers and employees concerning such conflicts, and shall inform DHH-OBH promptly of any potential conflict. The contractor shall warrant that it shall remove any conflict of interest prior to signing the contract.
8. If the contractor is a corporation, the following requirement must be met prior to execution of the contract:
 - a. If a for-profit corporation whose stock is not publicly traded-the contractor must file a Disclosure of Ownership form with the Louisiana Secretary of State.
 - b. If the contractor is a corporation not incorporated under the laws of the State of Louisiana-the contractor must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.
 - c. The contractor must provide written assurance to the agency from contractor's legal counsel that the contractor is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the contract.

RFP Attachments:

- I. Certification Statement
- II. DHH Standard Contract Form (CF-1)
- III. HIPAA BAA
- IV. Cost Template
- V. Certification of Compliance with Pro-Children Actor of 1994
- VI. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions
- VII. Certification Regarding Lobbying

CERTIFICATION STATEMENT**ATTACHMENT I**

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

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

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

Proposer certifies that the above information is true and grants permission to DHH-OBH 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 accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP.
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 proposal and cost proposal are valid for at least 120 days from the date of proposer's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have business days from the date of delivery of final contract in which to complete contract negotiations, if any, and execute the final contract document
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 www.epls.gov).

Authorized Signature: _____

(Must be an original signature signed in ink)

Typed or Printed Name: _____

Title: _____

Company Name: _____

**AGREEMENT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS**

AND

FOR

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

1) Contractor (Legal Name if Corporation)	5) Federal Employer Tax ID# or Social Security # (11 digits)
2) Street Address	6) Parish(es) Served
City and State	Zip Code
7) License or Certification #	
3) Telephone Number	8) Contractor Status
4) Mailing Address (if different)	Subrecipient: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Corporation: <input type="checkbox"/> Yes <input type="checkbox"/> No
	For Profit: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Publicly Traded: <input type="checkbox"/> Yes <input type="checkbox"/> No
City and State	Zip Code
	8a) CFDA#(Federal Grant #)

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

Include description of work to be performed and objectives to be met; description of reports or other deliverables and dates to be received (when applicable). In a consulting service, a resume of key contract personnel performing duties under the terms of the contract and amount of effort each will provide under terms of contract should be attached.

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: (stipulate rate or standard of payment, billing intervals, invoicing provisions, etc.). Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	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 agreement, 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; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; 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. All contracts shall contain provisions requiring Equal Employment Opportunity Provisions. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.
2. Contractor shall abide by the laws and regulations concerning confidentiality which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of DHH-OBH, 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 DHH-OBH 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 DHH-OBH. 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 DHH-OBH 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 DHH-OBH such records within thirty (30) days of DHH-OBH's written request and shall deliver such records to DHH-OBH's central office in Baton Rouge, Louisiana, all without expense to DHH-OBH. Contractor shall allow DHH-OBH to inspect, audit or copy records at the contractor's site, without expense to DHH-OBH.
5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or notation), without written consent of DHH-OBH thereto, provided, however, that claims for money due or to become due to Contractor from DHH-OBH 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 DHH-OBH 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, and shall maintain, at Contractor's expense, all necessary insurance for its employees, including but not limited to automobile insurance, workers' compensation and general liability insurance.
7. 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.
8. 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.
9. 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.
10. All records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall, upon request, be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

11. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of DHH-OBH. Any subcontracts approved by DHH-OBH shall be subject to conditions and provisions as DHH-OBH 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 claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by DHH-OBH. In the event DHH-OBH determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, DHH-OBH 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.
13. 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 DHH-OBH; 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.
14. 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.
15. 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 DHH-OBH; and; if contract exceeds \$20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.
16. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.
17. 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, DHH-OBH 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.

18. 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 update, 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 DHH-OBH. Contractor agrees to deliver any such equipment to DHH-OBH within 30 days of termination of services.
19. 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.
20. 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.
21. 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 AGREEMENT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS AGREEMENT IS SIGNED AND ENTERED INTO ON THE DATE INDICATED BELOW.

CONTRACTOR

CONTRACTOR

SIGNATURE **DATE**

NAME

TITLE

**STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS**

DHH Secretary or designee **DATE**

HIPAA Business Associate Addendum:

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

1. The U. S. Department of Health and Human Services has issued final regulations, pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), governing the privacy of individually identifiable health information. See 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"). DHH-OBH of Health and Hospitals, ("DHH"), as a "Covered Entity" as defined by HIPAA, is a provider of health care, a health plan, or otherwise has possession, custody or control of health care information or records.
2. "*Protected health information*" ("PHI") means individually identifiable health information including all information, data, documentation and records, including but not limited to demographic, medical and financial information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual or payment for health care provided to an individual; and that identifies the individual or which DHH believes could be used to identify the individual.
 "*Electronic protected health information*" means PHI that is transmitted by electronic media or maintained in electronic media.
 "*Security incident*" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
3. Contractor is considered a Business Associate of DHH, as contractor either: (A) performs certain functions on behalf of or for DHH involving the use or disclosure of protected individually identifiable health information by DHH to contractor, or the creation or receipt of PHI by contractor on behalf of DHH; or (B) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, financial or social services for DHH involving the disclosure of PHI.
4. Contractor agrees that all PHI obtained as a result of this contractual agreement shall be kept confidential by contractor, its agents, employees, successors and assigns as required by HIPAA law and regulations and by this contract and addendum.
5. Contractor agrees to use or disclose PHI solely (A) for meeting its obligations under this contract, or (B) as required by law, rule or regulation or as otherwise permitted under this contract or the HIPAA Privacy Rule.
6. Contractor agrees that at termination of the contract, or upon request of DHH, whichever occurs first, contractor will 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 will 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.
7. Contractor will ensure that its agents, employees, subcontractors or others to whom it provides PHI received by or created by contractor on behalf of DHH agree to the same restrictions and conditions that apply to contractor with respect to such information. Contractor also agrees to take all reasonable steps to ensure that its employees', agents' or subcontractors' actions or omissions do not cause contractor to breach the terms of this Addendum. Contractor will use all appropriate safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this contract and Addendum.
8. Contractor shall, within 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.
9. 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.

10. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR 164.524.
11. 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.
12. 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 Privacy Rule.
13. Compliance with Security Regulations:

In addition to the other provisions of this Addendum, if Contractor creates, receives, maintains, or transmits electronic PHI on DHH's behalf, Contractor shall, no later than April 20, 2005:

 - (A) Implement 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;
 - (B) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and
 - (C) Report to DHH any security incident of which it becomes aware.
14. Contractor agrees to indemnify and hold DHH harmless from and against all liability and costs, including attorneys' fees, created by a breach of this Addendum by contractor, its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. 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 material term of this Addendum.

Cost Template

- 1. Annual Administrative and Care Management Expenses.** The Proposer shall include all anticipated costs of successful implementation of all deliverables outlined in the RFP. An item by item breakdown of costs shall be included in the proposal. The cost submission should be submitted separately and should include costs broken down in the detail contained in the table below for each year of the contract separately. The cost portion should also include any administrative and professional services subcontractor costs associated with any subcontractors proposed in the technical portion (a breakout of these costs is required).

Please note: Table 1 below is for informational purposes only. The Proposer should complete the cost proposal in an excel spreadsheet utilizing the format below, with separate tabs for Year 1 and Year 2. Table 1 details the expected administrative and care management expenses of the Proposer on an annual basis. This information will be used to ensure the Proposer's per member per month (PMPM) cost proposal is reasonable.

Table 1: Hourly Rates and Total Annual Expenses

Year XX	Estimated Hourly Rate	Total Annual Expenses
Administrative Staff including technical staff, salary and benefits (list by position)		
Member Services Staff including salary and benefits (list by position)		
Care Management /Utilization Management Staff including salary and benefits (list by position)		
Network Management Staff including salary and benefits (list by position)		
Quality Management Staff including salary and benefits (list by position)		
Contracted Staff (list by position)		
Information technology related expenditures and depreciation and amortization	Provide annual expenses only	
Total Staffing Costs		
Operating Costs:		
Rent		
Utilities		

Year XX	Estimated Hourly Rate	Total Annual Expenses
Telephone		
Insurance		
Office Supplies		
Other Costs (List):		
Administrative and Professional Services Subcontractors (List)		
Corporate Overhead Allocations (List)		
Depreciation and Amortization (Non-Information Technology related)		
Information technology related expenditures and depreciation and amortization		
Total Annual Expenses		

- 2. PMPM Proposal for Children.** The Proposer must submit its cost proposal for the administrative and care management expenses for Title XIX Children and Children in the CSoC program regardless of payer source, on a per member per month (PMPM) basis for each year of the contract in a format as outlined in Table 2 below. This information will be utilized for the cost evaluation of the proposal for administrative and care management services for children.

Table 2: PMPM Administrative and Care Management Proposal for Children

Title XIX Category	Year 1 Administrative and Care Management \$PMPM proposal	Year 2 Administrative and Care Management \$PMPM proposal
Children in 1915(b) Medicaid waiver only		
Children in CSoC program regardless of funding source		

3. Administrative Services Cost Proposal for Non Title XIX Populations

In the event of an award, the Contractor will be required to perform administrative services for populations that are not covered by Medicaid (Children in OJJ/DCFS/OBH, but not in the CSoC, and Adults receiving services through OBH for behavioral health including the SAPT and MHBG).

The Contractor will receive a reimbursement for the administrative services performed for OJJ and DCFS Non Title XIX children on the basis of a percentage of the medical claims payments associated with these Members. This amount will be set at 8% of medical claims payments. The Proposer must acknowledge that it will accept payment of administrative expenses for these Non Title XIX Members on this basis. The administrative services for these populations include claims payment.

For OBH Non-Title XIX children not enrolled in the CSoC and for adults, the Contractor shall propose costs for the administrative services outlined in the RFP exclusive of claims payment. OBH will continue to pay providers directly for Non-Title XIX members that receive Clinic

services and for Non-Title XIX members that receive specific OBH contract services. (Refer to the Procurement Library for information on Clinic services and OBH contracted services for Non-Title XIX members.)

The proposer must submit a cost proposal for providing administrative services exclusive of claims payment for Non Title XIX OBH members. The cost proposal should be based upon a percentage of the cost of services authorized for Non-Title XIX eligibles.

Table 3: Administrative Fees for Non-Title XIX Eligibles

Administrative Fee for DCFS/OJJ Non-Title XIX Eligibles	Administrative Fee for OBH Non-Title XIX Eligibles (Adults and Non CSoC Children)
Percentage of Medical Claims payments	Percentage of Cost of Services Authorized
8% (Pre-established)	To be proposed by Contractor

4. Adult Services At-Risk \$PMPM Proposal. Proposer must submit a cost proposal for the monthly capitation rate by rate cell in a format similar to Table 4 below. Refer to the Adult Services Data Book available in the Procurement Library to assist with calculation of the cost proposal for adult services. Information from Table 3 below will be utilized for the cost evaluation of the proposal for the capitated adult services. Please note that all Title XIX adult expenses (medical, administrative and care management) will be paid as part of the overall capitated rate. The at-risk \$PMPM proposal for Adult rate cells is for year 1 only. The year 2 rate will be recalculated based upon actuarial analysis.

Table 4: PMPM Proposal for Adults

Adult Rate Cell	Year 1 At-Risk \$PMPM proposal
Non-Disabled Adults, Ages 21-64	
Disabled Adults, Ages 21-64	
Aged Adults, Ages 65+	

CERTIFICATION OF COMPLIANCE WITH PRO-CHILDREN ACT OF 1994

Contractors must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where WIC coupons are redeemed.

The Contractor further agrees that the above language will be included in any subawards that contain provisions for children's services and that all sub grantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to \$1000 per day.

Signature: _____

Title: _____

Organization: _____

Date: _____

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND
VOLUNTARY EXCLUSION -- LOWER TIER COVERED TRANSACTIONS**

By signing and submitting this proposal, the proposer is providing the certification set out below:

1. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the proposer knowingly rendered an erroneous certification, in addition to other remedies available to the federal government the Contracting Agencies may pursue available remedies, including suspension and/or debarment.

2. The proposer shall provide immediate written notice to the person to whom this proposal is submitted if at any time the proposer learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

3. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principle, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

4. The proposer agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Contracting agencies.

5. The proposer further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

6. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. A participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Non-procurement Programs.

7. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

8. Except for transactions authorized under paragraph 4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a

person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the Contracting Agencies may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AN VOLUNTARY EXCLUSION--LOWER TIER COVERED TRANSACTIONS

(1) The proposer 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.

(2) Where the proposer is unable to certify to any of the statements in this certification, such proposer shall attach an explanation to this Proposal.

(Signature)

(Title)

(Company Name)

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

- A. No federal appropriated funds have been paid or will be paid on behalf of the Contractor to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of the Congress, an officer or employee of the Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan or cooperative agreement.
- B. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of the Congress, or an employee of a member of Congress in connection with this Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- C. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C.A. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Signature: _____

Title: _____

Organization: _____

Date: _____