



**Office of State Procurement
PROACT Contract Certification of Approval**

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

Reference Number: 2000506243

Vendor: MCNA Insurance Company, d/b/a MCNA Dental Plans

Description: PAHP delivering core dental benefits to eligible LA Medicaid enrollees

Approved By: Pamela Rice

Approval Date: 10/02/2020

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

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

**CONTRACT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH**

LAGOV: **2000506243**

LDH:

BHSF

Bureau of Health Services Financing

Agency # **305**

AND

MCNA Insurance Company, d/b/a MCNA Dental

FOR

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

RFP NUMBER (if applicable): 3000013043

| | |
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| <p>1) Contractor (Registered Legal Name) MCNA Insurance Company, d/b/a MCNA Dental</p> | <p>5) Federal Employer Tax ID# State LDR Account # 52-2459969 368056</p> |
| <p>2) Street Address 200 West Cypress Creek Road, Suite 500</p> | <p>6) Parish(es) Served Statewide ST</p> |
| <p>City State Zip Code Fort Lauderdale FL 33309</p> | <p>7) License or Certification # N/A</p> |
| <p>3) Telephone Number (800)494-6262</p> | <p>8) Contractor Status</p> <p>Subrecipient: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Corporation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No For Profit: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Publicly Traded: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> |
| <p>4) Mailing Address (if different) N/A</p> | <p>8a) CFDA#(Federal Grant #) N/A</p> |
| <p>City State Zip Code N/A NA N/A</p> | |

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

Contractor will function as a risk-bearing, Prepaid Ambulatory Health Plan health care delivery system that provides specified core dental benefits and services for eligible Louisiana Medicaid enrollees as defined in the Louisiana Medicaid State Plan, administrative rules, and Medicaid Policy and Procedures manuals. See attachment B.

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| 10) Effective Date 01-01-2021 | 11) Termination Date 12-31-2023 |
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12) **Maximum Contract Amount** \$355,700,072.00

13) **Estimated Amounts by Fiscal Year** FY21: \$56,689,544 ; FY22: \$116,780,460; FY23: \$120,283,873; FY24: \$61,946,195

14) **Terms of Payment**
If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows:
The contractor will be a paid a per member per month capitation payment upon successful completion of required contract deliverables.

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

| | | | |
|--|--|-------------------------------------|--|
| PAYMENT WILL BE MADE ONLY UPON APPROVAL OF: | First Name Stacy | Last Name Guidry | |
| | Title Section Chief/Medicaid Program Manager 4 | Phone Number 337-857-6115 | |

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

| | | |
|---|--|---|
| <p>Attachment A: HIPAA Addendum Attachment B: Statement of Work Attachment D: Rate Certification (reserved)</p> | <p>Exhibit 1: Resumes Exhibit 2: Board Resolution Exhibit 3: Disclosure of Ownership Exhibit 4: Certificate of Authority Exhibit 5 Multi-Year Justification Letter</p> | <p>Attachment:HIPAA Addendum Attachment:Standard Provisions Attachment:Special Provisions Attachment:Statement of Work Attachment:Fee Schedule Attachment:Budget Attachment: Exhibit:Board Resolution Exhibit:Disclosure of Ownership Exhibit:Multi Year Letter Exhibit:Late Letter Exhibit:Out of State Justification Exhibit:Certificate of Authority Exhibit:Resume Exhibit:License Exhibit:</p> |
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During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. **Discrimination Clause:** Contractor hereby agrees to abide by the requirements of the following as applicable: Titles VI and VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990; the Rehabilitation Act of 1973; Federal Executive Order 11246 as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Fair Housing Act of 1968; and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services.

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

2. **Confidentiality:** Contractor shall abide by the laws and regulations concerning confidentiality which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)
3. **Auditors:** The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a five year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Louisiana Department of Health, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

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

4. **Record Retention:** Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.
5. **Record Ownership:** All records, reports, documents and other material delivered or transmitted to Contractor by the Department shall remain the property of the Department, and shall be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract. All records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of the Department, and shall, upon request, be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract.
6. **Nonassignability:** Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of State Procurement.
7. **Taxes:** Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The Contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.
8. **Insurance:** Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Louisiana Department of Health, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.
9. **Travel:** In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.
10. **Political Activities:** No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the Legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.
11. **State Employment:** Should Contractor become an employee of the classified or unclassified service of the State of Louisiana during the 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.
12. **Ownership of Proprietary Data:** All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

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

14. **Conflict of Interest:** Contractor warrants that no person and no entity providing services pursuant to this contract on behalf of Contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 42:1113.
15. **Unauthorized Services:** No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.
16. **Fiscal Funding:** This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds \$2,000, the Division of Administration, Office of State Procurement.

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

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

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

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

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

18. **Amendments:** Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if the contract exceeds \$2,000, by the Division of Administration, Office of State Procurement. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.
19. **Non-Infringement:** Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against LDH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in LDH's name, but at Contractor's expense and shall indemnify and hold harmless LDH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.
20. **Purchased Equipment:** Any equipment purchased under this contract remains the property of the Contractor for the period 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 LDH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.
21. **Indemnity:** Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, LDH, 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 R.S. 40:1237.1 et seq. 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 LDH.

22. **Severability:** Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.
23. **Entire Agreement:** Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.
24. **E-Verify:** Contractor acknowledges and agrees to comply with the provision of R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under this contract.
25. **Remedies for Default:** Any claim or controversy arising out of this contract shall be resolved by the provisions of R.S. 39:1672.2-1672.4.
26. **Governing Law:** This contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana, including but not limited to R.S. 39:1551-1736; rules and regulations; executive orders; standard terms and conditions, and specifications listed in the RFP (if applicable); and this Contract.
27. **Contractor's Cooperation:** The Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the state when requested. This applies even if this Contract is terminated and/or a lawsuit is filed. Specifically, the Contractor shall not limit or impede the State's right to audit or shall not withhold State owned documents.
28. **Continuing Obligation:** Contractor has a continuing obligation to disclose any suspension or debarment by any government entity, including but not limited to the General Services Administration (GSA). Failure to disclose may constitute grounds for suspension and/or termination of the Contract and debarment from future contracts.
29. **Eligibility Status:** Contractor and each tier of Subcontractors, shall certify that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving federal funds or grants from the Federal Government. Contractor and each tier of Subcontractors shall certify that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with E.O.s 12549 and 12689, "Debarment and Suspension," as set forth at 24CFR Part 24, and "NonProcurement Debarment and Suspension" set forth at 2CFR Part 2424.
30. **Act 211 Taxes Clause:** In accordance with R.S. 39:1624(A)(10), the Louisiana Department of Revenue must determine that the prospective contractor is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the state and collected by the Department of Revenue prior to the approval of this contract by the Office of State Procurement. The prospective contractor hereby attests to its current and/or prospective compliance, and agrees to provide its seven-digit LDR Account Number to LDH so that the prospective contractor's tax payment compliance status may be verified. The prospective contractor further acknowledges understanding that issuance of a tax clearance certificate by the Louisiana Department of Revenue is a necessary precondition to the approval and effectiveness of this contract by the Office of State Procurement. LDH reserves the right to withdraw its consent to this contract without penalty and proceed with alternate arrangements should the vendor fail to resolve any identified apparent outstanding tax compliance discrepancies with the Louisiana Department of Revenue within seven (7) business days of such notification.
31. **Termination for Cause:** The Department may terminate this Contract for cause based upon the failure of the Contractor to comply with the terms and/or conditions of the Contract; provided that the Department shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the Department may, at its option, place the Contractor in default and the Contract shall terminate on the date specified in such notice. The Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the Department to comply with the terms and conditions of this contract; provided that the Contractor shall give the Department written notice specifying the Department's failure and a reasonable opportunity for the state to cure the defect.
32. **Termination for Convenience:** The Department may terminate this Contract at any time by giving thirty (30) days written notice to the Contractor. The Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.
33. **Prohibition of Discriminatory Boycotts of Israel:** In accordance with Executive Order Number JBE 2018-15, effective May 22, 2018, for any contract for \$100,000 or more and for any contractor with five or more employees, Contractor, or any Subcontractor, hereby certifies it is not engaging in a boycott of Israel, and shall, for the duration of this contract, refrain from a boycott of Israel. The State reserves the right to terminate this contract if the Contractor, or any Subcontractor, engages in a boycott of Israel during the term of the contract.
34. **Countersignature:** This contract may be executed in two or more counterparts, each of which shall be deemed an original, but all of which, taken together, shall constitute one and the same instrument.
35. **No Employment Relationship:** Nothing in this Agreement shall be construed to create an employment or agency relationship, partnership or joint venture between the employees, agents, or subcontractors of the Contractor and the State of Louisiana.
36. **Venue:** Venue for any action brought with regard to this Agreement shall be in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana.
37. **Commissioner's Statements:** Statements, acts and omissions made by or on behalf of the Commissioner of Administration regarding the RFP or RFP process, this Contract, any Contractor and/or any subcontractor of the Contractor shall not be deemed a conflict of interest when the Commissioner is discharging his duties and responsibilities under law, including, but not limited, to the Commissioner of Administration's authority in procurement matters.
38. **Order of Precedence Clause:** In the event of any inconsistent or incompatible provisions in an agreement which resulted from an RFP, this signed Agreement (excluding the RFP and Contractor's proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of the Contractor's proposal. *This Order of Precedence Clause applies only to contracts that resulted from an RFP.*

SIGNATURES TO FOLLOW ON THE NEXT PAGE

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

MCNA Insurance Company, d/b/a MCNA Dental

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

 7/31/2020

SIGNATURE **DATE**

SIGNATURE **DATE**

Carlos Lacasa

NAME

NAME

Senior Vice President and General Counsel

TITLE

TITLE

Bureau of Health Services Financing

 7/31/20

SIGNATURE **DATE**

SIGNATURE **DATE**

Ruth Johnson

NAME

NAME

Medicaid Director

TITLE

TITLE

Rev. 06/2016

HIPAA Business Associate Addendum

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

1. The Louisiana Department of Health ("LDH") is a Covered Entity, as that term is defined herein, because it functions as a health plan and as a health care provider that transmits health information in electronic form.
2. Contractor is a Business Associate of LDH, as that term is defined herein, because contractor either: (a) creates, receives, maintains, or transmits PHI for or on behalf of LDH; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for LDH involving the disclosure of PHI.
3. Definitions: As used in this addendum –
 - a. The term "HIPAA Rules" refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 C.F.R. Parts 160 and 164, which were originally promulgated by the U. S. Department of Health and Human Services (LDHS) pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and were subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health ("HITECH") Act of the American Recovery and Reinvestment Act of 2009.
 - b. The terms "Business Associate", "Covered Entity", "disclosure", "electronic protected health information" ("electronic PHI"), "health care provider", "health information", "health plan", "protected health information" ("PHI"), "subcontractor", and "use" have the same meaning as set forth in 45 C.F.R. § 160.103.
 - c. The term "security incident" has the same meaning as set forth in 45 C.F.R. § 164.304.
 - d. The terms "breach" and "unsecured protected health information" ("unsecured PHI") have the same meaning as set forth in 45 C.F.R. § 164.402.
4. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this contract and addendum as required by the HIPAA Rules and by this contract and addendum.
5. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule or regulation (including the HIPAA Rules) or as otherwise required or permitted by this contract and addendum.
6. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this contract and addendum, including administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of LDH.
7. In accordance with 45 C.F.R. § 164.502(e)(1)(ii) and (if applicable) § 164.308(b)(2), contractor shall ensure that any agents, employees, subcontractors or others that create, receive, maintain, or transmit PHI on behalf of contractor agree to the same restrictions, conditions and requirements that apply to contractor with respect to such information, and it shall ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees' or subcontractors' actions or omissions do not cause contractor to violate this contract and addendum.
8. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1. Disclosures which must be reported by contractor include, but are not limited to, any security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La.R.S. 51:3071 *et seq.* At the option of LDH, any harm or damage resulting from any use or disclosure which violates this contract and addendum shall be mitigated, to the extent practicable, either: (a) by contractor at its own expense; or (b) by LDH, in which case contractor shall reimburse LDH for all expenses that LDH is required to incur in undertaking such mitigation activities.
9. To the extent that contractor is to carry out one or more of LDH's obligations under 45 C.F.R. Part 164, Subpart E, contractor shall comply with the requirements of Subpart E that apply to LDH in the performance of such obligation(s).
10. Contractor shall make available such information in its possession which is required for LDH 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 LDH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR § 164.528 for at least six (6) years after the date of the last such disclosure.
11. Contractor shall make PHI available to LDH upon request in accordance with 45 CFR § 164.524.
12. Contractor shall make PHI available to LDH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
13. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of LDH available to the Secretary of the U. S. LDHS for purposes of determining LDH's compliance with the HIPAA Rules.
14. Contractor shall indemnify and hold LDH harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this addendum by contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. The parties agree that the legal relationship between LDH and contractor is strictly an independent contractor relationship. Nothing in this contract and addendum shall be deemed to create a joint venture, agency, partnership, or employer-employee relationship between LDH and contractor.
16. Notwithstanding any other provision of the contract, LDH shall have the right to terminate the contract immediately if LDH determines that contractor has violated any provision of the HIPAA Rules or any material term of this addendum.
17. At the termination of the contract, or upon request of LDH, whichever occurs first, contractor shall return or destroy (at the option of LDH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor shall extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.



Bureau of Health Services Financing

Attachment B

Statement of Work

For

Dental Benefit Program Management

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PART 1: GENERAL INFORMATION

1.1 Background

The mission of the Louisiana Department of Health (LDH) is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. LDH is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner.

LDH is comprised of program offices, including the Bureau of Health Services Financing (BHSF) (Medicaid), the Office for Citizens with Developmental Disabilities (OCDD), the Office of Behavioral Health (OBH), 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 LDH.

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

Louisiana provides state-approved dental services for eligible Medicaid enrollees through a Prepaid ambulatory health plan (PAHP).

1.2 Goals and Objectives

The Contractor shall deliver services to a portion of the population of approximately 1.5 million full benefit Medicaid enrollees. A contract is necessary to achieve the following goals:

- 1.2.1** Improved coordination of care;
- 1.2.2** Better dental health outcomes;
- 1.2.3** Increased quality of dental care;
- 1.2.4** Improved access to essential specialty dental services;
- 1.2.5** Outreach and education to promote dental health; and
- 1.2.6** Increased enrollee responsibility and self-management.

1.3 Term of Contract

The term of this Contract shall begin on January 1, 2021 and end on December 31, 2023. With all proper approvals and concurrence with the Contractor, LDH may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms, and conditions of the initial Contract Term. Prior to the extension of the Contract beyond the initial thirty-six (36) month term, approval by the Joint

Legislative Committee on the Budget (JLCB) or other approval required by law shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the Contract amendment to the Office of State Procurement (OSP) to extend the Contract beyond the initial three (3) year term. The total Contract Term, with extensions, shall not exceed five (5) years. The continuation of the Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

1.4 General Requirements

- 1.4.1** The Dental Benefit Program Manager (DBPM) must comply with Louisiana Medicaid conflict-of-interest safeguards at least equal to federal safeguards (41 USC §423) are in place per §1932(d)(3) of the Social Security Act.
- 1.4.2** The DBPM shall be responsible for the administration and management of its requirements and responsibilities under the Contract, in accordance with federal and state laws, rules, regulations, and guidance. This is also applicable to all subcontractors, employees, agents, and anyone acting for, or on behalf of, the DBPM.
- 1.4.3** The Contractor shall maintain a license or certificate of authority issued by the Louisiana Department of Insurance (LDI) to operate as a Medicaid risk bearing “prepaid entity” pursuant to La R.S. 22:1016.
- 1.4.4** The Centers for Medicare and Medicaid Services (CMS) must approve the Contract. If CMS does not approve the Contract entered into under the terms and conditions described herein, the Contract shall be considered null and void.
- 1.4.5** All information, whether data or documentation and reports that contain references to that information involving or arising out of the Contract is owned by LDH. The DBPM is expressly prohibited from sharing or publishing LDH’s information and reports without the prior written consent of LDH. In the event of a dispute regarding the sharing or publishing of information and reports, LDH’s decision on this matter shall be final.

PART 2: SCOPE OF SERVICES

2.1 Dental Benefit Program Requirements

- 2.1.1** The DBPM shall provide enrollees, at a minimum, those covered dental benefits and services specified in the Contract and as defined in the Louisiana Medicaid State Plan, and administrative rules. The DBPM shall possess the expertise and resources to ensure the delivery of quality services to DBPM enrollees in accordance with Louisiana Medicaid program standards and the prevailing dental community standards.
- 2.1.2** The DBPM shall participate in the State’s efforts to promote the delivery of services in a culturally competent manner to all members and comply with the U.S. Department of Health and Human Services, the Office of Minority Health’s “National Culturally and Linguistically Appropriate Services Standards (National CLAS Standards)”, which can be found at: <https://www.thinkculturalhealth.hhs.gov/clas/standards> and participate in the State’s efforts to promote the delivery of services in a culturally competent manner to all enrollees.

2.1.3 The DBPM must have a comprehensive written Cultural Competency Plan describing how the DBPM will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The Cultural Competency Plan must be developed in adherence to the National CLAS Standards. This plan must be submitted during readiness reviews.

2.1.4 Confidentiality

2.1.4.1 The DBPM shall comply with the HIPAA Privacy Rule, as well as other applicable federal and state laws and regulations, and the provisions of the Contract in its use and disclosure of dental records and any and all other health and enrollment information relating to enrollees, which is provided to or obtained by or through the DBPM's performance under the Contract, whether verbal, written, electronic file, or otherwise. The DBPM shall not use such information in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Contract.

2.1.4.2 Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning enrollees shall be limited to purposes directly connected with the administration of the Contract.

2.1.5 Required Document Submission

2.1.5.1 Formal policies and procedures must be submitted for initial review and approval during the readiness review process. If changes to policies and procedures are expected to have an impact on provider payment, network adequacy, or enrollee services, those must be submitted to LDH in writing sixty (60) calendar days prior to effective date for LDH approval. Methods for educating both the providers and the enrollees about changes shall be addressed in these policies and procedures.

2.1.5.2 In accordance with 42 CFR §438.207, the DBPM shall submit documentation regarding the adequacy of capacity and services in a format and at intervals specified by the State, but no less frequently than the following: 1) at the time it enters into a contract with the State; 2) on an annual basis; 3) at any time there has been a significant change (as defined by the State) in the DBPM's operations that would affect the adequacy of capacity and services, including changes in DBPM services, benefits, geographic service area, composition of or payments to its provider network, or at the enrollment of a new population in the DBPM.

2.1.6 Communication with LDH

Inquiries from LDH must be acknowledged by the next business day and the resolution, or process for resolution, communicated to LDH within twenty-four (24) hours.

2.2 Staffing Requirements

2.2.1 General Provisions

2.2.1.1 The DBPM shall have in place the organizational, operational, managerial, and

administrative systems capable of fulfilling all requirements under the Contract. The DBPM shall be staffed by qualified persons in numbers appropriate to the number of enrollees.

2.2.1.2 For the purposes of the Contract, the DBPM shall not employ or contract for the furnishing of health care, utilization review, medical social work, administrative services, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation. issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2.2.1.2.1 The DBPM shall check the following:

2.2.1.2.1.1 Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);

2.2.1.2.1.2 Louisiana Adverse Actions List Search;

2.2.1.2.1.3 The System of Award Management (SAM); and

2.2.1.2.1.4 Other applicable sites as determined by LDH.

2.2.1.3 The DBPM must employ sufficient staffing and utilize appropriate resources to achieve compliance with the Contract. The DBPM's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and LDH requirements, including the requirement for providing culturally competent services. If the DBPM does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring or regulatory action may be employed by LDH, including but not limited to requiring the DBPM to hire additional staff and the levying of monetary penalties.

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

2.2.1.5 The DBPM shall comply with LDH Policy 47.1, "Criminal History Records Check of Applicants and Employees", which requires criminal background checks to be performed on all employees of LDH contractors who have access to electronic protected health information on Medicaid applicants and beneficiaries. The DBPM shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any or all of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of the Contract.

2.2.1.6 The DBPM's administrative office shall maintain normal business hours of 8:00 a.m. to 5:00 p.m. CT Monday through Friday, excluding LDH designated state holidays. The administrative office shall not assume it may close if the LDH administrative office closes.

2.2.1.7 Employment of Personnel

2.2.1.7.1 In all hiring or employment made possible by or resulting from the Contract, the DBPM agrees that:

2.2.1.7.1.1 There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, gender, or national origin; and

2.2.1.7.1.2 Action shall be taken to ensure that employees are treated during employment in accordance with all state and federal laws applicable to employment of personnel.

2.2.1.7.2 This requirement shall apply to, but not be limited to, the following: employment, promotion, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The DBPM further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color, religion, sex, gender, or national origin.

2.2.1.7.3 All inquiries made to the DBPM concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, gender, or national origin. All responses to inquiries made to the DBPM concerning employment made possible or as a result of the Contract shall conform to federal, state, and local regulations.

2.2.1.7.4 The DBPM may terminate any of its employees designated to perform work or services under the Contract, as permitted by applicable law.

2.2.2 Key Personnel Positions

2.2.2.1 An individual staff member shall not occupy more than one of the key personnel positions listed below without prior approval from LDH or otherwise stated below.

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

- 2.2.2.3** Replacement of key personnel shall require prior written approval from LDH, which shall not be unreasonably withheld provided a suitable candidate is proposed.
- 2.2.2.4** The DBPM shall, with the approval of LDH, replace any of the key personnel with a person of equivalent experience, knowledge and talent, within sixty (60) calendar days of resignation/termination of previous staff.
- 2.2.2.5** For the duration of the Contract, the Contractor must fill the following key personnel positions, which shall be dedicated one hundred percent (100%) to the Contract and shall be available during all business hours:
 - 2.2.2.5.1** DBPM CEO, who must have a bachelor's degree and at least three (3) years' experience managing a dental or medical program or contract of equal or greater scope. Medicaid experience is preferred.
 - 2.2.2.5.1.1** This position shall be responsible for providing overall direction for the DBPM, developing strategies, formulating policies, and overseeing operations to ensure deliverables are met. Must serve in a full time (minimum of forty (40) hours weekly) position available during LDH working hours (8:00 AM to 4:30 PM) to fulfill the responsibilities of the position.
 - 2.2.2.5.1.2** This position shall be physically located in Louisiana.
 - 2.2.2.5.2** Contract Operations Manager, who must have a bachelor's degree and at least three (3) years' experience managing a Medicaid project of equal or greater scope.
 - 2.2.2.5.2.1** This position shall be knowledgeable and responsible for managing day-to-day operations of multiple levels of staff and multiple functions/departments across the DBPM to meet performance requirements. This position is accountable to the DBPM CEO for operational results, and shall be authorized and empowered to represent the DBPM regarding all matters pertaining to the Contract.
 - 2.2.2.5.2.2** This position shall be physically located in Louisiana.
 - 2.2.2.5.3** Dental Director, who must be a Louisiana-licensed Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS), with no restrictions or other licensure limitations.
 - 2.2.2.5.3.1** This position shall be empowered and authorized to make quality management policies, Utilization Review (UR) decisions and clinical decisions, and address quality of care issues.
 - 2.2.2.5.3.2** This position shall be physically located in Louisiana.

2.2.2.5.4 IT Manager, who must have a bachelor's degree and at least three (3) years' experience in managing an information technology project of equal or greater scope.

2.2.2.5.4.1 This position shall be knowledgeable and responsible for managing IT infrastructure, including but not limited to security, computer systems, network access, and electronic data operations.

2.2.2.5.5 Claims Manager, who must have a bachelor's degree and have at least three (3) years' experience in managing a Medicaid claims unit of equal or greater scope.

2.2.2.5.5.1 This position shall be knowledgeable and responsible for managing all functions associated with dental claims, including but not limited to payment, coding, timely filing, and auditing.

2.2.2.5.6 Provider Network Manager, who must have a bachelor's degree and have at least three (3) years' experience in managing a Medicaid provider network of equal or greater scope.

2.2.2.5.6.1 This position shall be knowledgeable and responsible for all provider network requirements including but not limited to network adequacy, geomapping, provider complaints, and network development plans.

2.2.2.5.7 Compliance Officer, who must have a bachelor's degree and have at least three (3) years' experience working as a compliance officer for a Medicaid project of equal or greater scope.

2.2.2.5.7.1 This position will serve as the primary point-of-contact for all DBPM compliance issues related to this contract, will manage the connection of DBPM personnel to LDH business owners, and will develop and implement written policies, procedures, and standards to ensure compliance with the requirements of the Contract. These primary functions may include but are not limited to coordinating the tracking and submission of all Contract deliverables, fielding and coordinating responses to LDH inquiries, coordinating the preparation and execution of Contract requirements, random and periodic audits and ad hoc requests.

2.2.2.6 Additional Required Personnel

The DBPM must designate additional management and technical personnel who will be assigned to the Contract for the following functional areas:

2.2.2.6.1 Enrollee Services;

- 2.2.2.6.2** Benefit Administration and Utilization;
- 2.2.2.6.3** Quality Improvement;
- 2.2.2.6.4** Financial Operations; and
- 2.2.2.6.5** Reporting.

2.2.3 Substitution of Personnel

The DBPM's key personnel assigned to the Contract shall not be replaced without the prior written consent of LDH. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any DBPM personnel become unavailable due to resignation, illness, or other factors outside of the DBPM's reasonable control, as the case may be, the DBPM shall be responsible for providing an equally qualified replacement in time to avoid delays in completing tasks. The DBPM will make every reasonable attempt to assign the personnel listed in his proposal.

2.2.4 Written Policies, Procedures, and Position Descriptions

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

- 2.2.4.3.1** An updated organization chart complete with the key personnel positions. The chart must include the person's name, title, e-mail address, and telephone number.
- 2.2.4.3.2** A functional organization chart of the key program areas, responsibilities and the areas that report to that position.
- 2.2.4.3.3** A listing of all functions and their locations; and a list of any functions that have moved outside of the State of Louisiana in the past calendar year.

2.2.5 Staff Training and Meeting Attendance

- 2.2.5.1** The DBPM shall ensure that all staff members have appropriate training, education, experience, and orientation to fulfill their requirements of their position. The DBPM shall ensure that all marketing agents are trained annually on state and federal requirements and on details specific to the Dental Benefit Program. The DBPM training programs shall be approved by LDH, and shall be made available to LDH upon request.
- 2.2.5.2** The DBPM must provide initial and ongoing staff training that includes an overview of Medicaid Policy, Contract, and state and federal requirements specific to individual job functions. The DBPM shall ensure that all staff members having contact with enrollees or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.
- 2.2.5.3** New and existing prior authorization and enrollee services representatives must be trained in the geography of Louisiana and have access to mapping search engines (e.g. MapQuest, Google Maps, ArcGIS) for the purposes of authorizing services and recommending providers in the most geographically appropriate location.
- 2.2.5.4** The DBPM shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by LDH. All meetings shall be considered mandatory unless otherwise indicated. Staff shall attend in person as directed by LDH.
- 2.2.5.5** LDH reserves the right to attend any and all training programs and seminars conducted by the DBPM. The DBPM shall provide LDH a list of any training dates, time, and location, at least fourteen (14) calendar days prior to the actual date of training.

2.3 Eligibility and Enrollment

Some Subsections of this section are only applicable if more than one (1) DBPM holds a contract with the State.

2.3.1 Mandatory Populations

- 2.3.1.1** The DBPM will serve eligible Louisiana Medicaid enrollees in the following categories:

- 2.3.1.1.1** Group A - as specified in LAC 50:XV.6901, Medicaid beneficiaries who are under twenty-one (21) years of age; and
- 2.3.1.1.2** Group B - as specified in LAC 50:XXV.303, Medicaid beneficiaries who are twenty-one (21) years of age and older and whose Medicaid coverage includes the full range of Medicaid services.

2.3.2 Excluded Populations

2.3.2.1 Individuals who are twenty-one (21) years of age and older that are certified in the following Medicaid programs are not eligible for the Dental Benefit Program:

- 2.3.2.1.1** Qualified Medicare Beneficiary (QMB) only;
- 2.3.2.1.2** Specified Low-Income Medicare Beneficiary (SLMB);
- 2.3.2.1.3** Qualified Individual (QI 1);
- 2.3.2.1.4** Long Term Care (LTC) Co-Insurance;
- 2.3.2.1.5** Program of All-Inclusive Care for the Elderly (PACE);
- 2.3.2.1.6** Take Charge Plus;
- 2.3.2.1.7** Illegal/Ineligible Aliens Emergency Services;
- 2.3.2.1.8** Louisiana Behavioral Health Partnership (LBHP);
- 2.3.2.1.9** Tuberculosis (TB); and
- 2.3.2.1.10** Qualified Disabled Working Individual (QDWI)

2.3.3 Changes to Population Groups

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

2.3.4 DBPM Enrollment Procedures

2.3.4.1 Acceptance of All Enrollees

- 2.3.4.1.1** The Contractor shall enroll any mandatory Medicaid beneficiary who selects the Contractor or is assigned to it.
- 2.3.4.1.2** The Contractor shall accept new enrollment from individuals in the order in which they are submitted by the enrollment broker without restriction as specified by LDH, up to the limits set under this Contract [42 CFR §438.3(d)(1)].

2.3.4.1.3 The Contractor shall not discriminate against enrollees on the basis of their health history, health status, need for health care services or adverse change in health status; or on the basis of age, religious belief, sex, gender, sexual orientation, gender identity, or disability. Further, the Contractor shall not use any policy or practice that has the effect of discriminating on the basis of age, religious belief, race, color, national origin, sex, sexual orientation, gender identity, or disability. This applies to enrollment, re-enrollment or disenrollment from the DBPM. The Contractor shall be subject to monetary penalties and other sanctions if it is determined by LDH that the DBPM has requested disenrollment for any of these prohibited reasons.

2.3.4.1.4 The Contractor shall comply with all federal and state statutes and rules governing direct reimbursement to Medicaid enrollees for payments made by them for medical services and supplies delivered during a period of retroactive eligibility.

2.3.4.2 Effective Date of Enrollment

2.3.4.2.1 The effective date of initial enrollment in a DBPM shall be the date provided on the outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance electronic transaction initiated by the enrollment broker.

2.3.4.2.2 An enrollee's effective date of enrollment in a DBPM shall be the same as the enrollee's effective date of eligibility for Medicaid, subject to the following limitations:

2.3.4.2.2.1 Individuals may be retroactively eligible for Medicaid. Individuals retroactively eligible for Medicaid may be retroactively enrolled in a DBPM. However, retroactive enrollment in a DBPM is limited to twelve (12) months.

2.3.4.2.2.2 In cases of retroactive eligibility, the effective date of DBPM enrollment may occur prior to either the individual or the DBPM being notified of the person's DBPM enrollment.

2.3.4.2.3 The Contractor shall not be liable for the cost of any DBPM covered services prior to the effective date of DBPM enrollment, but shall be responsible for the costs of covered services obtained on or after 12:01 am on the effective date of DBPM enrollment.

2.3.4.2.4 LDH shall make monthly capitation payments to the Contractor from the effective date of an enrollee's DBPM enrollment.

2.3.4.2.5 The Contractor shall ensure that enrollees are held harmless for the cost of covered services provided as of the effective date of enrollment with the DBPM.

2.3.5 Suspension of and/or Limits on Enrollments

- 2.3.5.1** The DBPM shall identify the maximum number of DBPM members it is able to enroll and maintain under the Contract prior to initial enrollment of Medicaid beneficiaries. The DBPM shall accept Medicaid enrollees as DBPM members in the order in which they are submitted by the enrollment broker without restriction [42 CFR §438.3(d)(1)] as specified by LDH up to the limits specified in this Contract. LDH reserves the right to approve or deny the maximum number of DBPM members to be enrolled in the DBPM based on LDH's determination of the adequacy of DBPM capacity.
- 2.3.5.2** Consistent with the reporting requirements of the Contract, the DBPM shall submit a quarterly update of the maximum number of members. The DBPM shall track slot availability and notify LDH's enrollment broker when filled slots are within ninety percent (90%) of capacity. The DBPM is responsible for maintaining a record of total primary care dentist (PCD) linkages of Medicaid members and provide this information quarterly to LDH.
- 2.3.5.3** LDH will notify the DBPM when the DBPM's enrollment levels reach ninety-five percent (95%) of capacity, at which time, LDH will cease automatically assigning Medicaid eligibles.
- 2.3.5.4** In the event the DBPM's enrollment reaches sixty percent (60%) of the total enrollment in the state, the DBPM will not receive additional members through the automatic assignment algorithm. However, the DBPM may receive new members as a result of: member choice and newborn enrollments; reassignments when a member loses and regains eligibility; selection when other family or case members are members of the DBPM; the need to ensure continuity of care for the member; or determination of just cause by LDH. LDH's evaluation of a DBPM's enrollment market share will take place on a calendar quarter.

2.3.6 Change in Status

- 2.3.6.1** The Contractor shall report to LDH in the manner and format determined by LDH of any changes in demographic information or living arrangements for families or individual enrollees within five (5) business days of discovery, including changes in mailing address, residential address, e-mail address, and/or telephone number.
- 2.3.6.2** The Contractor shall submit notifications to LDH for other known changes in status which may affect eligibility for participation in Medicaid including, but not limited to, death, admission to intermediate care facility for people with developmental disabilities for enrollees age twenty-one (21) and over, and entry into involuntary custody/incarceration, in the manner and format determined by LDH.

2.3.7 Disenrollment

- 2.3.7.1** General Requirements

2.3.7.1.1 The Contractor shall, at a minimum, continue to provide DBPM covered services and all other services required under this Contract to enrollees up to 12:00 a.m. of the day after the effective date of disenrollment.

2.3.7.1.2 The Contractor shall demonstrate a satisfactorily low voluntary enrollee disenrollment request rate as compared with other DBPMs, as determined by LDH.

2.3.7.2 Voluntary Disenrollment Requested by the Enrollee

An enrollee may request disenrollment from the DBPM as follows:

2.3.7.2.1 **For cause**, at any time. The following circumstances are cause for disenrollment:

- The Contractor does not, because of moral or religious objections, cover the service the enrollee seeks;
- The enrollee needs related services to be performed at the same time; not all related services are available within the DBPM and the enrollee's Primary Dental Provider (PDP) or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;
- The Contract between the Contractor and LDH is terminated;
- Poor quality of care rendered by the Contractor as determined by LDH;
- Lack of access to DBPM covered services as determined by LDH; or
- Any other reason deemed to be valid by LDH and/or its agent.

2.3.7.2.2 **Without cause** for the following reasons:

- During the ninety (90) calendar days following the date of the beneficiary's initial enrollment into the DBPM or during the ninety (90) days following the date the enrollment broker sends the beneficiary notice of that enrollment, whichever is later;
- Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual open enrollment opportunity;
- When LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3); or

- After LDH notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.

2.3.7.3 Involuntary Disenrollment Requested by the DBPM

2.3.7.3.1 The Contractor may request involuntary disenrollment of an enrollee if the enrollee's utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee's ID card to another person to obtain services. In such case the Contractor shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).

2.3.7.3.2 The Contractor shall submit disenrollment requests to the enrollment broker, in a format and manner to be determined by LDH.

2.3.7.3.3 The Contractor shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

2.3.7.3.4 The Contractor shall not request disenrollment because of an adverse change in physical or mental health status or because of the enrollee's health diagnosis, utilization of medical services, diminished mental capacity, preexisting medical condition, refusal of medical care or diagnostic testing, attempt to exercise his/her rights under the Contractor's grievance system, or attempt to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. Further, the Contractor shall not request disenrollment because of an enrollee's uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to either this particular enrollee or other enrollees. [42 CFR §438.56(b)(2)]

2.3.7.3.5 The Contractor shall not request disenrollment for reasons other than those stated in this Contract. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the Contractor is not requesting disenrollment for other reasons by reviewing and rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker.

2.3.7.3.6 All disenrollment requests shall be reviewed on a case-by-case basis and the final decision is at the sole discretion of LDH or its designee (enrollment broker). All decisions are final and not subject to the dispute resolution process by the Contractor.

2.3.7.3.7 When the Contractor's request for involuntary disenrollment is approved by LDH, the Contractor shall notify the enrollee in writing of the requested disenrollment. The notice shall include:

2.3.7.3.7.1 The reason for the disenrollment;

- 2.3.7.3.7.2** The effective date;
- 2.3.7.3.7.3** An instruction that the enrollee choose a new DBPM; and
- 2.3.7.3.7.4** A statement that if the enrollee disagrees with the decision to disenroll, the enrollee has a right to submit a request for a State Fair Hearing.

2.3.7.3.8 Until the enrollee is disenrolled by the enrollment broker, the Contractor shall continue to be responsible for the provision of all DBPM covered services to the enrollee.

2.3.7.4 Disenrollment Effective Date

2.3.7.4.1 The effective date of disenrollment shall be no later than the first day of the second month following the calendar month the request for disenrollment is filed.

2.3.7.4.2 If LDH or its designee fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment is filed, the disenrollment is deemed approved.

2.3.7.4.3 LDH, the Contractor, and the enrollment broker shall reconcile enrollment and/or disenrollment issues at the end of each month utilizing an agreed upon procedure.

2.3.8 Enrollment and Disenrollment Updates

2.3.8.1 LDH's enrollment broker shall notify each DBPM at specified times each month of the Medicaid beneficiaries that are enrolled, re-enrolled, or disenrolled from their DBPM for the following month. The DBPM shall receive this notification through the ANSI ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction, or in instances of corrections to closed segments, the DBPM shall receive this notification through a manual correction processing file.

2.3.8.2 LDH shall use its best efforts to ensure that the Contractor receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or irreconcilable differences between LDH and the Contractor regarding enrollment, disenrollment and/or termination, LDH's decision is final.

2.3.9 Updates

The enrollment broker shall make available to the Contractor daily via electronic media (ANSI ASC X12N 834 Benefit Enrollment and Maintenance transaction) updates on beneficiaries newly enrolled into the DBPM in the format specified in the Systems Companion Guide. The Contractor shall have written policies and procedures for receiving these updates, incorporating them into its management information system and ensuring this information is available to their providers. Policies and procedures shall be available during readiness reviews.

In instances of corrections or updates to closed segments, the Contractor shall receive data through a weekly manual correction processing file.

2.3.10 Reconciliation

2.3.10.1 Enrollment

The Contractor is responsible for monthly and quarterly reconciliation of the membership list of enrollments and disenrollments received from the enrollment broker when compared to its own internal records. The Contractor shall provide written notification to the enrollment broker of any data inconsistencies within ten (10) calendar days of receipt of the monthly and quarterly reconciliation data file.

2.3.10.2 Payment

The Contractor shall receive a monthly electronic file (ANSI ASC X12N 820 Transaction) from the Medicaid Fiscal Intermediary (FI) listing all enrollees for whom the Contractor received a capitation payment and the amount received. The Contractor is responsible for reconciling this listing against its internal records. It is the Contractor's responsibility to notify the FI of any discrepancies within three (3) months of the file date.

2.3.11 Assignment of Primary Dental Provider

2.3.11.1 The DPBM shall afford each beneficiary a Primary Dental Provider (PDP) who will supervise and coordinate the beneficiary's care and shall afford the beneficiary a choice of PDP. The DBPM shall encourage the continuation of any existing provider/beneficiary relationship with current primary dental providers participating in the Dental Benefit Program.

2.3.11.2 The DBPM shall contact the enrollee within ten (10) business days of receiving the member file to assist the enrollee in making a selection of a Primary Dental Provider (PDP). The DBPM shall confirm the PDP selection information or auto-assign a PDP when no selection is made within thirty (30) calendar days of enrollment. Upon initial selection or subsequent PDP changes, confirmation must be provided to the enrollee in a written notice within two (2) business days after selection.

2.3.11.3 The DBPM shall inform the enrollee that each family member has the right to choose his/her own primary dental provider. The DBPM may explain the advantages of selecting the same PDP for all family members, as appropriate.

2.3.11.4 Enrollees, for whom the DBPM is the primary payer, who do not proactively choose a PDP will be auto-assigned to a PDP by the DBPM. Enrollees, for whom the DBPM is the secondary payer, will not be auto-assigned to a PDP by the DBPM, unless the enrollee requests that the DBPM do so.

2.3.11.5 The DBPM shall have written policies and procedures allowing enrollees to select a

new primary dental provider, including auto-assignment, and provide information on options for selecting a new PDP when it has been determined that a PDP is terminated from the DBPM, or when a PDP change is ordered as part of the resolution to a grievance proceeding. The DBPM shall allow enrollees to select another PDP within ten (10) business days of the postmark date of the termination of PDP notice to enrollees and provide information on options for selecting a new primary dental provider.

2.3.12 Primary Dental Provider Auto-Assignments

2.3.12.1 The DBPM is responsible for developing a PDP automatic assignment methodology, approved by LDH, to auto-assign an enrollee for whom the DBPM is the primary payer to a PDP when the enrollee:

2.3.12.1.1 Does not make a PDP selection; or

2.3.12.1.2 Selects a PDP within the DBPM that has restrictions/limitations (e.g. pediatric only practice).

2.3.12.2 General Provisions

2.3.12.2.1 Assignment shall be made to a PDP with whom the enrollee has a provider-beneficiary relationship. If there is no provider-beneficiary relationship, the enrollee may be auto-assigned to a provider who is the assigned PDP for a household family member enrolled in the Dental Benefit Program. If other household family members do not have an assigned primary dental provider, auto-assignment shall be made to a provider with whom a family member has a provider-beneficiary relationship.

2.3.12.2.2 If there is no enrollee or household family provider-beneficiary relationship, enrollees shall be auto-assigned to a PDP, based on criteria such as age, geographic proximity, and spoken languages.

2.3.12.2.3 The PDP automatic assignment methodology must be reviewed and approved by LDH. This methodology must be made available via the DBPM's website and provider manual.

2.3.12.2.4 An enrollee shall be allowed to request at any time, verbally or in writing, to change his or her primary dental provider.

2.3.13 Enrollment Files

2.3.13.1 Daily File

2.3.13.1.1 The Fiscal Intermediary (FI) will provide the DBPM with a daily member file in the format specified in the Systems Companion Guide. The DBPM shall have written policies and procedures for receiving these updates,

incorporating them into its information system and ensuring this information is available to their providers.

- 2.3.13.1.2** LDH will use its best efforts to ensure that the DBPM receives timely and accurate information. In the event of discrepancies or irresolvable differences between LDH and the DBPM regarding beneficiaries eligible for enrollment, LDH's decision is final.

2.3.13.2 Weekly Reconciliation File

- 2.3.13.2.1** The FI will provide the DBPM with a full member file on a weekly basis. The DBPM is responsible for reconciliation of the weekly member file received from the FI against its internal records. The DBPM shall provide written notification to the FI of any data inconsistencies within ten (10) calendar days of receipt of the data file.

- 2.3.13.2.2** The DBPM shall process all daily member files prior to the weekly reconciliation file. Noncompliance with the reconciliation process may result in monetary penalties.

2.3.14 State Responsibilities

2.3.14.1 Enrollment, Assignment, and Disenrollment Process

2.3.14.1.1 Enrollment Verification

LDH shall verify and inform the Contractor of each enrollee's eligibility and enrollment status in the DBPM through the State's electronic eligibility systems and through the ANSI ASC X12N 834 Outbound Enrollment file.

2.3.14.1.2 Enrollment

LDH shall:

- 2.3.14.1.2.1** Maintain sole responsibility for the enrollment of LDH Medicaid beneficiaries into the DBPM, as described in this section. LDH shall present all options available to its enrollees under Louisiana Medicaid in an unbiased manner and shall inform each enrollee at the time of enrollment of their right to terminate enrollment at any time;
- 2.3.14.1.2.2** Make available to the Contractor each business day, via the ANSI ASC X12N 834 Outbound Daily Enrollment file, information pertaining to all enrollments, including the Effective Date of Enrollment, which shall be updated each business day;
- 2.3.14.1.2.3** At its discretion, automatically re-enroll on a prospective basis in the DBPM, enrollees who were disenrolled from the DBPM due

to loss of eligibility and whose eligibility was reestablished by LDH;

2.3.14.1.2.4 At its discretion, auto-assign potential enrollees to the DBPM based on a methodology defined by LDH. If there is more than one DBPM, no auto-assignments shall occur once the Contractor's enrollment capacity reaches sixty percent (60%) or more of total statewide membership;

2.3.14.1.2.5 Make best efforts to provide the Contractor with the most current demographic information available to LDH. Such demographic data shall include, when available to LDH, the enrollee's name, address, Louisiana Medicaid identification number, date of birth, telephone number, race, gender, ethnicity, and primary language; and

2.3.14.1.2.6 Review and respond to written complaints from the Contractor about the enrollment broker within a reasonable time. LDH may request additional information from the Contractor in order to perform any such review.

2.3.14.1.3 Open Enrollment

Open enrollment is applicable only if more than one (1) DBPM contract is awarded.

2.3.14.1.3.1 LDH, through its enrollment broker, will provide an opportunity for all DBPM members to retain or select a new DBPM during a single statewide annual open enrollment period. Prior to the annual open enrollment period, the enrollment broker will mail a re-enrollment offer to the DBPM member

2.3.14.1.3.2 Each DBPM member shall receive information and will be offered assistance with making informed choices about the participating DBPMs and the availability of choice counseling. The enrollment broker shall provide the individual with information on the DBPMs from which they may select. Each Medicaid enrollee shall be given sixty (60) calendar days to retain their existing DBPM or select a new DBPM.

2.3.14.1.3.2.1 Automatic Assignment

2.3.14.1.3.2.1.1 LDH shall auto-assign potential enrollees who do not request enrollment in a specified DBPM, or who cannot be enrolled into the requested DBPM for reasons including, but not limited to, the DBPM having reached its enrollment capacity limit or as a result of LDH-initiated sanctions.

- 2.3.14.1.3.2.1.2** In accordance with 42 CFR §438.54 the automatic assignment methodology shall seek to preserve existing provider-beneficiary relationships during the previous year and relationships with providers that have traditionally served Medicaid beneficiaries. After consideration of provider-beneficiary relationships, the methodology shall assign beneficiaries equitably among DBPMs, excluding those subject to the intermediate sanction described in 42 CFR §438.702(a)(4).
- 2.3.14.1.3.2.1.3** If the Contractor is noncompliant with the terms of the Contract, LDH may exclude the Contractor from any or all components of automatic assignment until the defect is cured to LDH's satisfaction. LDH shall have sole discretion to determine compliance with all such requirements and to define the period of exclusion. LDH may make such determination on a case-by-case basis and failure to exclude a DBPM from automatic assignment or to take any other punitive action shall not constitute ratification or approval of such noncompliance.
- 2.3.14.1.3.2.1.4** The automatic assignment methodology for all populations shall be based on the following hierarchy:
- 2.3.14.1.3.2.1.4.1** If the enrollee has household enrollees enrolled in a DBPM, the enrollee shall be enrolled in that DBPM. If multiple DBPM linkages exist within the household, the enrollee shall be enrolled to the DBPM of the youngest household enrollee.
 - 2.3.14.1.3.2.1.4.2** If DBPM assignment cannot be made based on the beneficiary's household enrollment, the enrollment broker shall seek to preserve existing provider-beneficiary relationships. If the enrollee has had a relationship with a Medicaid PDP within the past twelve (12) months, the enrollee will be assigned to a DBPM in which the PDP participates, using a round robin method.
 - 2.3.14.1.3.2.1.4.3** If the member has neither a family enrollee relationship nor recent PDP

relationship, the enrollee will be assigned to a DBPM using a round robin method.

2.3.14.1.3.2.1.4.4 Auto-assignments on any basis other than household enrollment in DBPM will not be made to a DBPM whose enrollee share is at or above sixty percent (60%) of the total statewide membership.

2.3.14.1.3.2.1.5 LDH reserves the right to adjust the automatic assignment algorithm to assign sufficient enrollees to ensure viability of a new DBPM.

2.3.14.1.4 Voluntary Selection of DBPM for New Enrollees

Voluntary Selection is applicable only if more than one (1) DBPM contract is awarded.

2.3.14.1.4.1 Potential enrollees shall be given an opportunity to choose a DBPM at the time of application. Once the potential enrollee is determined eligible, their choice of DBPM shall be transmitted to the enrollment broker.

2.3.14.1.4.2 During the ninety (90) days following the date of the enrollee's initial enrollment into a DBPM, the enrollee shall be allowed to request disenrollment without cause by submitting an oral or written request to the enrollment broker.

2.3.14.1.4.3 All eligible enrollees shall be provided an annual open enrollment period at least once every twelve (12) months thereafter.

2.3.14.1.4.4 All enrollees shall be given an opportunity to choose a DBPM at the start of a new DBPM contract either through the regularly scheduled open enrollment period or special enrollment period.

2.3.14.1.5 Disenrollment

2.3.14.1.5.1 Disenrollment Conditions

LDH shall disenroll an enrollee from the DBPM and he or she shall no longer be eligible for services under the DBPM following:

2.3.14.1.5.1.1 Loss of Louisiana Medicaid eligibility;

2.3.14.1.5.1.2 Completion of the enrollee's voluntary disenrollment request;

2.3.14.1.5.1.3 LDH approval of a request by the Contractor for involuntary termination; or

2.3.14.1.5.1.4 Loss of eligibility for the Louisiana Medicaid Dental Program.

2.3.14.1.5.2 Except as otherwise provided under federal law or waiver, an enrollee may disenroll voluntarily:

2.3.14.1.5.2.1 For cause, at any time, in accordance with 42 CFR §438.56(d);

2.3.14.1.5.2.2 Without cause when the Contractor repeatedly fails to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act or 42 CFR §438; and

2.3.14.1.5.2.3 Without cause, at any time during an open enrollment period.

2.3.14.1.5.3 Disenrollment Information

LDH shall:

2.3.14.1.5.3.1 Make available to the Contractor each business day, via the ANSI ASC X12N 834 Outbound Enrollment File, information pertaining to all disenrollments, including the effective date of disenrollment and the disenrollment reason code; and

2.3.14.1.5.3.2 Provide the Contractor with information related to the reason for voluntary disenrollment as received from enrollees via the State's enrollment broker, on a monthly basis.

2.3.14.2 Enrollment Broker

Enrollment broker services are applicable only if more than one (1) DBPM contract is awarded.

LDH or its designee shall:

2.3.14.2.1 Present the DBPM in an unbiased manner to enrollees who are newly eligible or seeking to transfer from one DBPM to another DBPM. Such presentation(s) shall ensure that enrollees are informed prior to enrollment of the following:

2.3.14.2.1.1 The nature of the requirements of participation in a DBPM, including but not limited to:

2.3.14.2.1.1.1 Use of Network Providers;

2.3.14.2.1.1.2 Maintenance of existing relationships with Network Providers; and

2.3.14.2.1.1.3 The importance of Primary Dental Care;

2.3.14.2.1.2 The nature of the Contractor's delivery system, including, but not limited to the Provider Network, ability to accommodate non-English-speaking enrollees, referral system, and requirements and rules which enrollees shall follow once enrolled in the DBPM; and

2.3.14.2.1.3 Orientation and other enrollee services made available by the Contractor.

2.3.14.2.2 Enroll, disenroll and process transfer requests of enrollees in the DBPM, including completion of LDH's enrollment and disenrollment forms;

2.3.14.2.2.1 Ensure that enrollees are informed at the time of enrollment or transfer, of their right to terminate their enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

2.3.14.2.2.2 Be knowledgeable about the Contractor's policies, services, and procedures;

2.3.14.2.2.3 At its discretion, develop and implement processes and standards to measure and improve the performance of the enrollment broker staff; and

2.3.14.2.2.4 Include all contracted DBPMs in all LDH-sponsored open enrollment activities.

2.4 Coverage and Authorization of Services

2.4.1 General Provisions

2.4.1.1 In no instance may the DBPM impose coverage and service limitations or exclusions more stringent than those specified in the Contract, Louisiana Medicaid State Plan, state statutes, and administrative rules.

2.4.1.2 The DBPM may exceed specific coverage criteria included in the above and specific coverage exclusions specified in the aforementioned documents.

2.4.1.3 The DBPM shall not place any time caps or expenditure caps on services for children under the age of twenty-one (21) years. The DBPM shall develop a special services process to authorize services exceeding the coverage in each service-specific coverage policy, if medically necessary.

2.4.1.4 The DBPM shall ensure the provision of services specified in the Contract in sufficient amount, duration, and scope to be reasonably expected to achieve the purpose for

which the services are furnished and shall ensure the provisions of the covered services defined and specified in the Contract. Accessibility of services, including geographic access, appointments, and wait times shall be in accordance with the requirements of the Contract. These minimum requirements do not release the DBPM from ensuring that all necessary services required by its enrollees are provided pursuant to the Contract.

- 2.4.1.5** The DBPM shall ensure that all coverage and service requirements are incorporated into the DBPM’s provider agreements. This includes professional licensure and certification standards for all providers.
- 2.4.1.6** The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of services.
- 2.4.1.7** The DBPM may offer additional benefits that are outside the required scope of services to individual enrollees on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the enrollee and/or enrollee’s family, the potential for improved health status of the enrollee, and functional necessity. The DBPM may provide alternative services or deliver services in alternative settings in accordance with 42 CFR. §438.3(e)2.
- 2.4.1.8** If new Medicaid dental services are added, or if services are expanded, eliminated, or otherwise changed, the Contract shall be amended. LDH will make every effort to give the DBPM sixty (60) calendar days advance notice of the change; however, the DBPM shall add, delete, or change any service as may be deemed necessary by LDH within the timeframe required by LDH if mandated by federal or state legislation or court order.
- 2.4.1.9** Any cost sharing imposed on Medicaid enrollees must be in accordance with federal regulations and cannot exceed cost sharing amounts in the Louisiana Medicaid State Plan. Louisiana currently has no cost sharing requirements for any dental services. LDH reserves the right to amend cost-sharing requirements.

2.4.2 Covered Dental Benefits and Services

- 2.4.2.1** The DBPM shall provide dental services to Medicaid enrollees based on their eligibility group.

- 2.4.2.1.1** Group A - Children Under Age Twenty-One (21)

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

- 2.4.2.1.1.1** Diagnostic Services including oral examinations, radiographs and oral/facial images, diagnostic casts and accession of tissue – gross and microscopic examinations;

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

2.4.2.1.2 Group B - Adult Denture Program Age Twenty-One (21) and Above

The DBPM shall provide Group B the services listed in LAC 50:XXV.501 and as specified in the LDH Dental Services Manual, which include but are not limited to the following services:

- 2.4.2.1.2.1** Comprehensive oral examination;
- 2.4.2.1.2.2** Intraoral radiographs, complete series;
- 2.4.2.1.2.3** Complete denture, maxillary;
- 2.4.2.1.2.4** Complete denture, mandibular;
- 2.4.2.1.2.5** Immediate denture, maxillary;
- 2.4.2.1.2.6** Immediate denture, mandibular;
- 2.4.2.1.2.7** Maxillary partial denture, resin base (including clasps);
- 2.4.2.1.2.8** Mandibular partial denture, resin base (including clasps);
- 2.4.2.1.2.9** Repair broken complete denture base;
- 2.4.2.1.2.10** Replace missing or broken tooth, complete denture, per tooth;
- 2.4.2.1.2.11** Repair resin denture base, partial denture;
- 2.4.2.1.2.12** Repair or replace broken clasp, partial denture;
- 2.4.2.1.2.13** Replace broken teeth, partial denture, per tooth;
- 2.4.2.1.2.14** Add tooth to existing partial denture;
- 2.4.2.1.2.15** Add clasp to existing partial denture;
- 2.4.2.1.2.16** Reline complete maxillary denture (laboratory);
- 2.4.2.1.2.17** Reline complete mandibular denture (laboratory);
- 2.4.2.1.2.18** Reline maxillary partial denture (laboratory);
- 2.4.2.1.2.19** Reline mandibular partial denture (laboratory); and
- 2.4.2.1.2.20** Unspecified removable prosthodontic procedure.

2.4.2.2 Post-stabilization Dental Services

- 2.4.2.2.1** In accordance with federal regulations, the DBPM shall cover post-stabilization care services without authorization, regardless of whether the enrollee obtains a service through a participating or non-participating provider. Only those post-stabilization dental services that are specifically dental services shall be the responsibility of the DBPM. Those post-stabilization dental services that a treating physician viewed as medically necessary after stabilizing an emergency dental condition are non-emergency services. The DBPM may choose not to cover non-

emergency services if they are provided by a non-participating provider, except in the circumstances detailed below:

- 2.4.2.2.1.1** Post-stabilization dental care services that were pre-approved by the DBPM;
- 2.4.2.2.1.2** Post-stabilization dental care services that were not pre-approved by the DBPM because the DBPM did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request; or
- 2.4.2.2.1.3** The treating provider could not contact the DBPM for pre-approval.

2.4.2.3 Emergency Dental Services

2.4.2.3.1 The DBPM shall be responsible for dental related services provided in an emergency context. Requirements for the DBPM to provide emergency dental services are as follows:

- 2.4.2.3.1.1** The DBPM shall make provisions for and advise all enrollees described in Group A of the provisions governing emergency use pursuant to federal regulations. Emergency-related terms are in the Glossary.
- 2.4.2.3.1.2** The DBPM shall cover emergency services. Provision of these services in an emergency context broadens the DBPM's responsibilities to include payment for these services to out-of-network providers as described in this section.

2.4.2.3.2 In providing for emergency dental services and care as a covered service, the DBPM shall not:

- 2.4.2.3.2.1** Require prior authorization for emergency dental services and care.
- 2.4.2.3.2.2** Indicate that emergencies are covered only if care is secured within a certain period of time.
- 2.4.2.3.2.3** Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.
- 2.4.2.3.2.4** Deny payment based on the enrollee's failure to notify the DBPM in advance or within a certain period of time after the care is given.

2.4.2.3.3 The DBPM shall not deny payment for emergency dental care.

- 2.4.2.3.4** The DBPM shall not deny payment for treatment obtained when an enrollee had an emergency dental condition.
- 2.4.2.3.5** The hospital-based provider and the PDP may discuss the appropriate care and treatment of the enrollee. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient in accordance with federal law to determine if the patient is an enrollee of the DBPM, if emergency dental services and care are not delayed.
- 2.4.2.3.6** The DBPM shall not deny emergency dental services claims submitted by a non-contracted provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds three hundred sixty-five (365) calendar days.
- 2.4.2.3.7** If third party liability (TPL) exists, payment of claims shall be determined in accordance with this Contract.
- 2.4.2.3.8** The DBPM must review and approve or disapprove emergency service claims based on the definition of emergency dental services and care specified in the Glossary.
 - 2.4.2.3.8.1** The DBPM shall ensure the enrollee has a follow-up appointment scheduled within seven (7) calendar days after the emergency treatment.

2.4.2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

- 2.4.2.4.1** In accordance with 42 CFR §441.56(b)(1)(vi) and periodicity charts posted on Louisiana Medicaid’s website at www.lamedicaid.com, the DBPM shall provide dental screening services furnished by direct referral to a dentist for children beginning at the eruption of the first tooth and no later than twelve (12) months of age and within ninety (90) days of the effective date of enrollment for all other enrollees. The Contractor shall provide dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.
- 2.4.2.4.2** The DBPM shall accurately report, via encounter data submissions all dental screenings and access to preventive services as required for LDH to comply with federally mandated CMS 416 reporting requirements.
- 2.4.2.4.3** See the DBPM Systems Companion Guide for format and timetable for reporting of EPSDT data at: <http://ldh.la.gov/index.cfm/page/3196>.

2.4.3 Value Added Benefits

- 2.4.3.1** As permitted under 42 CFR §438.3(e), the DBPM may offer value-added benefits and services to enrollees in addition to the covered benefits and services specified in the

Contract. Value-added benefits and services are those optional benefits and services offered by the DBPM, including those proposed in the RFP response, that are not covered benefits and services.

2.4.3.2 The following departmental priority(ies) may be addressed through value-added services:

2.4.3.2.1 Extractions for individuals in Group B defined in Section 2.4.2.1.2.

2.4.3.3 Value-added benefits and services are provided at the DBPM's expense, are not included in the capitation rate, and shall be identified as value-added benefits or services in encounter data in the manner directed by LDH.

2.4.3.4 Transportation to the value-added benefit or service is the responsibility of the enrollee and/or DBPM, at the discretion of the DBPM. Encounters for transportation related to value-added benefits or services shall be identified as such in the manner directed by LDH.

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

2.4.3.6 The DBPM shall provide LDH a description of the value-added benefits and services that includes amount, duration and scope to be offered by the DBPM for approval. Additions, deletions or modifications to value-added benefits or services made during the Contract Term shall be submitted to LDH for approval ninety (90) calendar days in advance of the proposed change.

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

2.4.3.8 For each value-added benefit or service proposed, the DBPM shall:

2.4.3.8.1 Define and describe the benefit or service;

2.4.3.8.2 Note any limitations or restrictions that apply to the benefit or service;

2.4.3.8.3 Propose how and when providers and enrollees will be notified about the availability of such benefits or services; and

2.4.3.8.4 Describe how a enrollee may obtain or access the benefit or service.

2.4.3.9 For the initial thirty-six (36) month term of the Contract, the DBPM shall:

2.4.3.9.1 Indicate the PMPM actuarial value of benefits or services assuming enrollment of 800,000 Group B enrollees, accompanied by a statement from the preparing/consulting actuary who is a member of the

American Academy of Actuaries certifying the accuracy of the information; and

2.4.3.9.2 Include a statement of commitment to provide the benefits or services throughout the initial thirty-six (36) month term of the Contract.

2.4.3.10 LDH will work with its contract actuary to independently review any statements of actuarial value.

2.4.3.11 If for some reason, including but not limited to lack of enrollee participation, the aggregated annual PMPM proposed is not expended, LDH reserves the right to require the DBPM to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

2.4.4 Excluded Services

2.4.4.1 General Provisions

2.4.4.1.1 The DBPM is not obligated to provide any services not specified in the Contract, except as federally required under EPSDT provisions.

2.4.4.1.2 Enrollees who require services not covered by the Contract shall receive the services through other appropriate Medicaid and non-Medicaid programs. In such cases, the DBPM's responsibility shall include coordination and referrals.

2.4.4.1.3 The DBPM is prohibited from providing experimental or investigational drugs, procedures or equipment unless approved by LDH. Elective cosmetic surgery may not be provided.

2.4.4.2 Moral or Religious Objections

2.4.4.2.1 The DBPM shall provide or arrange for the provision of all covered services. If, during the course of the Contract and pursuant to federal regulations, the DBPM elects not to provide or reimburse for counseling or referral to a covered service because of an objection on moral or religious grounds, the DBPM shall notify:

2.4.4.2.1.1 LDH within one hundred twenty (120) days before implementing the policy with respect to any covered service; and

2.4.4.2.1.2 Enrollees within sixty (60) days before implementing the policy with respect to any covered service.

2.4.5 Coverage Provisions

2.4.5.1 Service-Specific Requirements

2.4.5.1.1 The DBPM shall permit enrollees to request to change PDPs at any time. If the enrollee is not received by the DBPM established monthly cut-off date for system processing, the PDP change will be effective the first day of the next month.

2.4.5.1.2 The DBPM shall assign all enrollees that are re-enrolled to the PDP to which they were assigned prior to loss of eligibility, unless the enrollee specifically requests another PDP, or the PDP is at capacity or no longer participates in the DBPM.

2.4.5.2 Enrollee Screening and Education

2.4.5.2.1 The DBPM shall use the enrollee's record to identify enrollees who have not received well-child dental screenings in accordance with the LDH approved periodicity schedule.

2.4.5.2.2 The DBPM shall develop and implement an education and outreach program to increase the number of enrollees receiving annual dental visits and preventative dental visits. This program shall include, at a minimum, the following:

2.4.5.2.2.1 A tracking system to identify enrollees for whom a visit is due or overdue;

2.4.5.2.2.2 Systematic reminder notices sent to enrollees before a visit is due. The notice shall include an offer to assist with scheduling and transportation;

2.4.5.2.2.3 If the DBPM well-child visit rate is below eighty percent (80%), notices sent to all new enrollees under the age of twenty-one (21) years to inform them of well-child visit services and to offer assistance with scheduling and transportation; and

2.4.5.2.2.4 Provision of enrollee education and outreach in community settings.

2.4.5.2.3 The DBPM shall develop and implement an education and outreach program to encourage preventative dental visits and a dental home.

2.4.5.2.4 The DBPM shall take immediate action to address any identified urgent dental needs.

2.4.5.2.5 The DBPM may have a program for recognizing dental homes. If the DBPM has a dental home program, it shall submit its procedures for such program to LDH, which shall include recognition standards developed by the DBPM for the program.

2.4.5.3 New Enrollee Procedures

- 2.4.5.3.1** The DBPM shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee's enrollment to conduct an initial screening of the enrollee's needs and to offer to schedule the enrollee's initial appointment with the PDP, which should occur within one hundred eighty (180) days of enrollment.
- 2.4.5.3.2** Within thirty (30) days of enrollment, the DBPM shall ask the enrollee to authorize release of the provider's enrollee records to the new PDP or other appropriate provider and shall assist by requesting those records from the enrollee's previous provider(s).
- 2.4.5.3.3** For all enrollees, written documentation of prior authorization of ongoing dental services shall include the following, provided that the services were prearranged prior to enrollment with the DBPM:
 - 2.4.5.3.3.1** Prior existing orders;
 - 2.4.5.3.3.2** Provider appointments;
 - 2.4.5.3.3.3** Prior authorizations; and
 - 2.4.5.3.3.4** Treatment plan / plan of care.
- 2.4.5.3.4** The DBPM shall not delay service authorization if written documentation is not available in a timely manner. However, the DBPM is not required to approve claims for which it has received no written documentation.

2.4.6 Care Coordination and Case Management

2.4.6.1 General Provisions

- 2.4.6.1.1** The DBPM shall be responsible for care coordination of oral health services for enrollees as specified in the Contract.
- 2.4.6.1.2** The DBPM shall have protocols in place to identify enrollees who require care coordination services, and maintain written procedures for identifying, assessing, and implementing interventions for enrollees.
- 2.4.6.1.3** The DBPM shall ensure care coordinators meet the appropriate experience and educational requirements.

2.4.6.2 Care Coordination and Case Management Requirements

- 2.4.6.2.1** The DBPM shall maintain written care coordination and continuity of care procedures that include the following minimum functions:
 - 2.4.6.2.1.1** Appropriate referral and scheduling assistance for enrollees needing specialty dental care;

- 2.4.6.2.1.2** A mechanism for access to specialists, without the need for a referral, for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs;
 - 2.4.6.2.1.3** Coordination with the enrollee’s MCO for oral health issues exceeding the coverage of the Contract;
 - 2.4.6.2.1.4** Coordination with the enrollee’s MCO for transportation to and from covered dental services; and
 - 2.4.6.2.1.5** Coordination with the enrollee’s MCO regarding value-added dental benefits offered by the enrollee’s MCO.
- 2.4.6.2.2** The DBPM shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex health issues, I/DD, high service utilization, intensive dental care needs, or who consistently access services at the highest level of care.
 - 2.4.6.2.3** The DBPM shall be responsible for coordination of care for new enrollees transitioning to the DBPM.

2.4.7 Coordination with Other Service Providers

- 2.4.7.1** When appropriate, the DBPM shall facilitate the cooperation and communication of network providers and subcontractors with other service providers who serve Medicaid enrollees. Such other service providers may include: Managed Care Organizations; Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; FQHCs and RHCs; dental schools; dental hygiene programs; and parish school systems. Such cooperation may involve sharing of information (with the consent of the enrollee).

2.4.8 Dental Records

- 2.4.8.1** The DBPM shall have a method to verify that services for which payment was made, was provided to enrollees. The DBPM shall have policies and procedures to maintain, or require DBPM providers and contractors to maintain, an individual dental record for each enrollee. The DBPM shall ensure the dental record is:
 - 2.4.8.1.1** Accurate and legible;
 - 2.4.8.1.2** Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all enrollees evaluated or treated, and is accessible for review and audit; and
 - 2.4.8.1.3** Readily available for review and provides dental and other clinical data required for Quality and Utilization Management (UM) review.
- 2.4.8.2** The DBPM shall ensure the dental record includes, minimally, the following:

- 2.4.8.2.1** Enrollee identifying information, including name, identification number, date of birth, sex and legal guardianship, as applicable if applicable;
- 2.4.8.2.2** Primary language spoken by the enrollee and any translation needs of the enrollee;
- 2.4.8.2.3** Services provided through the DBPM, date of service, service site, and name of service provider;
- 2.4.8.2.4** Medical history, diagnoses, treatment prescribed, and drugs administered or dispensed, beginning with, at a minimum, the first enrollee visit;
- 2.4.8.2.5** Referrals including follow-up and outcome of referrals;
- 2.4.8.2.6** Documentation of emergency and/or after-hours encounters and follow-up;
- 2.4.8.2.7** Signed and dated consent forms, as applicable;
- 2.4.8.2.8** Documentation of advance directives, as appropriate; and
- 2.4.8.2.9** Documentation of each visit, which must include:
 - 2.4.8.2.9.1** Date and begin and end times of service;
 - 2.4.8.2.9.2** Chief complaint or purpose of the visit;
 - 2.4.8.2.9.3** Diagnoses or dental impression;
 - 2.4.8.2.9.4** Objective findings;
 - 2.4.8.2.9.5** Patient assessment findings;
 - 2.4.8.2.9.6** Studies ordered and results of those studies;
 - 2.4.8.2.9.7** Medications prescribed;
 - 2.4.8.2.9.8** Name and credentials of the provider rendering services and the signature or initials of the provider; and
 - 2.4.8.2.9.9** Initials of providers must be identified with correlating signatures.
- 2.4.8.2.10** The DBPM must provide one (1) free copy per calendar year of any part of enrollee's record upon their request.
- 2.4.8.2.11** All documentation and/or records maintained by the DBPM or any and all of its network providers shall be maintained for at least ten (10) years after the last service or has been provided to an enrollee or an

authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

2.4.8.3 Release of Records

2.4.8.3.1 The DBPM shall release dental records upon request by an enrollee or their authorized representative, as may be directed by authorized personnel of LDH, appropriate agencies of the State of Louisiana, or the United States Government and subject to reasonable charges. Release of dental records shall be consistent with the provisions of confidentiality as expressed in the Contract. The ownership and procedure for release of dental records shall be controlled by state and federal regulations and subject to reasonable charges. The DBPM shall not charge LDH or their designated agent for any copies requested.

2.5 Utilization Management

2.5.1 General Provisions

2.5.1.1 The DBPM shall establish and maintain a utilization management (UM) system to monitor utilization of services, including an automated service authorization system for denials, service limitations, and reduction of authorization. The DBPM shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the enrollee's diagnosis, type of illness, or condition.

2.5.1.2 The DBPM may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose.

2.5.1.3 The DBPM shall ensure that applicable evidence-based guidelines are utilized with consideration given to characteristics of the local delivery systems available for specific enrollees as well as enrollee-specific factors such as age, co-morbidities, complications, progress in treatment, and psychosocial situation.

2.5.1.4 The DBPM shall provide that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

2.5.1.5 The DBPM shall develop a process for authorization of any medically necessary service for enrollees under the age of twenty-one (21) years when:

2.5.1.5.1 The service is not listed as a covered service or in the fee schedule; or

2.5.1.5.2 The amount, frequency, or duration of the service exceeds specified limitations or the fee schedule.

2.5.1.6 The DBPM may utilize a national standardized set of criteria or other evidence-based

guidelines approved by LDH to approve services. Such criteria and guidelines shall not be solely used to deny, reduce, suspend, or terminate a good or service, but may be used as evidence of generally accepted dental practices that support the basis of a medical necessity determination.

2.5.2 Utilization Management Program Description

2.5.2.1 The UM program shall comply with federal regulations reflected in a written UM program description. The DBPM shall submit an electronic copy of the UM policies and procedures to LDH for written approval within thirty (30) calendar days from the date the Contract is signed by the DBPM, but no later than prior to the Readiness Review, annually thereafter, and prior to any revisions. It shall include the following minimum requirements:

- 2.5.2.1.1.1** Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses;
- 2.5.2.1.1.2** Procedures for reporting fraud and abuse information to LDH Program Integrity Unit;
- 2.5.2.1.1.3** Procedures for enrollees to obtain a second dental opinion at no expense to the enrollee and for the DBPM to authorize claims for such services;
- 2.5.2.1.1.4** Protocols for prior authorization and denial of services;
- 2.5.2.1.1.5** Process used to evaluate initial and continuing authorization;
- 2.5.2.1.1.6** Objective evidence-based criteria to support authorization decisions;
- 2.5.2.1.1.7** Mechanisms to ensure consistent application of review criteria for authorization decisions, including consultation with the requesting provider when appropriate;
- 2.5.2.1.1.8** Practitioner profiling;
- 2.5.2.1.1.9** Retrospective review;
- 2.5.2.1.1.10** Timely approval or denial of authorization of out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval. Written follow-up documentation of the approval must be provided to the non-participating provider within one (1) business day after the approval; and
- 2.5.2.1.1.11** For enrollees with special health care needs determined through an assessment by appropriate qualified individuals who need a

course of treatment or regular care monitoring, a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified need.

- 2.5.2.2** The DBPM shall develop and maintain policies and procedures with defined structures and processes for the UM program that incorporate procedures to evaluate medical necessity and the process used to review and approve the provision of dental services.
- 2.5.2.3** The UM Program policies and procedures shall meet all Utilization Review Accreditation Commission (URAC) standards or equivalent and include:
 - 2.5.2.3.1** The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, and/or efficiency of dental care services;
 - 2.5.2.3.2** The data sources and clinical review criteria used in decision making;
 - 2.5.2.3.3** The fully documented appropriateness of clinical review;
 - 2.5.2.3.4** The process for conducting informal reconsiderations for adverse benefit determinations;
 - 2.5.2.3.5** Mechanisms to ensure consistent application of review criteria and compatible decisions; and
 - 2.5.2.3.6** Data collection processes and analytical methods used in assessing utilization of dental care services.
- 2.5.2.4** The DBPM shall have written procedures listing the information required from an enrollee or dental care provider in order to make medical necessity determinations. Such procedures shall be given verbally or in writing to the enrollee, the enrollee's authorized representative, or healthcare provider within ten (10) calendar days when requested. The procedures shall outline the process to be followed in the event the DBPM determines the need for additional information not initially requested.
- 2.5.2.5** The DBPM shall have written procedures to address the failure or inability of a provider or enrollee to provide all the necessary information for review. In cases where the provider or enrollee will not release necessary information, the DBPM may deny authorization of the requested service(s).
- 2.5.2.6** The DBPM shall use LDH's medical necessity definition as defined in LAC 50:I.1101 for medical necessity determinations. The DBPM shall make medical necessity determinations that are consistent with LDH's definition.
- 2.5.2.7** Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.

2.5.3 Utilization Management Committee

- 2.5.3.1** The UM program shall include a Utilization Management Committee that integrates

with other functional units of the DBPM as appropriate and supports the Quality Assessment and Performance Improvement (QAPI) Program (refer to the Quality Management subsection for details regarding the QAPI Program).

2.5.3.2 The UM Committee shall provide utilization review and monitoring of UM activities of both the DBPM and its providers and as directed by the DBPM Dental Director. The UM Committee shall convene no less than quarterly and shall submit a summary of the meeting minutes to LDH upon request. UM Committee responsibilities include:

- 2.5.3.2.1** Monitoring providers' requests for rendering services to its enrollees;
- 2.5.3.2.2** Monitoring the dental appropriateness and necessity of services provided to its enrollees utilizing provider quality and utilization profiling;
- 2.5.3.2.3** Reviewing the effectiveness of the utilization review process and making changes to the process as needed;
- 2.5.3.2.4** Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;
- 2.5.3.2.5** Monitoring consistent application of "medical necessity" criteria;
- 2.5.3.2.6** Application of clinical practice guidelines;
- 2.5.3.2.7** Monitoring over- and under-utilization;
- 2.5.3.2.8** Review of outliers; and
- 2.5.3.2.9** Dental record reviews.

2.5.3.3 Dental record reviews shall be conducted to ensure that primary dental providers provide high quality healthcare that is documented according to established standards. The DBPM shall establish and distribute to providers standards for record reviews that include all dental record documentation requirements addressed in the Contract.

2.5.3.3.1 The DBPM shall maintain a written strategy for conducting dental record reviews, reporting results, and the corrective action process. The strategy shall include, at a minimum, the following:

- 2.5.3.3.1.1** Designated staff to perform this duty;
- 2.5.3.3.1.2** The method of case selection;
- 2.5.3.3.1.3** The anticipated number of reviews by practice site;
- 2.5.3.3.1.4** The tool the DBPM shall use to review each site; and

2.5.3.3.1.5 How the DBPM shall link the information compiled during the review to other DBPM functions (e.g. quality improvement (QI), credentialing, peer review, etc.).

2.5.3.4 The DBPM shall conduct reviews at all primary dental providers that have treated more than one hundred (100) unduplicated enrollees in a calendar year, including individual offices and large group facilities. The DBPM shall review each site at least one (1) time during each three (3) year-contract period.

2.5.3.5 The DBPM shall review ten (10) records, in a randomized process, at each site to determine compliance. For group practices with more than five (5) primary dental providers, or when additional data is necessary, additional reviews shall be completed.

2.5.3.6 The DBPM shall report the results of all record reviews to LDH quarterly with an annual summary.

2.5.4 Service Authorization System

2.5.4.1 The DBPM UM Program policies and procedures shall include service authorization policies and procedures consistent with state and federal laws and regulations, and the court-ordered requirements of *Chisholm v. Gee* and *Wells v. Gee* for initial and continuing authorization of services.

2.5.4.2 The DBPM shall notify the provider and give the enrollee written notice to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

2.5.4.3 The DBPM shall not require authorization for payment of primary and preventive dental care services furnished by a contracted provider.

2.5.4.4 The DBPM shall not require service authorization for emergency dental services as described in this Section whether provided by an in-network or out-of-network provider.

2.5.4.5 The DBPM shall not require service authorization or referral for EPSDT dental screening services.

2.5.4.6 The DBPM shall not require service authorization for the continuation of covered services of a new enrollee transitioning into the DBPM or transitioning from the prior contracted DBPM, regardless of whether such services are provided by an in-network or out-of-network provider; however, the DBPM may require prior authorization of services beyond thirty (30) calendar days.

2.5.4.7 The DBPM shall have automated authorization systems and may not require paper authorization as a condition of providing treatment.

2.5.4.8 The DBPM shall not delay service authorization if written documentation is not available in a timely manner. However, the DBPM is not required to approve claims

for which it has received no written documentation.

- 2.5.4.9** The DBPM's service authorization system shall have capacity to electronically store and report all service authorization requests, decisions made by the DBPM regarding the service requests, clinical data to support the decision, and time frames for notification to providers and enrollees of decisions.
- 2.5.4.10** The DBPM's service authorization systems shall provide the authorization number and effective dates for authorization to providers and non-participating providers.
- 2.5.4.11** The DBPM shall comply with the following standards, measured on a monthly basis, for processing authorization requests in a timely manner:
 - 2.5.4.11.1** The DBPM shall process ninety-five percent (95%) of all standard authorizations within ten (10) calendar days and one hundred percent (100%) in fourteen (14) days.
 - 2.5.4.11.2** The DBPM shall process ninety-five percent (95%) of all expedited authorizations within two (2) business days and one hundred percent (100%) in three (3) calendar days.
- 2.5.4.12** The DBPM shall submit a monthly report of the authorization timelines standards to LDH in a format specified by LDH.

2.5.5 Practice Guidelines/Evidence-based Criteria

- 2.5.5.1** The DBPM shall adopt practice guidelines that meet the following requirements:
 - 2.5.5.1.1** Are based on valid and reliable clinical evidence or a consensus of dental professionals;
 - 2.5.5.1.2** Consider the needs of the enrollee;
 - 2.5.5.1.3** Are adopted in consultation with providers; and
 - 2.5.5.1.4** Are reviewed and updated periodically, as appropriate.
- 2.5.5.2** The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:
 - 2.5.5.2.1** The vendor must be identified if the criteria were purchased;
 - 2.5.5.2.2** The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society; and
 - 2.5.5.2.3** The guideline source must be identified if the criteria are based on national best practice guidelines.
- 2.5.5.3** The DBPM shall disseminate any revised practice guidelines to all affected providers

and, upon request, to enrollees.

- 2.5.5.4** The DBPM shall ensure consistency with regard to all decisions relating to UM, enrollee education, covered services, and other areas to which the practice guidelines apply.

2.5.6 Clinical Decision-Making

- 2.5.6.1** The DBPM shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration, or scope that is less than requested, must be:
 - 2.5.6.1.1** Made by a licensed dentist, as appropriate, or other professional as approved by LDH, who has appropriate clinical experience in treating the enrollee's condition; and
 - 2.5.6.1.2** Determined using the acceptable standards of care, state and federal laws, LDH's medical necessity definition, and clinical judgment of a licensed dentist, as appropriate, or other professional as approved by LDH.
- 2.5.6.2** The individual(s) making these determinations shall have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body.
- 2.5.6.3** The individual making these determinations is required to attest that no adverse benefit determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.

2.5.7 Service Authorization Standards for Decisions

- 2.5.7.1** The DBPM shall notify the provider and give the enrollee written notice to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- 2.5.7.2** The DBPM shall comply with the following standards, measured on a monthly basis, for notifying providers and enrollees in a timely manner:
 - 2.5.7.2.1** The DBPM shall provide standard authorization decisions within no more than fourteen (14) calendar days following receipt of the request for service.
 - 2.5.7.2.2** The DBPM may extend the timeframe for standard authorization decisions up to fourteen (14) additional calendar days, if the enrollee or the provider requests extension, or the DBPM justifies the need for additional information and how the extension is in the enrollee's interest.

2.5.7.2.3 The DBPM shall provide expedited authorization decisions within no later than seventy-two (72) hours following receipt of the request for service.

2.5.7.2.4 The DBPM may extend the timeframe for expedited authorization decisions up to fourteen (14) additional calendar days, if the enrollee or the provider requests extension, or the DBPM justifies the need for additional information and how the extension is in the enrollee's interest.

2.5.7.3 If the DBPM extends the timeframe for a service authorization decision, it shall:

2.5.7.3.1 Notify the enrollee of the reason for extending the timeframe and advising of the right to file a grievance if the enrollee disagrees with the extension of time;

2.5.7.3.2 Issue and carry out its determination as expeditiously as possible but no later than the date the extension expires; and

2.5.7.3.3 Send notice of the extension to the enrollee within five (5) business days of determining the need for an extension.

2.5.8 Notice of Adverse Benefit Determination

2.5.8.1 The DBPM shall notify the enrollee in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other adverse benefit determination as defined in the Contract. The notice to enrollees shall be consistent with federal regulations and requirements in the Contract and approved by LDH.

2.5.8.2 The DBPM shall include an identifying number on each notice of adverse benefit determination in a manner prescribed by LDH.

2.5.8.3 The DBPM shall mail the notice of adverse benefit determination as follows:

2.5.8.3.1 For termination, suspension or reduction of previously authorized covered services no later than ten (10) days before the adverse benefit determination is to take effect;

2.5.8.3.2 By the date of the action when any of the following occur:

2.5.8.3.2.1 The enrollee has died.

2.5.8.3.2.2 The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result.

- 2.5.8.3.2.3** The enrollee has been admitted to a facility where he or she is ineligible under the DBPM for further services.
 - 2.5.8.3.2.4** The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address.
 - 2.5.8.3.2.5** The enrollee is accepted for Medicaid services by another state.
 - 2.5.8.3.2.6** The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care.
- 2.5.8.3.3** For denial of payment, at the time of any adverse benefit determination affecting the clean claim; and
 - 2.5.8.3.4** For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.
- 2.5.8.4** Content of Notice of Adverse Benefit Determination
- 2.5.8.4.1** The Notice of Adverse Benefit Determination must explain the following:
 - 2.5.8.4.1.1** The action the DBPM or its subcontractor has taken or intends to take;
 - 2.5.8.4.1.2** The reasons for the action;
 - 2.5.8.4.1.3** The enrollee's right to file an appeal with the DBPM;
 - 2.5.8.4.1.4** The enrollee's right to request a State Fair Hearing, after the DBPM's appeal process has been exhausted;
 - 2.5.8.4.1.5** The procedures for exercising the rights specified in this Section;
 - 2.5.8.4.1.6** The circumstances under which expedited resolution is available and how to request it; and
 - 2.5.8.4.1.7** The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to repay the costs of these services.
- 2.5.8.5** Timing of Notice of Action
- 2.5.8.5.1** The DBPM must mail the Notice of Action within the following timeframes:
 - 2.5.8.5.1.1** For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) business

days before the date of action, except when the period of advanced notice is shortened to five (5) business days if probable enrollee fraud has been verified by the date of the action for the following:

- 2.5.8.5.1.1.1** In the death of an enrollee;
 - 2.5.8.5.1.1.2** A statement signed by the enrollee requesting service termination or giving information requiring termination or reduction of services;
 - 2.5.8.5.1.1.3** The enrollee's admission to an institution where he or she is ineligible for further services;
 - 2.5.8.5.1.1.4** The enrollee's address is unknown and mail directed to him or her has no forwarding address;
 - 2.5.8.5.1.1.5** The enrollee is receiving Medicaid services in another state; or
 - 2.5.8.5.1.1.6** The enrollee's dentist prescribes a change in the level of dental care.
- 2.5.8.5.1.2** For denial of payment, at the time of any action affecting the claim.

2.5.9 Post Authorization Reviews

- 2.5.9.1** The DBPM shall make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate dental information that may be required, but in no instance later than one-hundred eighty (180) calendar days from the date of service.
- 2.5.9.2** The DBPM shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the enrollee's health condition made by the provider.

2.5.10 Changes to Utilization Management Components

- 2.5.10.1** The DBPM shall obtain written approval from LDH for its service authorization protocols and any changes thereto.
- 2.5.10.2** The DBPM shall provide no less than sixty (60) days' written notice to LDH before making any changes to the administration and/or management procedures and/or authorization, denial or review procedures, including any delegations.

2.6 Provider Network Requirements

2.6.1 General Provisions

- 2.6.1.1** The DBPM shall design, develop and maintain a network that shall be designed to: (1) reflect the needs and service requirements of the DBPM's enrolled population; (2) be sufficient to serve the number of enrollees; and (3) to maximize the availability of primary dental services and specialty dental services.
- 2.6.1.2** The DBPM must provide a comprehensive network to ensure its membership has access at least equal to, or better than, community norms.
- 2.6.1.3** The DBPM shall develop and maintain a provider network that meets the needs of enrollees in accordance with the requirements of the Contract. The DBPM shall submit model Provider Agreement templates to LDH for review and approval.
- 2.6.1.4** The DBPM shall maintain a statewide network of providers in sufficient numbers to meet the network capacity and geographic access standards for services. The network must provide a geographically convenient flow of patients among network providers.
- 2.6.1.5** LDH will establish standards and requirements for provider networks, review DBPM provider networks and the DBPM must monitor the network continuously to ensure provider networks remain capable of meeting the needs of their enrollees and are sufficient to serve the number of enrollees in the DBPM in accordance with the Contract.
- 2.6.1.6** The DBPM shall take any and all necessary action to ensure that all medically necessary covered services are provided to enrollees with reasonable promptness, including but not limited to the following:
 - 2.6.1.6.1** Utilizing out-of-network providers; and
 - 2.6.1.6.2** Using financial incentives to induce network or out-of-network providers to accept an enrollee as a patient/client and provide all medically necessary covered services with reasonable promptness.
- 2.6.1.7** The DBPM shall ensure appropriate access to dental services (distance traveled, waiting time, length of time to obtain an appointment, and after-hours care) in accordance with the provision of services under the Contract.
- 2.6.1.8** If the DBPM is unable to provide necessary services required under the Contract with in-network providers, the DBPM shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted. The DBPM shall ensure coordination with respect to authorization and payment issues in these circumstances.
- 2.6.1.9** The DBPM shall provide available, accessible, and adequate numbers of service locations, service sites, and dental professionals for the provision of covered dental benefits and services, and shall take corrective action if there is failure to comply by any provider.

- 2.6.1.10** All providers shall be in compliance with federal regulations and Americans with Disabilities Act requirements and provide physical access, reasonable accommodations and accessible equipment for Medicaid enrollees with disabilities.
- 2.6.1.11** The DBPM shall allow each enrollee to choose among participating providers.
- 2.6.1.12** The DBPM shall perform ongoing monitoring activities, including LDH-prescribed secret shopper activities, and review of provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply.
- 2.6.1.13** The DBPM shall conduct appointment availability surveys annually. The surveys shall be submitted to LDH annually. The DBPM may be subject to monetary penalties for providers' non-compliance with applicable appointment and wait time requirements set forth in the Contract.
- 2.6.1.14** LDH reserves the right to change provider qualifications and minimum network adequacy requirements.

2.6.2 Network Capacity and Geographic Access Standards

- 2.6.2.1** The PDP may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or outpatient clinic). The DBPM shall provide contract with a sufficient number of PDPs needed to meet the geographic access, appointment, and wait time standards outlined in this Contract. ~~at least one (1) full time equivalent (FTE) PDP per five thousand (5,000) enrollees. LDH defines a full time PDP as a provider that provides dental care services for a minimum of thirty two (32) hours per week of practice time. Once an individual PDP has more than five thousand (5,000) Medicaid linkages, the Contractor shall not auto-assign any additional enrollees to the PDP; however, enrollees may continue to select the PDP proactively.~~ The PDPs must furnish accessible, quality care. If the DBPM or Department determines that the PDP's enrollment exceeds the ability of the PDP to provide this care, the PDP may be prohibited from receiving further beneficiary assignments.
- 2.6.2.2** The DBPM shall report to LDH the total number of linkages per primary dental provider, and remaining capacity of each individual PDP on a quarterly basis in the format and manner determined by LDH.
- 2.6.2.3** The DBPM shall provide access to dentists that offer extended office hours (before 8:00 a.m., after 4:30 p.m., and/or on Saturdays) at least one (1) day per week.
- 2.6.2.4** Network providers must offer office hours at least equal to those offered by commercial dental insurance plans.
- 2.6.2.5** If an enrollee requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the DBPM network who accepts new patients, it shall not be considered a violation of the access requirements for the

DBPM to grant the enrollee's request. The DBPM shall not submit encounters for travel outside of the access standards if an appropriate provider was available within the access standards.

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

2.6.2.6.1 Distance to Primary Dental Services

Travel distance from enrollee's place of residence shall not exceed thirty (30) miles or sixty (60) minutes one-way for rural areas and ten (10) miles or twenty (20) minutes for urban areas.

2.6.2.6.2 Distance to Specialty Dental Services

Travel distance shall not exceed sixty (60) miles one-way from the enrollee's place of residence for at least seventy-five (75) percent of enrollees and shall not exceed ninety (90) minutes one-way from the enrollee's place of residence for all enrollees.

2.6.2.7 The DBPM shall ensure, at a minimum, the availability of the following specialists and other providers for enrollees under the age of twenty-one (21) years:

2.6.2.7.1 Endodontists;

2.6.2.7.2 Maxillofacial Surgeons;

2.6.2.7.3 Oral Surgeons;

2.6.2.7.4 Orthodontists;

2.6.2.7.5 Pedodontists;

2.6.2.7.6 Periodontists;

2.6.2.7.7 Prosthodontists; and

2.6.2.7.8 Special Needs Pedodontists.

2.6.2.8 The DBPM must use specialists with pediatric expertise when the need for pediatric specialty care is significantly different from the need for a general dentist.

2.6.2.9 The DBPM shall ensure the availability of providers offering conscious sedation, general/deep sedation, and pediatric conscious sedation, as medically necessary.

2.6.2.10 The DBPM shall ensure the availability of access to specialty providers for all Group A enrollees. The DBPM shall ensure access standards and guidelines to specialty

providers are met as specified in this Section in regard to timeliness and service area.

2.6.2.11 The DBPM shall establish and maintain a provider network of dentist specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the dental needs of its enrollees (adults and children) without excessive travel requirements. This means that, at a minimum:

2.6.2.11.1 The DBPM has signed a contract with providers of the specialty types listed above who accept new enrollees and are available on at least a referral basis; and

2.6.2.11.2 The DBPM is in compliance with access and availability requirements.

2.6.3 Provider Enrollment

2.6.3.1 In accordance with 42 CFR §438.602(b) and upon LDH implementation of a provider management system, the DBPM and its subcontractors shall not enter into a network Provider Agreement with a provider to provide services to Medicaid beneficiaries when the provider is not otherwise appropriately screened by and enrolled with the State according to the standards under 42 CFR §455 Subparts B and E and upon implementation of appropriate systems. Such enrollment includes providers that order, refer, or furnish services under the State Plan and Waivers. Such enrollment does not obligate providers to participate in the Fee-for-Service (FFS) healthcare delivery system.

2.6.3.2 Once providers are screened and enrolled with the State, the DBPM may further credential providers to verify they are qualified to perform the services they are seeking to provide and execute network Provider Agreements. The State may implement a NCQA-certified Credentials Verification Organization (CVO), in which case the DBPM must participate on the CVO credentialing committee and accept the final credentialing decisions of the CVO.

2.6.3.3 Exclusion from Participation

2.6.3.3.1 The DBPM shall not pay claims to or execute contracts with individuals or groups of providers who have been excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act or state funded health care programs.

2.6.3.3.2 The DBPM shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 or Section 1156 of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings:

2.6.3.3.2.1 Exclusion from the Medicaid program;

- 2.6.3.3.2.2** Termination from the Medicaid program;
- 2.6.3.3.2.3** Withholding of Medicaid payment as authorized by the Department’s Surveillance and Utilization Review (SURS) Rule; or
- 2.6.3.3.2.4** The Louisiana Attorney General’s Office has seized the assets of the service provider.

2.6.3.3.3 The DBPM shall not remit payment for services provided under the Contract to providers whose practice location or pay-to location is located outside of the United States. The term “United States” means the fifty (50) states, the District of Columbia, and any U.S. territories.

2.6.3.4 Other Enrollment and Disenrollment Requirements

2.6.3.4.1 The DBPM shall not discriminate with respect to participation in the program, payment or indemnification against any provider solely on the provider’s type of licensure or certification. The DBPM shall establish and follow a documented process for credentialing and re-credentialing of network providers. In addition, the DBPM shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment.

2.6.4 Demonstration of Network Adequacy

2.6.4.1 The DBPM shall submit a provider network file of all participating providers to LDH or its agent(s) on a weekly basis and at any time upon request of LDH with sufficient evidence that the DBPM has the capacity to provide covered services to all enrollees, including evidence that the DBPM:

2.6.4.1.1 Maintains a network of providers offering an appropriate range of services in sufficient numbers to meet the access standards established by LDH; and

2.6.4.1.2 Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients to provide adequate access to all services covered under the Contract for all enrollees in the service area.

2.6.5 Timely Access Standards

2.6.5.1 The DBPM shall contract with and maintain a provider network sufficient to comply with timely access standards as specified in the Contract.

2.6.5.2 In accordance with federal regulations, the DBPM shall establish mechanisms to ensure network providers comply with timely access requirements, monitor regularly to determine compliance, and take corrective action if there is a failure to comply.

2.6.5.3 The DBPM shall ensure that PDP services and referrals to participating specialists are

available on a timely basis, as follows:

- 2.6.5.3.1** Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;
 - 2.6.5.3.2** Primary Dental Care – within thirty (30) days; and
 - 2.6.5.3.3** Follow-up Dental Services – within thirty (30) days after assessment.
- 2.6.5.4** Quarterly, the DBPM shall review a statistically valid sample of average appointment wait times to ensure services are in compliance with the Contract, and report the results to LDH.
- 2.6.5.5** The DBPM shall meet standards for timely access to all specialists. For enrollees determined to need a course of treatment or regular care monitoring, the DBPM must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee’s condition and identified needs.
- 2.6.5.6** The DBPM shall ensure that its network providers have an appointment system for covered dental benefits and services that is in accordance with prevailing dental community standards.
- 2.6.5.7** The DBPM shall disseminate changes to appointment standard policies and procedures to its in-network providers and to its enrollees at least sixty (60) days prior to implementing the changes. The DBPM shall monitor compliance with appointment standards.
- 2.6.5.8** The DBPM shall establish processes to monitor and reduce the appointment “no-show” rate for primary dental providers. These processes must be submitted to LDH within thirty (30) days of the start date of the Contract and when changes are made.
- 2.6.5.9** The DBPM shall have written policies and procedures about educating its provider network about appointment time requirements. Appointment standards shall be included in the provider manual and in Provider Agreements.

2.6.6 Provider Network Development and Management Plan

- 2.6.6.1** The DBPM shall develop and maintain a provider Network Development and Management Plan (hereinafter referred to as “Network Plan”) which ensures that the provision of covered dental benefits and services will occur. The Network Plan shall be submitted to LDH for approval within thirty (30) calendar days from the date the DBPM signs the Contract with LDH, as well as when material changes occur and annually thereafter within thirty (30) calendar days of the start of each calendar year. The Network Plan shall include the DBPM’s process to develop, maintain and monitor an appropriate provider network that is supported by written provider agreements and is sufficient to provide adequate access to all required services included in the Contract. When designing the network of providers, the DBPM shall consider the following:

- 2.6.6.1.1** Anticipated maximum number of Medicaid enrollees;
 - 2.6.6.1.2** Expected utilization of services, taking into consideration the characteristics and dental needs of the enrollees in the DBPM;
 - 2.6.6.1.3** The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid covered dental benefits and services;
 - 2.6.6.1.4** The numbers of DBPM providers who are not accepting new DBPM enrollees; and
 - 2.6.6.1.5** The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.
- 2.6.6.2** The Network Plan shall include assurances related to:
- 2.6.6.2.1** Adequate capacity and services;
 - 2.6.6.2.2** Timely access to primary dental providers;
 - 2.6.6.2.3** Timely access to specialists;
 - 2.6.6.2.4** Service area;
 - 2.6.6.2.5** Timely access to obtain second opinions; and
 - 2.6.6.2.6** Coverage of out-of-network providers.
- 2.6.6.3** The Network Plan shall identify gaps in the DBPM’s provider network and describe the process by which the DBPM shall ensure all covered services are delivered to DBPM enrollees. Planned interventions to be taken to resolve such gaps shall also be included.
- 2.6.6.4** The DBPM shall provide geomapping and coding of all network providers for each provider type no later than thirty (30) days after signing the Contract, to geographically demonstrate network capacity. The DBPM shall provide updated geocoding to LDH quarterly, upon material change or upon request.
- 2.6.6.5** The DBPM shall develop and implement network development and management policies and procedure that comply with federal regulations.
- 2.6.6.6** The DBPM shall monitor network compliance with policies and rules of LDH and the DBPM, including compliance with all policies and procedures related to the grievance and appeal processes and ensuring the enrollee’s care is not compromised during the grievance and appeal processes.
- 2.6.6.7** The DBPM shall evaluate the quality of services delivered by the network.

- 2.6.6.8** The DBPM shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.
- 2.6.6.9** The DBPM shall monitor the adequacy, accessibility and availability of its provider network to meet the needs of its enrollees, including the provision of care to enrollees with limited proficiency in English, or with physical or mental disabilities.
- 2.6.6.10** The DBPM shall process expedited and temporary credentials. During the readiness period, LDH will allow a grace period of sixty (60) calendar days from the date the Contract has been signed to have all providers credentialed.
- 2.6.6.11** The DBPM shall provide training for its providers and maintain records of such training. Records must be made available to LDH upon request.

2.6.7 Material Change to Provider Network

- 2.6.7.1** The DBPM shall provide written notice to LDH, no later than seven (7) business days prior to any network provider contract termination that materially impacts the DBPM's provider network, whether terminated by the DBPM or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the DBPM's ability to meet the performance and network standards as described in the Contract, including but not limited to the following:
 - 2.6.7.1.1** Any change that would cause more than five percent (5%) of enrollees to change the location where services are received or rendered;
 - 2.6.7.1.2** A decrease in the total of individual primary dental providers by more than five percent (5%);
 - 2.6.7.1.3** A loss of any participating specialist which may impair or deny the enrollees' adequate access to providers; or
 - 2.6.7.1.4** Other adverse changes to the composition of providers which may impair or deny the enrollees' adequate access to providers.
- 2.6.7.2** The DBPM shall also submit an assurance that services to enrollees will not be impacted if there has been a significant change in its operations.
- 2.6.7.3** When the DBPM has advance knowledge that a material change will occur, it must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected enrollees, sixty (60) calendar days prior to the expected implementation of the change.
- 2.6.7.4** The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.
- 2.6.7.5** LDH will respond within thirty (30) calendar days to the material change request and the notice received from the DBPM. If LDH fails to respond within such time, the

request and notice will be considered approved. Changes and alternative measures must be within the contractually agreed requirements. The DBPM shall within thirty (30) calendar days give advance written notice of provider network material changes to affected enrollees. The DBPM shall notify LDH of emergency situations and submit a request to approve material changes. LDH will act to expedite the approval process.

2.6.7.6 The DBPM shall notify LDH within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for enrollees due to provider illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network. The notification shall include:

2.6.7.6.1 Information about how the provider network change will affect the delivery of covered services; and

2.6.7.6.2 The DBPM's plan for maintaining the quality of enrollee care, if the provider network change is likely to affect the delivery of covered services.

2.6.8 Provider Credentialing

2.6.8.1 The DBPM must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230, §438.602(b) for the review and credentialing and re-credentialing of licensed, independent providers and provider groups both with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the DBPM selects and directs its enrollees to see a specific provider or group of providers. These procedures must include a process for the DBPM's usage of a state-contracted Credential Verification Organization's credentialing and re-credentialing functions.

2.6.8.1.1 Prior to contracting, the DBPM shall ensure that providers have been properly credentialed and screened by the State once the State-contracted CVO is established to ensure provider facilities, organizations, and staff meet all qualifications and requirements established by LDH policy and state and federal laws. DBPM credentialing files on providers shall include verification of meeting said requirements.

2.6.8.2 The DBPM shall accept the Louisiana Standardized Credentialing Application Form or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The DBPM must allow providers to use CAQH if available for their provider type.

2.6.8.3 The DBPM shall utilize the current NCQA Standards and Guidelines for the Accreditation of PAHPs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

- 2.6.8.4** If the DBPM has NCQA accreditation those credentialing policies and procedures shall meet LDH's credentialing requirements.
- 2.6.8.5** The DBPM shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" includes that the DBPM shall:
- 2.6.8.5.1** Review, approve, and load approved applicants to its provider files in its claims processing system following screening, credentialing, and approval by the State; and
 - 2.6.8.5.2** Submit approved applicants on the weekly electronic provider directory to LDH or its designee.
- 2.6.8.6** The process for periodic re-credentialing shall be implemented at least once every thirty-six (36) months.
- 2.6.8.7** If the DBPM has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the Contract. The DBPM must require that the subcontractor provide assurance that all licensed dental professionals are credentialed in accordance with LDH's credentialing requirements. LDH will have final approval of the delegated entity. Delegated credentialing does not alter the requirement that providers be screened and enrolled by the State prior to the DBPM entering into a network provider agreement.
- 2.6.8.8** To the extent the DBPM has delegated credentialing agreements in place with any approved delegated credentialing agency and the providers under the delegated credentialing agreement have been screened and enrolled by the State, the DBPM shall ensure all providers submitted to the DBPM from the delegated credentialing agency is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt. The DBPM shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to ensure compliance with the Contract.
- 2.6.8.9** The DBPM shall develop and implement policies and procedures for the acceptance of new providers screened, enrolled, and approved by the State, and termination or suspension of providers to ensure compliance. The policies and procedures should include but are not limited to the encouragement of applicable board certification.
- 2.6.8.10** The DBPM shall develop and implement a mechanism, subject to LDH approval, for reporting quality deficiencies which result in suspension or termination of a network provider. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.
- 2.6.8.11** The DBPM shall develop and implement a provider dispute and appeal process, with LDH's approval, for sanctions, suspensions, and terminations imposed by the DBPM against network provider(s) as specified in the Contract. This process shall be

submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.

2.6.8.12 The State reserves the right to contract with a single Credentials Verification Organization (CVO). If this option is pursued, the DBPM and its subcontractors shall agree to use the CVO for the credentialing and re-credentialing of all participating providers. The DBPM will be given at least ninety (90) days' notice before implementation of any CVO contract.

2.6.8.13 The process of periodic re-credentialing, performed by the State-contracted CVO, shall be completed at least once every three (3) years.

2.6.8.14 At the direction of LDH, the DBPM must participate on the State-contracted Credentials Verification Organization's Credentialing Committee to evaluate provider credentialing files (including re-credentialing files) using a peer review process.

2.6.9 Provider Agreement Requirements

2.6.9.1 The DBPM may execute network provider agreements pending the outcome of the State screening, enrollment, and re-validation process of up to one hundred twenty (120) calendar days, but upon notification from the State that a provider's enrollment has been denied or terminated, or the expiration of the one hundred twenty (120) calendar day period without enrollment of the provider, the DBPM shall terminate such network provider immediately and notify affected enrollee that the provider is no longer participating in the network.

2.6.9.2 Prior to contracting with a network provider and/or paying a provider's claim, the DBPM shall ensure that the provider has a valid National Provider Identifier (NPI) Number, where applicable, has a valid license or certification to perform services in the State, has not been excluded or barred from participation in Medicare, Medicaid, and/or CHIP, and has obtained a Medicaid provider number from LDH upon implementation of appropriate systems. The DBPM may use the CVO's verifications to ensure compliance with these standards.

2.6.9.3 The DBPM shall ensure that all Provider Agreements comply with federal regulations.

2.6.9.4 The DBPM shall submit all Provider Agreement templates to LDH for review to determine compliance with Contract requirements. The DBPM shall submit to LDH, upon request, individual Provider Agreements as required by LDH. If LDH determines, at any time, that a Provider Agreement is not in compliance with a Contract requirement, the DBPM shall promptly revise the Provider Agreement to bring it into compliance.

2.6.9.5 All Provider Agreements and amendments executed by the DBPM shall be in writing, signed, and dated by the DBPM and the provider, and shall meet the following requirements:

- 2.6.9.5.1** Not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient regarding:
 - 2.6.9.5.1.1** The enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
 - 2.6.9.5.1.2** Any information the enrollee needs to decide among all relevant treatment options;
 - 2.6.9.5.1.3** The risks, benefits, and consequences of treatment or non-treatment; and
 - 2.6.9.5.1.4** The enrollee’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. (42 CFR §438.102(a)(1)).
- 2.6.9.5.2** Not prohibit a provider from advocating on behalf of the enrollee in any part of the grievance and appeal system or UM process, or individual authorization process to obtain necessary services;
- 2.6.9.5.3** Require providers to offer hours of operation that are no less than the hours of operation offered to commercial enrollees;
- 2.6.9.5.4** Require providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with special health care needs, including physical or intellectual and developmental disabilities;
- 2.6.9.5.5** Specify covered services, including applicable prior authorization requirements, acceptable billing codes, and populations to be served under the provider agreement;
- 2.6.9.5.6** Require providers to meet timely access standards pursuant to the Contract;
- 2.6.9.5.7** Include provisions for the provider to ensure immediate transfer to another provider if the enrollee’s health or safety is in jeopardy;
- 2.6.9.5.8** Provide for continuity of care for the course of treatment in the event a provider agreement terminates during the course of an enrollee’s treatment;
- 2.6.9.5.9** Require the provider to look solely to the DBPM for compensation for services rendered;

- 2.6.9.5.10** Require the provider to participate with the DBPM’s peer review, complaint, QI and UM activities, as directed by the DBPM;
- 2.6.9.5.11** Include the monitoring and oversight activities the DBPM shall follow, including monitoring of services rendered to enrollees, by the DBPM;
- 2.6.9.5.12** Identify the measures, metrics, and frequency of measurement that shall be used by the DBPM to monitor the quality and performance of the provider;
- 2.6.9.5.13** Require that any marketing materials related to the Contract that are displayed by the provider be submitted to LDH for written approval before use;
- 2.6.9.5.14** Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to enrollees on behalf of the DBPM;
- 2.6.9.5.15** Require that records be maintained for a period not less than ten (10) years from the end of the Contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the DBPM if the provider agreement is continuous;
- 2.6.9.5.16** Require providers to cooperate fully with LDH, CMS, the OIG, the Legislative Auditor, and Attorney General’s Office for the inspection, evaluation, and auditing of any records or documents (medical or financial) of the DBPM or its subcontractors at any time, related to the Contract;
- 2.6.9.5.17** Require providers to cooperate fully in any investigation by LDH, Medicaid Fraud Control Unit (MFCU) or other state or federal entity and in any subsequent legal action that may result from such an investigation involving the Contract;
- 2.6.9.5.18** Include the specific reports and clinical information required by the DBPM for QI or other administrative purposes out of claims processing;
- 2.6.9.5.19** Require providers to submit timely, complete, and accurate claims to the DBPM in accordance with the terms of the Contract, at a minimum;
- 2.6.9.5.20** Require compliance with the background screening requirements of the Contract;
- 2.6.9.5.21** Require compliance with the HIPAA Privacy and Security Rules;
- 2.6.9.5.22** Require providers to submit notice of withdrawal from the network at least ninety (90) days before the effective date of such withdrawal;

- 2.6.9.5.23** Specify that any provider whose participation is terminated pursuant to the Provider Agreement for any reason shall utilize the applicable appeal procedures outlined in the Provider Agreement. No additional or separate right of appeal to LDH or the DBPM is created as a result of the DBPM's act of terminating, or decision to terminate, any provider under the Contract.
- 2.6.9.5.24** Require an exculpatory clause, which survives Provider Agreement termination, including breach of Provider Agreement due to insolvency, and which ensures that neither Medicaid enrollees nor LDH will be held liable for any debts of the provider;
- 2.6.9.5.25** Require that the provider secure and maintain during the life of the Provider Agreement insurance as described in the Contract;
- 2.6.9.5.26** Require providers to notify the DBPM in the event of a lapse in insurance coverage, licensure, or certification, inclusive of all documentation from the accrediting body, within twenty-four (24) hours of receipt of notification, if required to be accredited;
- 2.6.9.5.27** Contain a clause indemnifying, defending, and holding LDH and the DBPM's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Provider Agreement. This clause must survive the termination of the Provider Agreement, including breach due to insolvency;
- 2.6.9.5.28** Specify the process for a network provider to report to the DBPM when the network provider has received an overpayment, to return the overpayment to the DBPM within sixty (60) days after the date on which the overpayment was identified, and to notify the DBPM in writing of the reason for the overpayment; and
- 2.6.9.5.29** Specify that any contracts or agreements entered into by the provider for purposes of carrying out any aspect of the Contract shall include assurances that the individuals who are signing the contract or agreement are so authorized and that it includes all the requirements of the Contract.
- 2.6.9.6** The DBPM shall comply timely with all sanctions imposed by the State on network providers, including enrollment revocation, termination, and mandatory exclusions.
- 2.6.9.7** The DBPM must offer a provider agreement to the following providers:
 - 2.6.9.7.1** Federally Qualified Health Centers (FQHCs);
 - 2.6.9.7.2** Rural Health Clinics (RHCs) - free-standing and hospital based; and

2.6.9.7.3 Indian Health Care Providers (IHCPs).

2.6.9.8 If a Medicaid provider requests participation in the DBPM's network, the DBPM shall make a good faith effort to execute a provider agreement. In the event an agreement cannot be reached and the provider does not participate in the DBPM's network, the DBPM has met this requirement. The DBPM shall maintain documentation detailing efforts made.

2.6.9.9 The provisions above do not prohibit the DBPM from limiting provider participation to the extent necessary to meet the needs of the DBPM's enrollees. These provisions also do not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under the Contract, nor does it preclude the DBPM from using payment amounts that are greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty.

2.6.9.10 If the DBPM declines requests of individuals or groups of providers to be included in the DBPM network, the DBPM must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision.

2.6.9.11 The DBPM shall have written policies and procedures for the selection and retention of providers.

2.6.9.11.1 Within thirty (30) days of signing the Contract, the DBPM shall provide LDH with written provider credentialing and re-credentialing policies that are compliant with NCQA accreditation standards and all applicable state laws; and

2.6.9.11.2 The DBPM provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.6.9.12 The DBPM may terminate an agreement with a provider for cause.

2.6.9.13 The DBPM shall inform all providers at the time they enter into a provider agreement about enrollees' rights to file grievances and appeals, and request state fair hearings as specified in 42 C.F.R § 438.400 through 42 CFR §438.424.

2.6.10 Provider Discrimination Prohibited

2.6.10.1 The DBPM shall not discriminate with respect to participation in the Dental Benefit Program, payment or indemnification against any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the provider's type of licensure or certification. In addition, the DBPM shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment.

2.6.11 Notice of Provider Termination

2.6.11.1 In the event of termination of a provider agreement for cause, the DBPM shall provide

immediate electronic notice to the provider, followed by a certified letter mailed within one (1) business day.

- 2.6.11.2** The DBPM shall notify the DBPM enrollees that their primary dental care provider's provider agreement has been terminated. Notice shall be sent within thirty (30) calendar days after issuance of the termination notice to the provider. This notice shall include a list of recommended network providers available to the enrollee in their surrounding area.
- 2.6.11.3** The DBPM shall provide notice to an enrollee, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the DBPM becomes aware of such, if it is prior to the change occurring.
- 2.6.11.4** Failure of the DBPM to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for enrollees due to illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, and/or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the DBPM becoming aware of the circumstances. The DBPM shall document the date and method of notification of termination.
- 2.6.11.5** The DBPM shall notify LDH when the DBPM denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

2.7 Provider Services

2.7.1 General Provisions

- 2.7.1.1** The DBPM shall establish and maintain a formal provider relations function to respond timely and adequately to inquiries, questions, and concerns from participating providers.
- 2.7.1.2** The DBPM shall provide sufficient information and procedural guidelines to all providers in order to operate in full compliance with the Contract and all applicable state and federal laws and regulations.
- 2.7.1.3** The DBPM shall monitor provider compliance with Provider Agreement and Contract requirements and take action when needed to ensure compliance.

2.7.2 Provider Relations

- 2.7.2.1** The DBPM shall, at a minimum, provide a provider relations help-desk function to provide support and assistance to all providers in their DBPM network. This function shall:

- 2.7.2.1.1** Be available Monday through Friday from 7:00 a.m. to 5:00 p.m. Central Time to address non-emergency provider issues or requests;
 - 2.7.2.1.2** Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements;
 - 2.7.2.1.3** Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate;
 - 2.7.2.1.4** Respond to inquiries about prior authorization requests;
 - 2.7.2.1.5** Provide information related to provider processes; and
 - 2.7.2.1.6** Receive provider complaints.
- 2.7.2.2** After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any DBPM enrollee with an emergency or urgent dental condition. This shall not be construed to mean that the provider must obtain verification before providing emergency/urgent care.
- 2.7.2.3** The provider service component of the toll-free telephone line must have the capability to track metrics substantially similar to those of the enrollee help line.

2.7.3 Provider Website

- 2.7.3.1** The DBPM shall have a provider website. The provider website may be developed on a page within the DBPM's member website (such as a portal) to meet these requirements.
- 2.7.3.2** The DBPM provider website shall include general and up-to-date information about the DBPM as it relates to the program. This shall include, but is not limited to:
 - 2.7.3.2.1** DBPM provider manual;
 - 2.7.3.2.2** DBPM-relevant LDH bulletins;
 - 2.7.3.2.3** Information on upcoming provider trainings;
 - 2.7.3.2.4** A copy of the provider training manual;
 - 2.7.3.2.5** Information on the provider complaint system;
 - 2.7.3.2.6** Information on obtaining prior authorization and referrals; and
 - 2.7.3.2.7** Information on how to contact the DBPM provider relations.
- 2.7.3.3** The DBPM provider website is considered marketing material and, as such, must be reviewed and approved by LDH in writing within thirty (30) calendar days of the date

the DBPM signs the Contract, and annually thereafter.

2.7.3.4 The DBPM must remain compliant with the HIPAA Privacy and Security Rules when providing any enrollee eligibility or enrollee identification information on the website.

2.7.3.5 The DBPM website must, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.

2.7.4 Provider Manual

2.7.4.1 The DBPM shall develop and issue a provider manual within thirty (30) calendar days from the date the DBPM signs the Contract with LDH. LDH must approve the provider manual before it may be published.

2.7.4.2 The DBPM may choose not to distribute the provider manual via mail, provided it submits a written notification to all providers that explains how to obtain the provider manual from the DBPM's website. This notification shall also detail how the provider can request a hard copy from the DBPM at no charge to the provider. Hard copy manuals must be mailed to the provider within five (5) business days of request.

2.7.4.3 All provider manuals and bulletins shall be in compliance with state and federal laws. The provider manual shall serve as a source of information regarding DBPM covered services, clinical and payment policies and procedures, statutes, regulations, telephone numbers and special requirements to ensure all DBPM requirements are met.

2.7.4.4 At a minimum, the provider manual shall include the following information:

2.7.4.4.1 Description of the DBPM;

2.7.4.4.2 Covered dental benefits and services the DBPM must provide;

2.7.4.4.3 Emergency dental service responsibilities;

2.7.4.4.4 Policies and procedures that cover the provider complaint system;

2.7.4.4.5 Information about the DBPM's enrollee appeal process, including that the provider may file an appeal on behalf of the enrollee with the enrollee's written consent, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the enrollee's right to request continuation of services during an appeal;

2.7.4.4.6 Medical necessity standards as defined by LDH;

2.7.4.4.7 Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

- 2.7.4.4.8** Primary dental provider responsibilities;
 - 2.7.4.4.9** Prior authorization and referral procedures;
 - 2.7.4.4.10** Dental records standards;
 - 2.7.4.4.11** Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;
 - 2.7.4.4.12** DBPM claims payment policies;
 - 2.7.4.4.13** DBPM prompt pay requirements;
 - 2.7.4.4.14** Quality performance requirements; and
 - 2.7.4.4.15** Provider rights and responsibilities.
- 2.7.4.5** The DBPM shall disseminate bulletins as needed to incorporate any changes to the provider manual. Changes must be disseminated sixty (60) days prior to the effective date of the change.

2.7.5 Provider Education and Training

- 2.7.5.1** The DBPM shall provide training to all providers and their staff regarding the requirements of the Contract. The DBPM shall conduct initial training within thirty (30) calendar days of placing a newly contracted provider, or provider group, on active status. The DBPM shall also conduct ongoing training, as deemed necessary by the DBPM or LDH, in order to ensure compliance with program standards and the Contract.
- 2.7.5.2** The DBPM shall submit a copy of the provider training manual and training schedule to LDH for approval within thirty (30) calendar days of the date the DBPM signs the Contract with LDH. Any changes to the manual shall be submitted to LDH for approval at least sixty (60) calendar days prior to the scheduled change and dissemination of such change.

2.7.6 Provider-Patient Communication

- 2.7.6.1** Any DBPM that violates the provider-enrollee communications provisions set forth in federal regulations shall be subject to intermediate sanctions.
- 2.7.6.2** The DBPM shall ensure the integrity of professional advice to enrollees, including interference with provider's advice to enrollees and information disclosure requirements related to provider incentive plans.

2.7.7 Provider Complaint System

- 2.7.7.1** The DBPM shall establish and maintain a provider complaint system for in-network and out-of-network providers that permits a provider to dispute the DBPM's

administrative functions, including proposed actions, claims/billing disputes, and service authorizations.

- 2.7.7.2** For the purposes of this subsection, a provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the DBPM, expressing dissatisfaction with a policy, procedure, payment or any other communication or action by the DBPM, excluding a request for reconsideration or appeal of specific claims. It does include general complaints about claim payment policies.
- 2.7.7.3** For purposes of this subsection, an action is defined as:
 - 2.7.7.3.1** The denial or limited authorization of a requested service, including the type or level of service; or
 - 2.7.7.3.2** The reduction, suspension, or termination of a previously authorized service; or
 - 2.7.7.3.3** The failure to provide services in a timely manner, as defined by the Contract; or
 - 2.7.7.3.4** The failure of the DBPM to act within the timeframes provided in the Contract.
- 2.7.7.4** This system must be capable of identifying and tracking complaints received by phone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the DBPM.
- 2.7.7.5** As part of the provider complaint system, the DBPM shall:
 - 2.7.7.5.1** Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;
 - 2.7.7.5.2** Designate the appropriate number of staff persons to receive and process provider complaints; and
 - 2.7.7.5.3** Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider agreement provisions, collecting all pertinent facts from all parties and applying the DBPM's written policies and procedures.
- 2.7.7.6** The DBPM shall have and implement written policies and procedures which detail the operation of the provider complaint system. The DBPM shall submit its provider complaint system policies and procedures to LDH for review and approval. Provider complaints must be acknowledged within three (3) business days. Provider complaints must be resolved as soon as feasible, but no later than thirty (30) calendar days unless both the provider and LDH have been notified of the outstanding issue and provided a timeline of resolution and reason for the extension of time. All complaints must be

resolved in no more than forty-five (45) calendar days. The policies and procedures shall include, at a minimum:

- 2.7.7.6.1** Allowing providers thirty (30) calendar days after the action to file a written complaint and a description of how providers file a complaint with the DBPM and the resolution time;
 - 2.7.7.6.2** A description of how and under what circumstances a provider may file a complaint with the DBPM for issues that are DBPM provider complaints, and under what circumstances a provider may file a complaint directly to LDH for those decisions that are not a unique function of the DBPM;
 - 2.7.7.6.3** A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee appeal in which the provider is acting on the enrollee's behalf with the enrollee's written consent;
 - 2.7.7.6.4** A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint;
 - 2.7.7.6.5** A process for thoroughly investigating each complaint using applicable provider agreement provisions, and for collecting pertinent facts from all parties during the investigation;
 - 2.7.7.6.6** A description of the methods used to ensure that DBPM executive staff with the authority to require corrective action are involved in the complaint process, as necessary;
 - 2.7.7.6.7** A process for giving providers (or their representatives) the opportunity to present their cases in person;
 - 2.7.7.6.8** Identification of specific individuals who have authority to administer the provider complaint process;
 - 2.7.7.6.9** A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and
 - 2.7.7.6.10** A provision requiring the DBPM to report the status of all provider complaints and their resolution to LDH on a monthly basis in the format required by LDH.
- 2.7.7.7** The DBPM shall distribute the DBPM's policies and procedures to in-network providers at time of the Provider Agreement and to out-of-network providers with the remittance advice. The DBPM may distribute a summary of these policies and

procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the DBPM's website. This summary shall also detail how the in-network provider can request a hard copy from the DBPM at no charge to the provider.

2.8 Provider Payments

2.8.1 General Provisions

2.8.1.1 The DBPM shall process claims and pay providers as required by the Contract, state law and the agreement between the DBPM and the provider.

2.8.1.2 The DBPM shall not pay for the following:

2.8.1.2.1 Any expenditures related to items or services for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; or

2.8.1.2.2 Items or services furnished by a provider during a period where LDH has determined there is reliable evidence of circumstances giving rise to the need for a withholding of payments, which involves fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients.

2.8.1.3 The DBPM may enter into incentive arrangements with providers in accordance with federal regulation.

2.8.2 Minimum Payment to In-Network Providers

2.8.2.1 The DBPM shall provide payment for covered dental benefits and services provided by an in-network provider. The rates of payment shall be no less than the rates on the published Medicaid dental fee schedule at the time of service.

2.8.3 Payment for Emergency Dental Services

2.8.3.1 The DBPM shall reimburse providers for emergency dental services rendered without a requirement for service authorization of any kind. The DBPM shall not deny payment for treatment obtained when an enrollee had an emergency dental condition.

2.8.3.2 The DBPM's protocol for provision of emergency dental services must specify that emergency dental services will be covered when furnished by a provider with which the DBPM does not have a contract or referral arrangement.

2.8.3.3 The DBPM may not limit what constitutes an emergency dental condition on the basis of diagnoses or symptoms or refuse to cover emergency dental services based on the emergency provider not notifying the enrollee's primary dentist of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency dental services.

2.8.3.4 The DBPM shall not deny payment for treatment when a representative of the DBPM

instructs the enrollee to seek emergency dental services.

- 2.8.3.5** The DBPM shall be financially responsible for emergency dental services and shall not retroactively deny a claim for emergency dental services to an enrollee because the enrollee's condition, which appeared to be an Emergency Dental Condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.
- 2.8.3.6** The DBPM shall make prompt payment for covered emergency dental services that are furnished by providers that have no arrangements with the DBPM for the provision of such services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, payment by the DBPM to out-of-network providers for the provision of emergency dental services shall be no more than what would be paid under the Medicaid Dental Fee Schedule.
- 2.8.3.7** Expenditures for emergency dental services as previously described must be factored into the capitation rate described in the Contract and the DBPM will not be entitled to receive any additional payments.

2.8.4 Indian Health Protections

- 2.8.4.1** The DBPM shall demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services available under the Contract from such providers for Indian enrollees who are eligible to receive services.
- 2.8.4.2** When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the DBPM, the DBPM shall pay the IHCP at an amount equal to the amount the DBPM would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from LDH to make up the difference between the amount the DBPM pays and what the IHCP FQHC would have received under FFS.
- 2.8.4.3** When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the DBPM or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology. In such case, the DBPM shall pay the IHCP the rate to which the IHCP is entitled.
- 2.8.4.4** The DBPM shall pay IHCPs, whether participating or not, for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows:
 - 2.8.4.4.1** At a rate negotiated between the DBPM and the IHCP, or
 - 2.8.4.4.2** In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the DBPM would make for the services to a participating provider which is not an IHCP; and
 - 2.8.4.4.3** Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices.

2.8.4.5 The DBPM shall permit any Indian who is enrolled in the DBPM that is not an Indian Managed Care Entity (IMCE) and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services.

2.8.4.6 The DBPM shall permit Indian enrollees to obtain services covered under the Contract from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

2.8.4.7 If timely access to covered services cannot be ensured due to few or no IHCPs, the DBPM shall be considered to have met the requirements of the Contract if:

2.8.4.7.1 Indian enrollees are permitted by the DBPM to access out-of-state IHCPs; or

2.8.4.7.2 If this circumstance is deemed to be good cause for disenrollment from both the DBPM and LDH's managed care program in accordance with §438.56(c).

2.8.4.8 The DBPM shall permit an out-of-network IHCP to refer an Indian enrollee to a network provider.

2.8.4.9 Enrollment in IMCEs

2.8.4.9.1 An IMCE may restrict its enrollment to Indians in the same manner as Indian Health Programs, as defined in 25 U.S.C. §1603(12), may restrict the delivery of services to Indians, without being in violation of federal regulations.

2.8.5 Payment to FQHCs and RHCs

2.8.5.1 The DBPM may stipulate that payment will be contingent upon receiving a clean claim.

2.8.5.2 The DBPM shall reimburse FQHCs and RHCs the Prospective Payment System (PPS) rate in effect on the date of service for each encounter. If the DBPM does not enter into a provider agreement with the FQHCs and/or RHCs within the geographic services area and within the time and distance travel standards of the primary dental care provider, the DBPM is not required to reimburse for out-of-network services. Exception is given when it is determined that the services provided were considered emergency services.

2.8.6 Inappropriate Payment Denials

2.8.6.1 If the DBPM has a pattern of inappropriately denying or delaying provider payments for services, the DBPM may be subject to penalties, Contract cancellation, or refusal to Contract in a future time period. This applies not only to situations where LDH has ordered payment after appeal but to situations where no appeal has been made.

2.8.7 Dental Full Medicaid Payment (FMP)

- 2.8.7.1** The DBPM shall ensure that any amounts designated in the PMPM for Dental FMP are used for payment to dentists pursuant to a network provider agreement and for a specific service or benefit provided to a specific enrollee covered under the Contract, or any other payment mechanism that is allowed pursuant to 42 CFR 438.6.

2.9 Enrollee Marketing, Education and Services

2.9.1 General Provisions

- 2.9.1.1** The DBPM is responsible for creation, production and distribution of educational materials as provided for in the Contract.
- 2.9.1.2** The DBPM shall use enrollee education and marketing tools to encourage each enrollee to be responsible for his or her own healthcare by becoming an informed and active participant in their care.
- 2.9.1.3** The DBPM shall ensure compliance with all state and federal marketing requirements, including monitoring and overseeing the activities of its subcontractors, and any other persons acting for, or on behalf of, the DBPM.
- 2.9.1.4** The DBPM shall not market nor distribute any materials without first obtaining LDH approval.
- 2.9.1.5** Enrollee education, which can be both verbal and written, is defined as communication with an enrollee.
- 2.9.1.6** The DBPM shall ensure that marketing, including marketing plans and materials, is accurate and does not mislead, confuse, or defraud the enrollee or LDH. The DBPM shall not distribute materials that are materially inaccurate, misleading, or otherwise make material misrepresentations.
- 2.9.1.7** The DBPM may use social/electronic media in accordance with the requirements of the Contract, as pre-approved by LDH, and in accordance with state and federal law.
- 2.9.1.8** All enrollee educational activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of enrollees or the general community.
- 2.9.1.9** The DBPM shall establish and maintain an enrollee services function with the capability to answer enrollee inquiries and ensure that enrollees are notified of their rights and responsibilities, through written materials, telephone, electronic, and face-to-face communication.
- 2.9.1.10** The DBPM shall provide written notice of changes affecting enrollees to those enrollees at least thirty (30) days before the effective date of change, unless otherwise specified in the Contract or directed by LDH.
- 2.9.1.11** The DBPM shall develop and maintain processes, compliant with applicable state and federal laws, which shall ensure that the DBPM possesses accurate and current

information indicating who has legal authority to make dental care decisions on behalf of an enrollee.

2.9.1.12 The DBPM may send notices to the enrollee's guardian or authorized representative as applicable.

2.9.2 Information Requirements

2.9.2.1 Basic Rules

2.9.2.1.1 The DBPM is responsible for producing and disseminating all required information to enrollees in a manner and format, approved by LDH, which is easily understood and readily accessible by such enrollees. All marketing and enrollee materials and activities shall comply with the information requirements in 42 CFR §438.10 and the LDH requirements set forth in this Contract and the Marketing and Enrollee Education Companion Guide.

2.9.2.1.2 The DBPM must develop and operate a web site that appears in English and Spanish and that provides information directly and links to the LDH website.

2.9.2.1.2.1 In accordance with 42 CFR §438.10(h), the DBPM must develop and implement an online provider directory, to be approved by LDH. The directory shall be interactive and user friendly and updated no less than once weekly. The provider directory shall include the following information:

2.9.2.1.2.1.1 Provider(s) names and group affiliations; street addresses; telephone numbers; website URLs; specialty credentials and other certifications; whether the provider is accepting new patients; the provider's cultural and linguistic capabilities including languages offered and whether the provider has completed cultural competence training; office hours; specific performance indicators; a statement that some providers may choose not to perform certain services based on religious or moral beliefs; and whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.

2.9.2.1.2.1.2 Providers arranged by name in alphabetical order, showing the provider's specialty, and providers listed by specialty in alphabetical order by name.

2.9.2.1.2.2 The DBPM shall update the printable version of the provider directory at least monthly and include versioning.

2.9.2.1.2.3 When distributing printed provider directories, the DBPM shall include information stating that the most current listing of providers is available by calling the DBPM or visiting the DBPM's website. The letter shall include the telephone number and the internet address that links directly to the online provider directory.

2.9.2.1.2.3.1 The DBPM shall receive provider data from LDH or its designee and the directory shall be updated weekly.

2.9.2.1.2.3.2 The DBPM shall reconcile provider data with LDH data weekly.

2.9.2.1.2.3.3 LDH reserves the right to request changes to the layout of the directory.

2.9.2.1.2.3.4 The DBPM must develop and implement changes to the provider directory and/or layout within sixty (60) calendar days of request by LDH, or within a timeframe as approved by LDH, and at no additional cost to LDH. This may include integration with or replacement by other components of the State's Provider Management System.

2.9.2.1.2.4 For consistency in the information provided to enrollees, the DBPM must utilize LDH approved terminology, and develop LDH approved enrollee notices.

2.9.2.1.2.5 Information is considered to be provided if the DBPM:

2.9.2.1.2.5.1 Mails a printed copy to the enrollee's mailing address;

2.9.2.1.2.5.2 Provides the information by email only after obtaining and documenting the enrollee's agreement to receive information by email;

2.9.2.1.2.5.3 Posts the information on the DBPM website and advises the enrollee in paper or electronic format that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. Enrollee information may be provided electronically only when all of the following are met:

2.9.2.1.2.5.3.1 The format is readily accessible;

2.9.2.1.2.5.3.2 The information is placed in a location on the Contractor’s web site that is prominent and readily accessible;

2.9.2.1.2.5.3.3 The information is provided in an electronic form which can be electronically retained and printed;

2.9.2.1.2.5.3.4 The information is consistent with the language and content requirements of LDH; and

2.9.2.1.2.5.3.5 The enrollee is informed that the information is available in paper format without charge upon request, and the DBPM must provide it upon request within five (5) business days.

2.9.2.1.2.5.4 Provides the information orally via the enrollee help line.

2.9.2.1.2.6 The DBPM must have in place mechanisms to help enrollees understand the requirements and benefits of the Dental Benefit Program.

2.9.2.1.3 Language and Format

2.9.2.1.3.1 LDH has identified Spanish as the prevalent non-English language spoken by enrollees throughout the State.

2.9.2.1.3.1.1 Within ninety (90) calendar days of notice from LDH, materials must be translated and made available.

2.9.2.1.3.2 All written materials for enrollees must be consistent with the following:

2.9.2.1.3.2.1 Use easily understood language and format;

2.9.2.1.3.2.2 Be at or below a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to ensure accuracy:

2.9.2.1.3.2.2.1 Flesch – Kincaid;

2.9.2.1.3.2.2.2 Fry Readability Index;

2.9.2.1.3.2.2.3 PROSE The Readability Analyst (software developed by Educational Activities, Inc.);

2.9.2.1.3.2.2.4 Gunning FOG Index;

2.9.2.1.3.2.2.5 McLaughlin SMOG Index; or

2.9.2.1.3.2.2.6 Other computer generated readability indices accepted by LDH.

2.9.2.1.3.2.3 Use a font size no smaller than 12 point;

2.9.2.1.3.2.4 Written material must also be made available in alternative formats upon request of the enrollee at no cost. Auxiliary aids such as TTY/TTD and American Sign Language (ASL) and services must also be made available upon request of the enrollee at no cost. Written materials must include taglines in the prevalent non-English languages, as well as large print, explaining the availability of written translation or oral interpretation to understand the information. Large print means printed in a font size no smaller than 18 point.

2.9.2.1.3.2.5 The DBPM must provide bilingual Spanish speakers to support the services of the Contract. Any languages that fall outside of the requirements must be handled through a language line service at no cost to LDH. The DBPM shall make oral interpretation services available free of charge to enrollees, and inform the enrollees:

2.9.2.1.3.2.5.1 Oral interpretations are available in all languages;

2.9.2.1.3.2.5.2 Written translation is available in each prevalent non-English language; and

2.9.2.1.3.2.5.3 How to access the interpretation services and written information.

2.9.2.1.3.3 The DBPM may exclude the following from the readability score: addresses, phone numbers, PDP, department names, required disclaimers, dental terminology, dental conditions, proper names, legal terms, and words that cannot be easily substituted.

2.9.3 Prohibited Statements and Claims

2.9.3.1 The DBPM shall not, whether orally or in writing:

2.9.3.1.1 Claim that the DBPM is recommended or endorsed by CMS, the federal or state government, or similar entity.

2.9.3.1.2 Claim that marketing agents are employees of the federal, state, or parish government or of anyone other than the DBPM or organization by whom they are reimbursed.

- 2.9.3.1.3** Use absolute superlatives unless they are substantiated with supporting data provided to LDH as a part of the material review and approval process.

2.9.4 Prohibited Activities

- 2.9.4.1** The DBPM shall not enlist the assistance of any government employee, officer, or elected official in recruitment of enrollees except as authorized in writing by LDH.
- 2.9.4.2** The DBPM shall not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities or market through unsolicited contacts.
- 2.9.4.3** If the DBPM receives permission to call or otherwise contact an enrollee, the DBPM shall treat the permission as event-specific and shall not interpret the permission as an open-ended permission to contact the enrollee after the DBPM has answered the enrollee's inquiry or questions.
- 2.9.4.4** The DBPM shall not rent or purchase email lists to distribute information about its Medicaid Dental Benefit Program to enrollees.
- 2.9.4.5** The DBPM shall not influence enrollment in conjunction with the sale or offering of any private insurance.
- 2.9.4.6** The DBPM shall provide instructions in its marketing materials to enrollees on how to opt out of receiving communications describing other health-related lines of business. The DBPM shall not send such communications to enrollees who have asked to opt out of receiving future marketing communications.
- 2.9.4.7** The DBPM shall not include enrollment applications for other health-related lines of business in Medicaid Dental Benefit Program marketing materials.

2.9.5 Provider-Based Activities

- 2.9.5.1** The DBPM may permit providers to display posters or other materials in common areas, such as the provider's waiting room.
- 2.9.5.2** The DBPM may not permit providers to:
 - 2.9.5.2.1** Mail marketing materials on behalf of the DBPM.
 - 2.9.5.2.2** Accept compensation directly or indirectly from the DBPM for marketing activities.

2.9.6 Marketing and Education Plan

- 2.9.6.1** The DBPM shall develop and implement a plan detailing the enrollee education activities it will undertake and materials it will create during the Contract Term. The detailed plan must be submitted to LDH for review and approval.
- 2.9.6.2** The DBPM shall submit a copy of the procedures to be used to contact Dental Benefit

Program enrollees for initial enrollee education to LDH for approval. These procedures shall adhere to the process and procedures outlined in this Contract.

2.9.6.3 The DBPM shall not begin enrollee education activities prior to the approval of the enrollee education plan.

2.9.6.4 The DBPM enrollee education plan shall:

2.9.6.4.1 List any subcontractors engaged in enrollee education activities for the DBPM;

2.9.6.4.2 State enrollee education goals and strategies; and

2.9.6.4.3 Include the DBPM's plans to monitor and enforce compliance with all enrollee education guidelines.

2.9.6.5 Any changes to the enrollee education plan or included materials or activities must be submitted to LDH for approval at least thirty (30) calendar days before implementation of the enrollee education activity, unless the DBPM can demonstrate just cause for an abbreviated timeframe.

2.9.7 Materials Approval Process and Standards

2.9.7.1 All enrollee education and marketing materials, in all mediums, must be reviewed and approved in writing by LDH prior to use. This includes, but is not limited to, print, television and radio advertisements; handbooks and provider directories; DBPM website screen shots; promotional items; brochures; letters and mass mailings; and emails.

2.9.7.2 The DBPM shall develop and maintain an enrollee handbook that adheres to the requirements in 42 CFR §438.10(g) and shall use the state developed model enrollee handbook for each of the covered populations as specified in this Contract. The DBPM shall conduct a quality check and ensure that all materials are consistent with the Contract and state and federal requirements prior to submitting materials for review by LDH. Generally, LDH will not review materials for typographical or grammatical errors, unless such errors render the material inaccurate or misleading.

2.9.7.3 The DBPM must obtain prior written LDH approval for all materials distributed by the DBPM, regardless of whether developed by the DBPM, a subcontractor, or other third party.

2.9.7.4 As directed by LDH, the DBPM shall include statements and disclaimers on materials.

2.9.7.5 The DBPM shall ensure all materials and services do not discriminate against Dental Benefit Program enrollees on the basis of their health history, health status, or need for healthcare services.

2.9.7.6 The DBPM shall include versioning on all enrollee materials including the following:

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

2.9.8 Required Materials and Services

2.9.8.1 The DBPM shall furnish the following materials within ten (10) business days following receipt of the member file to each person who is newly enrolled or re-enrolled :

2.9.8.1.1 An enrollee notice.

2.9.8.1.1.1 The DBPM shall include in its enrollment notice:

2.9.8.1.1.1.1 The effective date of enrollment;

2.9.8.1.1.1.2 A notice that enrollees who lose Medicaid eligibility and are dis-enrolled shall be automatically re-enrolled in the DBPM if Medicaid eligibility is regained within sixty (60) days;

2.9.8.1.1.1.3 A request to update the enrollee's name, address, parish of residence and telephone number, and include information on how to update this information with the DBPM and through the Social Security Administration; and

2.9.8.1.1.1.4 A postage-paid, pre-addressed return envelope.

2.9.8.1.2 An enrollee identification card, if required by LDH.

2.9.8.1.3 A current enrollee handbook.

2.9.8.1.4 A current provider directory.

2.9.8.2 The DBPM shall furnish a re-enrollment notice to a re-enrolled enrollee.

2.9.8.2.1 The DBPM shall include in its re-enrollment notice:

2.9.8.2.1.1 The effective date of the re-enrollment;

2.9.8.2.1.2 Instructions on how the enrollee can contact the DBPM if a new enrollee handbook or provider directory is needed;

2.9.8.2.1.3 A request to update the enrollee's name, address, parish of residence and telephone number, and include information on how to update this information with the DBPM and through the Social Security Administration; and

2.9.8.2.1.4 A postage-paid, pre-addressed return envelope.

2.9.8.3 Online Enrollee Materials

2.9.8.3.1 The DBPM shall make available electronically at the DBPM’s website without requiring enrollee login, the enrollee handbook, provider directory, and a searchable provider directory.

2.9.8.3.2 The DBPM shall provide enrollee information electronically in compliance with federal requirements

2.9.8.3.3 The DBPM may provide a link to smartphone applications for enrollee use that will take enrollees directly to existing, LDH-approved materials on the DBPM website.

2.9.8.3.4 The DBPM shall maintain an accurate and complete online provider directory containing all the information required in the printed provider directory. The online directory shall be made available in a machine-readable file and format in compliance with federal regulations.

2.9.8.3.5 The DBPM shall have written policies and procedures for at least the following, available online:

2.9.8.3.5.1 Orienting new enrollees of its benefits and services;

2.9.8.3.5.2 Role of the primary dental provider;

2.9.8.3.5.3 How to utilize services;

2.9.8.3.5.4 What to do in a dental emergency or urgent dental situation; and

2.9.8.3.5.5 How to file a grievance and appeal.

2.9.8.3.6 The DBPM shall identify and educate enrollees who access the system inappropriately and provide continuing education as needed.

2.9.8.4 Additional Enrollee Educational Materials

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

2.9.9 Identification Cards

- ~~2.9.9.1~~ Enrollees shall use their LDH issued Medicaid ID card to access benefits and services covered as part of the Dental Benefit Program. LDH reserves the right to require the DBPM to provide enrollees with a separate ID card.
- ~~2.9.9.2~~ The LDH issued Medicaid ID card shall not be proof of eligibility, but can be used for accessing LDH's electronic eligibility verification systems by DBPM providers. These systems will contain the most current information available. The Contractor shall issue a DBPM member ID card to each member enrolled in the DBPM.
- 2.9.9.3** LDH issues a separate ID card to all Medicaid beneficiaries, including DBPM members. This LDH-issued ID card is not proof of eligibility, but may be used by DBPM providers to access the State's electronic eligibility verification systems. These systems contain the most current information available to LDH, including information regarding DBPM enrollment. There will be no DBPM specific information printed on the card. The enrollee may need to show this card to access Medicaid services that are not DBPM covered services.
- 2.9.9.4** The Contractor shall design and, upon approval by LDH, produce, and distribute the DBPM member ID cards. The card shall contain information specific to the DBPM and be easily and readily distinguishable from all other insurance products operated by the Contractor or its parent corporation. The card shall at a minimum include, but not be limited to, the following information as it applies to the covered populations as specified in the *Eligibility and Enrollment* section:
- 2.9.9.4.1** The member's name and date of birth;
 - 2.9.9.4.2** The member's Unique Identifying number encoded into a standard 2D, QR machine-readable barcode and printed with a minimum 3/4" height and width;
 - 2.9.9.4.3** The DBPM's name and address;
 - 2.9.9.4.4** Instructions for emergencies;
 - 2.9.9.4.5** The PDP's name and telephone numbers (including after-hours number, if different from business hours number); and
 - 2.9.9.4.6** The toll-free number(s) for:
 - 2.9.9.4.6.1** Member Services Line;
 - 2.9.9.4.6.2** Provider Services and Prior Authorization; and
 - 2.9.9.4.6.3** Reporting Medicaid Fraud (1-800-488-2917).
- 2.9.9.5** The Contractor shall ensure that its subcontractors can identify enrollees in a manner which shall not result in discrimination against the enrollees, in order to provide or coordinate the provision of all covered services and/or value-added benefits and out-of-network services.

- 2.9.9.6** The Contractor shall mail the card to each new enrollee. The Contractor may provide the card in a separate mailing from the welcome packet, however the card shall be sent no later than ten (10) business days from the date of receipt of the ANSI ASC X12 834 file from LDH or the enrollment broker identifying the new enrollee. As part of the welcome packet information, the Contractor shall explain the purpose of the card, how to use the card, and how to use it in tandem with the LDH-issued card.
- 2.9.9.7** The card shall be issued without the PDP information if no PDP selection has been made as of the date of the mailing.
- 2.9.9.8** Once PDP selection has been made by the enrollee or through auto assignment, the Contractor shall reissue the card in keeping with the time guidelines in this Contract. As part of the mailing of the reissued card, the Contractor shall explain the purpose of the reissued card, the changes between the new card and the previous card, and what the enrollee should do with the previous card.
- 2.9.9.9** The Contractor shall reissue the card within ten (10) calendar days of notice that an enrollee reports a lost card, there is an enrollee name change, the PDP changes, or for any other reason that results in a change to the information on the card.
- 2.9.9.10** The holder of the card issued by the Contractor shall be a DBPM member or guardian of a member. If the Contractor has knowledge of any DBPM member permitting the use of this card by any other person, the Contractor shall immediately report this violation to the Medicaid Fraud Hotline number: 1-800-488-2917.

2.9.10 Toll-Free Enrollee Help Line

- 2.9.10.1** The DBPM shall operate a toll-free enrollee help line, physically located in the United States, that utilizes telephony infrastructure and qualified staff to respond to inquiries regarding all aspects of the Dental Benefit Program. The help line shall be adequately staffed with agents trained to accurately respond to enrollee questions in all areas including:
 - 2.9.10.1.1** Dental Benefit Program policies and procedures; prior authorizations; access information; information on primary dental providers or specialists; referrals to participating specialists; resolution of service and/or dental delivery problems; and grievances.
- 2.9.10.2** The toll-free number must be staffed between the hours of 7:00 a.m. and 7:00 p.m. Central Time, Monday through Friday, excluding state designated holidays. The toll-free line shall have an automated system, available twenty-four (24) hours a day, and seven (7) days a week, including all federal and state holidays. This automated system must include the capability of providing callers with operating instructions on what to do in case of a dental emergency and the option to leave a message, including instructions on how to leave a message and when that message will be returned. The DBPM must ensure that the voice mailbox has adequate capacity to receive all messages and that agents return all calls by close of business the following business day.

- 2.9.10.3** The DBPM shall have sufficient telephone lines to answer all incoming calls. The DBPM shall ensure sufficient staffing to meet performance standards outlined in the Contract. LDH reserves the right to specify a staffing ratio and/or other requirements if performance standards are not met or it is determined that the help line staffing/processes are not sufficient to meet enrollee needs as determined by LDH.
- 2.9.10.4** The DBPM must develop a contingency plan for hiring agents to address overflow calls and emails and to maintain enrollee access standards set forth for DBPM performance. The DBPM must develop and implement a plan to sustain performance levels in situations where there is high call/email volume or low staff availability.
- 2.9.10.5** The DBPM must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The DBPM shall submit these telephone help line policies and procedures, including performance standards, to LDH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The DBPM help line must have the capability to produce an electronic record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.
- 2.9.10.6** The DBPM shall develop and implement an operational manual relevant to the help line. This manual shall provide information to agents on how to conduct various tasks and provide procedures for processing enrollee inquiries, including procedures, such as call scripts, call-handling procedures, first call resolution, and escalation protocols.
- 2.9.10.7** The DBPM shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll- free telephone line. The DBPM shall submit call center quality criteria and protocols to LDH annually.
- 2.9.10.8** ACD System
- 2.9.10.8.1** The DBPM shall install, operate and monitor an automated call distribution (ACD) system for the enrollee help line. The ACD system shall:
- 2.9.10.8.1.1** Include an option for enrollees to bypass options and speak with an enrollee help line agent;
 - 2.9.10.8.1.2** Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;
 - 2.9.10.8.1.3** Transfer calls to other telephone lines;
 - 2.9.10.8.1.4** Provide an option to speak to a live person (during call center hours of operation);

- 2.9.10.8.1.5** Provide a message that notifies callers that the call may be monitored for quality control purposes;
- 2.9.10.8.1.6** Record calls;
- 2.9.10.8.1.7** Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines is not disrupted;
- 2.9.10.8.1.8** Provide interactive voice response (IVR) options that are user-friendly to enrollees and include a decision tree illustrating IVR system; and
- 2.9.10.8.1.9** Inform the enrollee to dial 911 if there is an emergency.

2.9.10.9 The DBPM shall develop performance standards and monitor enrollee help line performance by recording calls and employing other monitoring activities. Such standards shall be submitted to and approved by LDH before use, and comply with monetary penalties outlined in the Contract. The DBPM shall report its performance on these standards. These standards shall be measured on a monthly basis and, at a minimum, require that:

- 2.9.10.9.1** The average speed to answer shall not exceed thirty (30) seconds.
- 2.9.10.9.2** The call blockage rate for direct calls shall not exceed one-half of one percent (.05%).
- 2.9.10.9.3** The average call abandonment rate shall not exceed three percent (3%). A system which places calls in a queue may be used, but the average wait time in the queue shall not exceed sixty (60) seconds.

2.9.10.10 The DBPM shall submit hold time messages that promote the DBPM or include benefit information to LDH for prior approval.

2.10 Enrollee Grievances, Appeals and State Fair Hearings

2.10.1 General Provisions

- 2.10.1.1** The DBPM shall establish and maintain a system for receiving, reviewing and resolving enrollee grievances and appeals. Components must include a grievance process, an appeal process, and a process to access a state fair hearing.
- 2.10.1.2** The DBPM shall ensure that all enrollees are informed of all the processes. Forms with which enrollees may file grievances or appeals shall be available through the DBPM, and must be provided upon request of the enrollee. The DBPM shall make all forms easily available on the DBPM's website.
- 2.10.1.3** The DBPM shall ensure that all decisions on grievances and appeals are made by

dental professionals in accordance with federal regulations.

- 2.10.1.4** The DBPM shall refer all enrollees who are dissatisfied with the DBPM or its activities to the DBPM grievance system.
- 2.10.1.5** The DBPM shall assist the enrollee in completing forms and following the procedures for filing a grievance or appeal, or requesting a state fair hearing.
- 2.10.1.6** Upon request, the DBPM shall provide the enrollee and his or her authorized representative the enrollee's record, including all medical records and any other documents and records considered or relied upon by the DBPM regarding an appeal or state fair hearing, including the opportunity before and during the appeal or state fair hearing process for the enrollee or an authorized representative to examine the record. The DBPM shall provide such records free of charge and within seven (7) calendar days of request.
- 2.10.1.7** The DBPM shall maintain a complete and accurate record of all grievances and appeals. The DBPM shall maintain and make grievance and appeal records available upon request by LDH and CMS. The record of each grievance and appeal must contain, at a minimum, the information specified in 42 CFR 438.416(b).
- 2.10.1.8** The DBPM shall log, track and trend all grievances, regardless of the degree of seriousness or whether the enrollee expressly requests filing the concern.
- 2.10.1.9** The DBPM shall report on grievances and appeals to LDH in a manner and format determined by LDH.
- 2.10.1.10** The DBPM must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within the timeframes established herein.
- 2.10.1.11** A network provider may file an appeal or request a state fair hearing on behalf of the enrollee with the enrollee's written consent.

2.10.2 Process for Grievances

- 2.10.2.1** An enrollee, or authorized representative acting on the enrollee's behalf, may file a grievance orally or in writing at any time.
- 2.10.2.2** The DBPM's process for handling enrollee grievances must include acknowledgement in writing within five (5) business days of receipt of each grievance.
- 2.10.2.3** The DBPM shall review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than ninety (90) calendar days from the date the DBPM receives the grievance.
- 2.10.2.4** The DBPM shall extend the timeframe of disposition for a grievance by up to fourteen (14) calendar days if:

2.10.2.4.1 The enrollee requests the extension; or

2.10.2.4.2 The DBPM shows (to the satisfaction of LDH, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.

2.10.2.5 If the timeframe is extended other than at the enrollee's request, the DBPM shall provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay within two (2) calendar days of the determination.

2.10.3 Standard Resolution of Appeals

2.10.3.1 The DBPM shall adhere to the following timeframes for processing appeals:

2.10.3.1.1 An enrollee, authorized representative, or legal representative of the estate may file an appeal orally or in writing within sixty (60) calendar days from the date on the notice of adverse benefit determination.

2.10.3.1.2 Once an oral appeal is received:

2.10.3.1.2.1 The DBPM shall notify the enrollee verbally that a written confirmation is required for the appeal process to continue. The DBPM should inform the enrollee they will be receiving a notice for written confirmation of the appeal.

2.10.3.1.2.2 The DBPM will send a notice to the enrollee, acknowledging the oral appeal request was received and written confirmation is required. This notice must contain the timeframe for receipt of the written confirmation and future actions.

2.10.3.1.2.3 The DBPM will provide a form for the enrollee to sign and send back, as well as the options available for receipt of written confirmation (fax, email, regular postal mail).

2.10.3.1.2.4 The enrollee has fifteen (15) days from the date of the notice to send their written confirmation.

2.10.3.1.2.5 If written confirmation is not received within the fifteen (15) day timeframe:

2.10.3.1.2.5.1 The DBPM will close the appeal as incomplete for non-receipt of written confirmation.

2.10.3.1.2.5.2 The DBPM will send a notification to the enrollee of the appeal closure. This notice must consist of the reason for the incomplete appeal and inform the enrollee that they may submit a new appeal if they are within the original sixty (60) days of the adverse action. This closure does

not escalate the appeal to a State Fair Hearing since the initial appeal process was not been completed.

- 2.10.3.1.2.6** Once a request for an oral appeal has been closed for non-receipt of a written confirmation, a new appeal date can be established with an oral or written appeal request if it is within the original sixty (60) days of the adverse action.
- 2.10.3.1.3** Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The DBPM must inform the enrollee of the limited time available for this in the case of expedited resolution.
- 2.10.3.1.4** Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including dental records, and any other documents and records considered during the appeals process.
- 2.10.3.1.5** Include, as parties to the appeal:
 - 2.10.3.1.5.1** The enrollee and his or her representative; or
 - 2.10.3.1.5.2** The legal representative of a deceased enrollee's estate.
- 2.10.3.2** The date of the oral filing shall constitute date of receipt.
- 2.10.3.3** The DBPM shall acknowledge each appeal in writing within five (5) business days of receipt of each appeal unless the enrollee requests an expedited resolution.
- 2.10.3.4** The DBPM shall continue to provide benefits and services during the appeal if all of the following occur:
 - 2.10.3.4.1** The enrollee or the enrollee's authorized representative files the request for an appeal timely as defined in the Contract in accordance with federal regulations. As used in this section, "timely" filing means filing on or before the later of the following:
 - 2.10.3.4.1.1** Within ten (10) calendar days of the DBPM mailing the notice of adverse benefit determination; or
 - 2.10.3.4.1.2** The intended effective date of the DBPM's proposed action.
 - 2.10.3.4.2** The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
 - 2.10.3.4.3** The services were ordered by an authorized provider;
 - 2.10.3.4.4** The original period covered by the original authorization has not expired; and

2.10.3.4.5 The enrollee requests continuation of benefits.

2.10.3.5 If, at the enrollee's request, the DBPM continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

2.10.3.5.1 The enrollee withdraws the appeal;

2.10.3.5.2 Ten (10) calendar days pass after the DBPM mails the notice providing the resolution of the appeal adverse to the enrollee unless the enrollee, within the ten (10) calendar day timeframe, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached;

2.10.3.5.3 Following a state fair hearing, the administrative law judge issues a hearing decision adverse to the enrollee; or

2.10.3.5.4 The time period or service limits of a previously authorized service has been met.

2.10.3.6 The DBPM shall provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The DBPM must inform the enrollee of the time limits available for this in the case of expedited resolution.

2.10.3.7 For resolution, an appeal shall be heard and notice of appeal resolution shall be sent to the enrollee no later than thirty (30) calendar days from the date the DBPM receives the appeal.

2.10.3.8 Appeals shall be resolved no later than stated time frames and all parties shall be informed of the DBPM's decision. If a determination is not made in accordance with the timeframes specified in Section 2.10 of this Contract, the enrollee's request will be deemed to have exhausted the DBPM's appeal process as of the date upon which a final determination should have been made. The enrollee may then initiate a State Fair Hearing.

2.10.3.9 The DBPM shall consider as parties to the appeal the enrollee or an authorized representative or, if the enrollee is deceased, the legal representative of the estate.

2.10.4 Expedited Resolution for Appeals

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

2.10.4.2 The DBPM shall resolve each expedited appeal and provide notice to the enrollee, as quickly as the enrollee's health condition requires, within established timeframes not to exceed seventy-two (72) hours after the DBPM receives the appeal request,

whether the appeal was made orally or in writing.

2.10.4.3 The DBPM shall inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution, and ensure that the enrollee understands any time limits that apply.

2.10.4.4 If an enrollee asks for an extension, the DBPM shall treat the request as a denial for expedited appeal, immediately transfer the appeal to the timeframe for standard resolution, and so notify the enrollee. Nothing in this section relieves the DBPM of its obligation to resolve the enrollee's appeal as expeditiously as the enrollee's health condition requires, in accordance with federal regulations.

2.10.4.5 In the case of an expedited plan appeal denial, the DBPM shall also provide oral notice to the enrollee by close of business on the day of resolution, and written notice to the enrollee within two (2) calendar days of the disposition.

2.10.5 Notice of Appeal Resolution

2.10.5.1 The DBPM shall provide the enrollee with a written notice using a notice of appeal resolution template approved by LDH.

2.10.5.2 The DBPM shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the appeal.

2.10.5.3 The DBPM shall inform the enrollee of their right to seek a state fair hearing if the enrollee is not satisfied with the DBPM's decision in response to an appeal, and the process for doing so.

2.10.6 Process for State Fair Hearings

2.10.6.1 An enrollee or authorized representative, who has completed the DBPM's appeal process, may request a state fair hearing after receiving a notice of appeal resolution indicating that the DBPM is upholding, in whole or in part, the adverse benefit determination, or after the DBPM fails to adhere to the notice and timing requirements applicable to appeals.

2.10.6.2 Parties to the state fair hearing include the DBPM as well as the enrollee, or the enrollee's authorized representative.

2.10.6.3 The DBPM shall attend state fair hearings as scheduled and supply the necessary witnesses and evidentiary materials.

2.10.6.4 The DBPM shall submit an evidence packet to LDH and to the enrollee, free of charge, within ten (10) business days from the time the DBPM receives notification of the hearing. The evidence packet must be submitted to LDH in accordance with any prehearing instructions. The evidence packet must include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any dental

records or other documents and/or records considered or relied upon by the DBPM and supporting the DBPM's adverse benefit determination and appeal resolution.

- 2.10.6.5** Within two (2) business days of notification of the state fair hearing request, the DBPM shall provide the corresponding Notice of Adverse Benefit Determination and the Notice of Appeal Resolution that relate to the state fair hearing request to LDH.
- 2.10.6.6** The DBPM shall designate an email address for all state fair hearing-related communications from LDH and any party to the state fair hearing.
- 2.10.6.7** The DBPM shall continue the enrollee's benefits while the state fair hearing is pending if the enrollee timely files for continuation of benefits within ten (10) calendar days after the DBPM sends the notice of appeal resolution that is not wholly in the enrollee's favor.
- 2.10.6.8** The DBPM shall comply with all terms and conditions set forth in any orders and instructions issued by an administrative law judge.
- 2.10.6.9** If, at the enrollee's request, the DBPM continues or reinstates the benefits while the state fair hearing is pending, the benefits must continue until one (1) of the following occurs:
 - 2.10.6.9.1** The enrollee withdraws the state fair hearing request;
 - 2.10.6.9.2** The enrollee fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after the DBPM sends the notice of appeal resolution that is not wholly in the enrollee's favor; or
 - 2.10.6.9.3** The state fair hearing officer issues a hearing decision adverse to the enrollee.
- 2.10.6.10** If the DBPM's action is reversed by the administrative law judge and services were not furnished while the plan appeal was pending, the DBPM shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date the DBPM receives the notice reversing the determination.
- 2.10.6.11** The DBPM shall not create barriers to timely due process. The DBPM shall be subject to penalties if it is determined by LDH that the DBPM has created barriers to timely due process, and/or, if ten percent (10%) or higher of denied appeals are reversed or otherwise resolved in favor of the enrollee following a state fair hearing within a twelve (12) month period. Examples of creating barriers shall include but not be limited to:
 - 2.10.6.11.1** Labeling grievances as inquiries and funneling them into an informal review;
 - 2.10.6.11.2** Failure to inform enrollees of their rights to file grievances, appeals, and state fair hearings;

2.10.6.11.3 Failure to log and process grievances and appeals;

2.10.6.11.4 Failure to issue a proper notice including vague or illegible notices; and

2.10.6.11.5 Failure to inform of continuation of benefits.

2.10.6.12 The DBPM shall take no punitive action against a provider who either requests an expedited resolution on behalf of an enrollee, or supports an enrollee's appeal.

2.11 Quality Management

2.11.1 Quality Assessment and Performance Improvement (QAPI) Program

2.11.1.1 The DBPM shall establish and implement a Quality Assessment and Performance Improvement (QAPI) Program as required by this Contract and 42 CFR §438.330(a)1, to:

2.11.1.1.1 Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved enrollee outcomes;

2.11.1.1.2 Incorporate improvement strategies that include, but are not limited to:

2.11.1.1.2.1 Performance Improvement Projects (PIP) as approved by LDH;

2.11.1.1.2.2 Dental record audits;

2.11.1.1.2.3 Performance measures; and

2.11.1.1.2.4 Provider and enrollee surveys.

2.11.1.1.3 Detect underutilization and overutilization of services; and

2.11.1.1.4 Assess the quality and appropriateness of dental care furnished to enrollees with special healthcare needs.

2.11.1.2 The QAPI Program's written policies and procedures shall address components of effective dental care management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.

2.11.1.3 The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.

2.11.1.4 The DBPM shall submit its QAPI Program description to LDH for written approval by the deadline specified by LDH.

2.11.1.5 The DBPM shall ensure the QAPI Program is incorporated into the operations throughout the DBPM.

2.11.2 QAPI Committee

2.11.2.1 The DBPM shall form a QAPI Committee that shall, at a minimum include:

- 2.11.2.1.1** The DBPM Dental Director who must serve as either the chairman or co-chairman;
- 2.11.2.1.2** Appropriate DBPM staff representing the various departments of the organization who will have membership on the committee; and
- 2.11.2.1.3** The DBPM is encouraged to include an enrollee advocate representative on the QAPI Committee.

2.11.2.2 The QAPI Committee shall:

- 2.11.2.2.1** Meet on a quarterly basis;
- 2.11.2.2.2** Direct and review quality improvement (QI) activities;
- 2.11.2.2.3** Ensure that QAPI activities are implemented throughout the DBPM;
- 2.11.2.2.4** Review and suggest new and/or improved QI activities;
- 2.11.2.2.5** Direct task forces and/or committees to review areas of concern in the provision of healthcare services to enrollees;
- 2.11.2.2.6** Designate evaluation and study design procedures;
- 2.11.2.2.7** Conduct individual PDP and group practice quality performance measure profiling;
- 2.11.2.2.8** Report findings to appropriate executive authority, staff, and departments within the DBPM;
- 2.11.2.2.9** Direct and analyze periodic reviews of enrollees' service utilization patterns;
- 2.11.2.2.10** Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH upon request; and
- 2.11.2.2.11** Ensure that a QAPI Committee designee attends LDH Quality Committee meetings.

2.11.2.3 QAPI Work Plan

- 2.11.2.3.1** The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction. The QAPI plan shall be submitted to LDH annually, and prior to revisions. The QAPI plan, at a minimum, shall:

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

2.11.2.4 QAPI Reporting Requirements

- 2.11.2.4.1** The DBPM shall submit QAPI reports annually to LDH which, at a minimum, shall include:
 - 2.11.2.4.1.1** Quality improvement (QI) activities;
 - 2.11.2.4.1.2** Recommended new and/or improved QI activities; and
 - 2.11.2.4.1.3** Evaluation of the impact and effectiveness of the QAPI program.
- 2.11.2.4.2** Detailed data shall be made available to support any summary report of health outcomes.

2.11.3 Performance Improvement Projects

- 2.11.3.1** The DBPM shall conduct performance improvement projects (PIPs) that focus on both clinical and nonclinical areas, as identified by LDH.
- 2.11.3.2** Each PIP must be designed to achieve significant improvement, sustained over time, in dental outcomes and enrollee satisfaction, and must include the following elements:
 - 2.11.3.2.1** Measurement of performance using objective quality indicators;
 - 2.11.3.2.2** Implementation of interventions to achieve improvement in the access to and quality of care;
 - 2.11.3.2.3** Evaluation of the effectiveness of the interventions based on approved performance measures; and
 - 2.11.3.2.4** Planning and initiation of activities for increasing or sustaining improvement.
- 2.11.3.3** The DBPM must report the status and results of each PIP conducted to LDH as requested, but not less than annually.

2.11.3.4 As approved by LDH, the DBPM may develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement project.

2.11.4 Annual Enrollee Satisfaction Survey

2.11.4.1 The DBPM shall conduct annual LDH-approved enrollee satisfaction surveys comparable to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to enrollees each calendar year.

2.11.4.2 Survey results and a description of the survey process shall be reported to LDH.

2.11.4.3 The survey shall be administered to a statistically valid random sample of enrollees who are enrolled in the DBPM at the time of the survey.

2.11.4.4 The surveys shall provide valid and reliable data for results statewide.

2.11.4.5 Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.

2.11.4.6 Enrollee Satisfaction Survey Reports are due one-hundred twenty (120) calendar days after the end of each calendar year.

2.11.5 Provider Satisfaction Survey

2.11.5.1 The DBPM shall conduct an annual provider satisfaction survey to assess satisfaction with credentialing, communication, education, complaint resolution, claims processing, claims payment, prior authorization procedures, and utilization management processes. The provider satisfaction survey tool and methodology must be submitted to LDH for approval prior to administration.

2.11.5.2 The DBPM shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due one-hundred twenty (120) calendar days after the end of each calendar year.

2.11.6 External Quality Review Organization

2.11.6.1 The DBPM shall cooperate with LDH, the External Quality Review Organization (EQRO), and any other designees during monitoring.

2.11.6.2 The DBPM shall comply with all requests from the EQRO, including requests to review individual dental records, identify and collect management data, and other information concerning the use of services.

2.12 Program Integrity

2.12.1 General Provisions

- 2.12.1.1** The DBPM, its subcontractors and providers shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812; La. R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:l.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.
- 2.12.1.2** The DBPM shall meet with LDH and the Attorney General’s Medicaid Fraud Control Unit (MFCU), periodically, at LDH’s request, to discuss fraud, abuse, neglect and overpayment issues. For purposes of this Section, the DBPM’s Compliance Officer shall be the point of contact for the DBPM.
- 2.12.1.3** The DBPM shall cooperate and assist the State and any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, the United States Department of Health and Human Services (HHS), the United States and/or Louisiana’s Legislative Auditor's Office, the United States and/or Louisiana’s Office of the Attorney General, the United States Government Accountability Office (GAO), LDH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract Term and for a period of ten (10) years from the completion of an audit or expiration of the Contract (including any extensions of the Contract), whichever is later, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules. MFCU shall be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hours admission will be allowed.
- 2.12.1.4** The DBPM, its subcontractors and providers shall make all program and financial records and service delivery sites open to the representative or any designees of the above. Each federal and state agency shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with DBPM clients, employees, and Contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The DBPM shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the format and the language requested.
- 2.12.1.5** The DBPM’s employees, consultants and its contractors and their employees, shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.
- 2.12.1.6** The DBPM shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The DBPM shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the

Contract, and LDH policy.

2.12.1.7 The DBPM shall have programs and procedures pursuant to 42 CFR §438.608(a)(1) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The DBPM shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.

2.12.1.8 The DBPM, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements on disclosure reporting per 42 CFR §455.104 and 42 CFR §438.610. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of the Contract shall submit routine disclosures in accordance with timeframes specified in federal regulations and Louisiana Medicaid Policies and Procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) calendar days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

2.12.1.9 The DBPM, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements on exclusion and debarment screening. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by LDH and/or the DBPM dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

2.12.2 Policies and Procedures

2.12.2.1 Reporting and Investigating Suspected Fraud and Abuse

2.12.2.1.1 The DBPM shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its providers and subcontractors.

2.12.2.1.2 The DBPM shall report all tips, confirmed or suspected fraud, waste and abuse to LDH and the appropriate agency as follows:

2.12.2.1.2.1 All tips (regarding any potential billing or claims issue identified through either complaints or internal review received within the previous month) shall be reported to LDH Program Integrity monthly;

2.12.2.1.2.2 Take steps to triage and/or substantiate tips and provide updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated.

2.12.2.1.2.3 Suspected fraud and abuse in the administration of the program shall be reported to LDH Program Integrity and MFCU within five business days of the DBPM becoming aware of the issue;

- 2.12.2.1.2.4** All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH and MFCU; and
- 2.12.2.1.2.5** All confirmed or suspected enrollee fraud and abuse shall be reported immediately to LDH Program Integrity and local law enforcement of the enrollee's parish of residence.
- 2.12.2.1.3** When making a referral of suspected fraud, the DBPM shall utilize a Fraud Reporting Form deemed satisfactory by LDH.
- 2.12.2.1.4** The DBPM shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the DBPM shall not take any of the following actions as they specifically relate to Medicaid claims:
 - 2.12.2.1.4.1** Contact the subject of investigation about any matters related to the investigation;
 - 2.12.2.1.4.2** Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
 - 2.12.2.1.4.3** Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- 2.12.2.1.5** The DBPM shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.
- 2.12.2.2** The DBPM and/or its subcontractors are to stop payment to a network provider when the State determines there is a credible allegation of fraud, unless the State determines there is cause for not suspending payments to the network provider pending the investigation. The Contractor is responsible for sending the network provider the required notice and appeal rights as required by the 42 CFR §455.23.
- 2.12.2.3** The DBPM and/or subcontractors shall include in any and all of its Provider Agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with fraud, abuse and waste sections of the Contract. The DBPM shall not contract with providers who have been excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.
- 2.12.2.4** In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, the DBPM shall report overpayments made by LDH to the DBPM as well as overpayments made by the DBPM to a provider and/or subcontractor to LDH.

2.12.3 Prohibited Affiliations

- 2.12.3.1** In accordance with 42 CFR §438.610, the DBPM and its subcontractors are prohibited from knowingly having a relationship with: an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- 2.12.3.2** The DBPM may not knowingly have a relationship with an individual or entity directly or indirectly, that is an affiliate of an individual or entity that is debarred, suspended or excluded from participating in any federal health care program under Section 1128 or 1128A of the Social Security Act, in accordance with 48 CFR §2.101 and 42 CFR §438.610.
- 2.12.3.3** The DBPM shall not be controlled by a sanctioned individual under Section 1128(b)(8) of the Social Security Act.
- 2.12.3.4** If LDH finds the DBPM is not in compliance with 42 CFR §438.610(a) and (b), LDH:
 - 2.12.3.4.1** Shall notify the Secretary of the US Department of Health and Human Services (HHS) of the non-compliance;
 - 2.12.3.4.2** May continue an existing agreement with the DBPM unless the Secretary of HHS directs otherwise;
 - 2.12.3.4.3** May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary of HHS provides to LDH and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations; and
 - 2.12.3.4.4** Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under Section 1128, 1128A, or 1128B of the Social Security Act.
- 2.12.3.5** The DBPM and its subcontractors shall comply with all applicable provisions of 42 CFR §438.608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. The DBPM and its subcontractors shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children’s Health Insurance Program, and/or any federal health care programs. To help make this determination, the DBPM shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436.
- 2.12.3.6** The DBPM and its subcontractors shall conduct a search of Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), Louisiana Adverse Actions List Search,

The System of Award Management (SAM) and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to LDH within three (3) business days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2)e.

2.12.3.7 An individual who is an affiliate of a person described above can include:

2.12.3.7.1 A director, officer, or partner of the DBPM;

2.12.3.7.2 A subcontractor of the DBPM;

2.12.3.7.3 A person with an employment, consulting or other arrangement with the DBPM for the provision of items and services which are significant and material to the DBPM's obligations; or

2.12.3.7.4 A network provider.

2.12.3.8 The DBPM shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the DBPM or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the DBPM or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549 of February 18, 1986, which states that debarment or suspension of a participant in a program by one agency shall have government-wide effect.

2.12.3.9 The DBPM, through its Contract Compliance Officer, shall attest monthly to LDH in the format determined by LDH that a search of the websites referenced in this Section has been completed to capture all exclusions.

2.12.4 Payments to Excluded Providers

2.12.4.1 Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services as specified in 42 CFR §1001.1901; and

2.12.4.2 The DBPM is responsible for the return to the State of any money paid for services provided by an excluded provider within thirty (30) days of discovery. Failure by the DBPM to ensure compliance with requirements to prevent and return, as applicable, payments to excluded providers mandatory exclusions may also result in LDH assessing monetary penalties and/or other remedies.

2.12.5 Compliance Plan

- 2.12.5.1** In accordance with 42 CFR §438.608(a), the DBPM and its subcontractors, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under the Contract between the Contractor and the State, shall implement and maintain a compliance program that includes arrangements or procedures designed to prevent and detect fraud, waste and abuse.
- 2.12.5.2** In accordance with 42 CFR §438.608(a)(1)(ii), the arrangements and procedures of the compliance program must include all of the following elements:
 - 2.12.5.2.1** Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.
 - 2.12.5.2.2** The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.
 - 2.12.5.2.3** The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract.
 - 2.12.5.2.4** A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the Contract.
 - 2.12.5.2.5** Fraud, Waste and Abuse Training shall include, but not be limited to annual training of all employees; and new hire training within thirty (30) days of beginning date of employment.
 - 2.12.5.2.6** The DBPM will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws:
 - 2.12.5.2.6.1** Contractor Code of Conduct Training;
 - 2.12.5.2.6.2** Privacy and Security - Health Insurance Portability and Accountability Act;
 - 2.12.5.2.6.3** Fraud, waste, and abuse identification and reporting procedures;
 - 2.12.5.2.6.4** Federal False Claims Act and employee whistleblower protections;

- 2.12.5.2.6.5** Procedures for timely consistent exchange of information and collaboration with LDH;
- 2.12.5.2.6.6** Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and
- 2.12.5.2.6.7** Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.
- 2.12.5.2.7** Effective lines of communication between the compliance officer and the organization's employees.
- 2.12.5.2.8** Enforcement of standards through well-publicized disciplinary guidelines.
- 2.12.5.2.9** Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.
- 2.12.5.2.10** Procedures for prompt notification to LDH when the Contractor receives information about changes in an enrollee's circumstance that may affect the enrollee's eligibility including changes in the enrollee's residence and death of an enrollee.
- 2.12.5.2.11** Procedures for prompt notification to LDH when the Contractor receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the program.
- 2.12.5.2.12** Procedures for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract.
- 2.12.5.2.13** Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the Contractor. The Contractor shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the

extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH and/or the U.S. Office of Inspector General.

- 2.12.5.2.14** Procedures for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days of the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.
- 2.12.5.2.15** Procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential fraud.
- 2.12.5.3** In addition to the arrangements and procedures specified in 42 CFR §438.608(a), the Contractor's compliance program shall incorporate the following requirements:
 - 2.12.5.3.1** Detection and prevention of Medicaid program violations and possible fraud, waste and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.
 - 2.12.5.3.2** Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste and abuse, including: lists of pre-payment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms; and references in provider and member materials relative to identifying and reporting fraud to the plan and law enforcement.
 - 2.12.5.3.3** Provisions for the confidential reporting of plan violations, such as a dedicated hotline to report violations and a clearly designated individual, such as the Contract Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.
 - 2.12.5.3.4** Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.
 - 2.12.5.3.5** Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to enrollees, providers, Contractor employees and the public on the Contractor's website required under the Contract. The Contractor must implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted

2.12.5.4 The DBPM shall submit the Fraud and Abuse Compliance Plan to LDH. The DBPM shall submit updates or modifications to LDH for approval at least thirty (30) calendar days in advance of the effective date. LDH, at its sole discretion, may require that the DBPM modify its compliance plan.

2.12.6 LDH Program Integrity Oversight

2.12.6.1 The DBPM shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state office and Attorney General Medicaid Fraud Control Unit (MFCU) and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s). Additionally, the DBPM shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the DBPM, the DBPM's employee, or a network provider under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) that could result in exclusion, debarment, or suspension of the DBPM or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

2.12.6.2 The DBPM will report to LDH, within three (3) business days, when it is discovered that any Contractor employee(s), network provider, subcontractor, or subcontractor's employee(s) have been excluded, suspended, or debarred from any state or federal health care benefit program via the designated LDH Program Integrity contact.

2.12.6.3 Reporting

2.12.6.3.1 The DBPM, through its Compliance Officer, shall report all activities on a monthly basis to LDH. If fraud, abuse, waste, neglect and overpayment issues are suspected, the DBPM Compliance Officer shall report it to LDH immediately upon discovery. Reporting shall include, but is not limited to:

2.12.6.3.1.1 Number of complaints of fraud, abuse, waste, neglect and overpayments made to the DBPM that warrant preliminary investigation;

2.12.6.3.1.2 Number of complaints reported to the Compliance Officer; and

2.12.6.3.1.3 For each complaint that warrants investigation, the DBPM shall provide LDH, at a minimum, in accordance with 42 CFR §455.15 and §455.16, the following:

2.12.6.3.1.3.1 Name and ID number of provider and enrollee involved, if available;

2.12.6.3.1.3.2 Source of complaint;

2.12.6.3.1.3.3 Type of provider;

2.12.6.3.1.3.4 Nature of complaint;

2.12.6.3.1.3.5 Approximate dollars involved, if applicable; and

2.12.6.3.1.3.6 Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

2.12.6.3.1.4 The DBPM shall report overpayments made by LDH to the Contractor within sixty (60) calendar days from the date the overpayment was identified

2.12.6.3.1.5 The DBPM shall report to LDH Program Integrity at least monthly all unsolicited provider refunds, to include any payments submitted to the Contractor and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.

2.12.6.4 Rights of Review and Recovery by DBPM and LDH

2.12.6.4.1 The DBPM is responsible for investigating possible acts of provider fraud, abuse, and waste for all services under the Contract, including those services that the DBPM subcontracts to outside entities.

2.12.6.4.2 The DBPM and its subcontractors shall have the right to audit, review and investigate providers and enrollees within the DBPM's network for a one (1) year period from the date of payment of a claim via "automated" review. An automated review is one for which an analysis of the paid claims is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the provider to determine the existence of an overpayment. The collected funds from the DBPM's automated reviews are to remain with the DBPM. The DBPM shall not recover from providers via automated review for claims older than one year unless authorized by LDH.

2.12.6.4.3 The DBPM and its subcontractors shall have the right to audit, review and investigate providers and enrollees within the DBPM's network for a five (5) year period from the date of service of a claim via "complex" review. A complex review is one for which the review of medical, financial, and/or other records, including those onsite where necessary to determine the existence of an improper payment. The collected funds from the DBPM's complex reviews are to remain with the DBPM.

2.12.6.4.4 All complex reviews shall be completed within eight (8) months (two hundred-forty (240) calendar days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.

- 2.12.6.4.5** The Contractor must ensure compliance with all requirements of La. R.S. 46:460.72-73, including the requirement to void all claims and encounters associated with fraud, waste and abuse for the purpose of reducing per-member per-month rates, thereby returning overpayments to the State.
- 2.12.6.4.6** The DBPM shall confer with LDH before initiating a post-payment provider-focused review to ensure that review and recovery is permissible. Notification of Intent to Review and/or Recover shall include at a minimum: provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or National Drug Codes (NDCs) under review, date range for dates of service under review, and amount paid. LDH shall respond within ten (10) business days to each review notification. In the event LDH does not respond, the DBPM may proceed with the review. The DBPM and its subcontractors shall not pursue recovery until approved by LDH.
- 2.12.6.4.7** LDH or its designee will notify the DBPM when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:
- 2.12.6.4.7.1** The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a State or federal investigation and/or lawsuit, including but not limited to Federal False Claims Act cases; or
 - 2.12.6.4.7.2** The improperly paid funds have already been recovered by the State's Recovery Audit Contractor (RAC); or
 - 2.12.6.4.7.3** When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending federal or state litigation or investigation, or are being audited by the Louisiana RAC.
- 2.12.6.4.8** This prohibition described in the preceding section shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the DBPM obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, LDH may recover the funds from the DBPM.
- 2.12.6.4.9** Contact with a provider shall be prohibited in instances resulting from suspected fraud which the DBPM has identified and submitted a referral of fraud to LDH, MFCU, or other appropriate law enforcement agency, until approved by LDH.

- 2.12.6.4.10** If the DBPM fails to collect at least a portion of an identified recovery after three-hundred sixty-five (365) days from the date of notice to the Department, unless an extension or exception is authorized by the Department, and the DBPM has documented recovery efforts deemed sufficient by LDH upon review, the Department or its agent may recover the overpayment from the DBPM and said funds will be retained by the State.
- 2.12.6.4.11** LDH or its agent shall have the right to audit, review and investigate providers and enrollees within the DBPM’s network via “complex” or “automated” review. LDH may withhold from the DBPM any overpayments identified by LDH or its agent, and said recovered funds will be retained by the State. The DBPM may pursue recovery from the provider as a result of the State-identified overpayment withhold.
- 2.12.6.4.12** LDH shall not initiate its own review on the same claims for a network provider which has been identified by the DBPM as under a review approved by LDH. LDH shall not approve DBPM requests to initiate reviews when the audit lead and timeframe is already under investigation by LDH or its agents.
- 2.12.6.4.13** In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the DBPM Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The DBPM shall have ten (10) business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from LDH. If the State does not receive a response from the DBPM within ten (10) business days, the State may proceed with its review.
- 2.12.6.4.14** In the event the State or its agent investigates, reviews, or audits a provider or enrollee within the DBPM’s Network, the DBPM shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the DBPM and State.
- 2.12.6.4.15** LDH shall notify the DBPM and the network provider concurrently of overpayments identified by the State or its agents.
- 2.12.6.4.16** Upon the conclusion of provider rebuttals and appeals, if applicable, the State or its agent shall notify the DBPM of the overpayment.
- 2.12.6.4.17** The DBPM shall correct or initiate its own review on the identified encounters within fourteen (14) calendar days of notification from LDH. The DBPM shall submit confirmation that the claims corrections have been completed.

- 2.12.6.4.18** The DBPM and its subcontractors shall enforce LDH directives regarding sanctions on DBPM network providers and enrollees, up to termination or exclusion from the network.
- 2.12.6.4.19** The DBPM shall not remit payment to any provider for which the State-issued Medicaid Provider Identifier number has been revoked or terminated by LDH.

2.13 Systems and Technical Requirements

2.13.1 General Provisions

- 2.13.1.1** The DBPM must maintain hardware and software compatible with LDH requirements that are secure and sufficient to successfully perform the services detailed in the Contract as the service level specified, which are as follows:
 - 2.13.1.1.1** The DBPM shall adhere to federal regulations and guidelines, as well as industry standards and best practices for systems and/or functions required to support the requirements of the Contract.
 - 2.13.1.1.2** The DBPM is responsible for all expenses required to obtain access to LDH systems and/or resources that are relevant to successful completion of the requirements of the Contract. The DBPM is also responsible for expenses required for LDH to obtain access to the DBPM's systems or resources which are relevant to the successful completion of the requirements of the Contract. Such expenses are including, but not limited to, hardware, software, network infrastructure and any licensing costs.
 - 2.13.1.1.3** Any confidential information must be encrypted to FIPS 140-2 standards when at rest or in transit.
 - 2.13.1.1.4** DBPM owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA part 164).
 - 2.13.1.1.5** Any DBPM use of flash drives or hard drives for storage of LDH data must first receive written approval from LDH and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.
- 2.13.1.2** The DBPM shall maintain an automated Management Information System (MIS), hereafter referred to as "System," which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization that complies with LDH and federal reporting requirements. The DBPM shall ensure that its system meets the requirements of the Contract, State-issued guides, and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality, HIPAA, and privacy and security requirements.

- 2.13.1.3** The DBPM's application systems foundation shall employ the relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. It is mandatory that the DBPM's application systems support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.
- 2.13.1.4** All the DBPM's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as required with LDH's systems and shall conform to applicable standards and specifications set by LDH.
- 2.13.1.5** The DBPM's system shall have, and maintain, capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in enrollment requirements.
- 2.13.1.6** The State requires that the proposed solution integrate with components of the State's Enterprise Architecture (EA). All solutions must integrate into the EA components using standard API. The DBPM must integrate to the functional component(s) through the EA's Enterprise Service Bus and Identity Access Management components. The DBPM will be responsible for performing all work necessary to integrate its solution into the EA. The DBPM must work directly with the State's EA Governance Team and the State's EA contractor as necessary throughout the project to validate its integration methodology.
- 2.13.1.7** When fully implemented, the DBPM's system must provide, at a minimum, the following functionalities:
- 2.13.1.7.1** Interface and communicate with LDH and LDH designee systems via a secure protocol. Encryption will be governed in adherence with LDH security policies;
 - 2.13.1.7.2** Process transactions according to department-defined business rules;
 - 2.13.1.7.3** Successfully and securely interface, integrate and exchange files with LDH and all LDH designees with no more than a 0.01% file or transmission failure rate;
 - 2.13.1.7.4** Securely collect and maintain demographic data related to enrollees and providers;
 - 2.13.1.7.5** Maintain privacy of all enrollees in a secure technical environment;
 - 2.13.1.7.6** Conform and adhere to all applicable HIPAA requirements regarding participant privacy and data security;
 - 2.13.1.7.7** Establish and maintain telecommunications with an uptime to meet or exceed 99.99%, exclusive of planned maintenance downtimes;

- 2.13.1.7.8** Maintain high quality data for reporting processes, perform data cleansing and validation such that the data error rate will not exceed 5.00% on random sampling;
- 2.13.1.7.9** Batch transaction types include, but are not limited to, the following:
 - 2.13.1.7.9.1** ANSI ASC X12N 834 Benefit Enrollment and Maintenance;
 - 2.13.1.7.9.2** ANSI ASC X12N 835 Claims Payment Remittance Advice Transaction;
 - 2.13.1.7.9.3** ANSI ASC X12N 837D Dental Claim/Encounter Transaction;
 - 2.13.1.7.9.4** ANSI ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;
 - 2.13.1.7.9.5** ANSI ASC X12N 276 Claims Status Inquiry;
 - 2.13.1.7.9.6** ANSI ASC X12N 277 Claims Status Response;
 - 2.13.1.7.9.7** ANSI ASC X12N 278 Utilization Review Inquiry/Response; and
 - 2.13.1.7.9.8** ANSI ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.
- 2.13.1.8** Transaction types are subject to change and the DBPM shall comply with applicable HIPAA and other federal standards and regulations for information exchange as they occur.
- 2.13.1.9** The DBPM shall adhere to all applicable published State security policies, which may be located at <http://www.doa.la.gov/pages/ots/informationsecurity.aspx>.
- 2.13.1.10** The DBPM will be required to transmit all data which is relevant for analytical purposes to LDH on a regular schedule in XML format. Final determination of relevant data will be made by LDH based on collaboration between both parties. The schedule for transmission of the data will be established by LDH and dependent on the needs of LDH related to the data being transmitted. XML files for this purpose will be transmitted via Secure File Transfer Protocol (SFTP) to LDH. Any other data or method of transmission used for this purpose must be approved via written agreement by both parties.
- 2.13.1.11** MARS-E Compliance
 - 2.13.1.11.1** Contractor shall ensure appropriate protections of shared Personally Identifiable Information (“PII”), in accordance with 45 CFR §155.260.
 - 2.13.1.11.2** Contractor shall ensure that its system is operated in compliance with the CMS latest version of the *Minimum Acceptable Risk Standards for Exchanges (MARS-E)* Document Suite, currently MARS-E version 2.0.

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

2.13.1.11.2.2 A site-to-site tunnel is an extension of LDH’s network. For contractors that are utilizing a VPN site-to-site tunnel and also have remote users who access CMS data, the Contractor is responsible for providing and enforcing multi-factor authentication. Contractors that do not utilize a VPN site-to-site tunnel will be charged for dual authentication licensing and hardware tokens as necessary. Costs associated with the purchase and any replacement of lost hardware tokens will be charged to the Contractor.

2.13.2 Resource Availability and Systems Changes

2.13.2.1 Resource Availability

The DBPM shall provide systems help desk services to LDH and its FI staff that have direct, real-time access to the data in the DBPM’s systems. The systems help desk shall:

2.13.2.1.1 Be available via local and toll-free telephone service, and via email from 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday, excluding state holidays. Upon request by LDH, the DBPM shall be required to staff the systems help desk on a state holiday, Saturday, or Sunday;

2.13.2.1.2 Answer questions regarding the DBPM’s system functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the systems help desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate LDH staff;

2.13.2.1.3 Ensure individuals who place calls after hours have the option to leave a message. The DBPM’s staff shall respond to messages left between the hours of 7:00 p.m. and 7:00 a.m. by noon the following business day;

2.13.2.1.4 Ensure recurring systems issues are documented and reported to LDH within one (1) business day of recognition; and

2.13.2.1.5 Have an information systems (IS) service management system that provides an automated method to record, track and report all questions and/or problems reported to the systems help desk.

2.13.3 Systems Changes

- 2.13.3.1** The DBPM's systems shall conform to future federal and/or LDH specific standards for encounter data exchange within ninety (90) calendar days prior to the standard's effective date or earlier, as directed by CMS or LDH.
- 2.13.3.2** If a system update and/or change is necessary, the DBPM shall draft appropriate revisions for the documentation or manuals, and present them to LDH thirty (30) calendar days prior to implementation, for LDH review and approval. Documentation revisions shall be accomplished electronically and shall be made available for Department review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of the actual revision.
- 2.13.3.3** The DBPM shall submit written notice as an alert to LDH within ten (10) calendar days of identification of a required system update, change or 'fix'. This written notice shall include an overview of the system problem and its potential impact to providers, with the DBPM's estimated timeframe for implementation of a correction. The DBPM shall notify LDH of changes to its system within its span of control ninety (90) calendar days prior to the projected date of the change or within a timeframe specified and approved by LDH.
- 2.13.3.4** Changes include, but are not limited to major changes, upgrades, modification or updates to application or operating software associated with the following core production system:
 - 2.13.3.4.1** Claims processing;
 - 2.13.3.4.2** Eligibility and enrollment processing;
 - 2.13.3.4.3** Service authorization management;
 - 2.13.3.4.4** Reference file processing (e.g., procedure formularies, approved diagnoses, provider payment rates, etc.);
 - 2.13.3.4.5** Provider enrollment and data management; and
 - 2.13.3.4.6** Conversions of core transaction management systems.
- 2.13.3.5** The DBPM shall respond to LDH notification of system problems not resulting in system unavailability according to the following timeframes:
 - 2.13.3.5.1** Within five (5) calendar days of receiving notification from LDH, the DBPM shall respond in writing to notices of system problems.
 - 2.13.3.5.2** Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.
 - 2.13.3.5.3** The DBPM shall correct the deficiency by an effective date to be determined by LDH.

2.13.3.5.4 The DBPM's systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

2.13.3.5.5 The DBPM shall put in place procedures and measures for safeguarding against unauthorized modification to the DBPM's systems.

2.13.3.6 Unless otherwise agreed to in advance by LDH, the DBPM shall not schedule systems unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

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

2.13.4 Systems Refresh Plan

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

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

2.13.5 Other Electronic Data Exchange

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

2.13.6 Electronic Messaging

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

2.13.6.2 As requested, the DBPM shall be able to communicate with LDH over a secure Virtual Private Network (VPN).

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

2.13.7 Provider Enrollment

2.13.7.1 LDH shall publish and maintain at www.lamedicaid.com a non-comprehensive list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. In order to coordinate provider enrollment records, the DBPM shall utilize the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with LDH and the FI. The DBPM shall provide the following:

2.13.7.1.1 Provider service name, provider billing name/DBA name, service/practice address (street, city, state, zip+4), billing address (street, city, state, zip+4), alternate practice site address (if appropriate: street, city, state, zip+4), licensing information (including effective date(s)), tax ID/SSN, National Provider Identifier (NPI), taxonomy and bank direct deposit/EFT payment information;

2.13.7.1.2 All relevant provider ownership information as prescribed by LDH, federal or state laws; and

2.13.7.1.3 Performance of all federal or state mandated exclusion background checks on all providers (owners and managers). The providers shall perform the same for all their employees at least annually.

2.13.7.2 Provider enrollment systems shall include, at minimum, the following functionality:

2.13.7.2.1 Audit trail and history of changes made to the provider file;

2.13.7.2.2 Automated interfaces with all licensing and dental boards;

2.13.7.2.3 Automated alerts when provider licenses are nearing expiration;

2.13.7.2.4 Verification and retention of NPI requirements;

2.13.7.2.5 System generated letters to providers when their licenses are nearing expiration;

2.13.7.2.6 Linkages of individual providers to groups;

2.13.7.2.7 Credentialing information;

2.13.7.2.8 Provider office hours; and

2.13.7.2.9 Provider languages spoken.

2.13.7.3 The DBPM shall submit provider enrollment information weekly to LDH and the FI as a “registry” in a layout, format, and schedule as explained in the Systems Companion Guide. Should LDH and the FI find errors/issues with the registry submissions, the DBPM will resolve to correct the errors within twenty (20) business days or face potential monetary penalties.

2.13.8 Information Security and Access Management

2.13.8.1 The DBPM’s system shall:

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

2.13.8.1.1.1 Restrict access to information on a “least privilege” basis, such as users permitted inquiry privileges only will not be permitted to modify information;

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

2.13.8.1.1.3 Restrict unsuccessful attempts to access system functions to three (3) attempts with a system function that automatically prevents further access attempts and records these occurrences.

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

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

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

2.13.8.1.4.1 Contain a unique log-on, the date and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

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

- 2.13.8.1.4.3** Have the ability to trace data from the final place of recording back to its source data file and/or document;
 - 2.13.8.1.4.4** Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and
 - 2.13.8.1.4.5** Facilitate auditing of individual records as well as batch audits.
 - 2.13.8.1.5** Have inherent functionality that prevents the alteration of finalized records;
 - 2.13.8.1.6** Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The DBPM shall provide LDH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;
 - 2.13.8.1.7** Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;
 - 2.13.8.1.8** Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;
 - 2.13.8.1.9** Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of the DBPM's span of control. This includes, but is not limited to, any provider or enrollee service applications that are directly accessible over the Internet which shall be appropriately isolated to ensure appropriate access;
 - 2.13.8.1.10** Ensure that remote access users of its systems can only access said systems through two-factor user authentication and via methods such as a Virtual Private Network (VPN), which must be prior approved by LDH no later than fifteen (15) calendar days after the Contract is signed; and
 - 2.13.8.1.11** Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the DBPM shall conduct a security risk assessment and communicate the results in an information security plan provided no later than fifteen (15) calendar days after the Contract is signed. The risk assessment shall also be made available to appropriate federal agencies.
- 2.13.8.2** The DBPM shall ensure that written systems process and procedure manuals document and describe all manual and automated system procedures for its

information management processes and information systems.

- 2.13.8.3** The DBPM shall develop, prepare, print, maintain, produce, and distribute to LDH distinct systems design and management manuals, user manuals and quick reference guides, and any updates.
- 2.13.8.4** The DBPM shall ensure the systems user manuals contain information about, and instruction for, using applicable systems functions and accessing applicable system data.
- 2.13.8.5** The DBPM shall ensure when a system change is subject to LDH prior written approval, the DBPM will submit revision to the appropriate manuals at least sixty (60) days before implementing said systems changes.
- 2.13.8.6** The DBPM shall ensure all aforementioned manuals and reference guides are available in printed form and on-line; and
- 2.13.8.7** The DBPM shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.
- 2.13.8.8** The DBPM shall provide to LDH documentation describing its Systems Quality Assurance Plan.
- 2.13.8.9** All DBPM utilized computers and devices must:
 - 2.13.8.9.1** Be protected by industry standard virus protection software that is automatically updated on a regular schedule;
 - 2.13.8.9.2** Have installed all security patches that are relevant to the applicable operating system and any other system software; and
 - 2.13.8.9.3** Have encryption protection enabled at the operating system level.
- 2.13.8.10** Safeguarding Information
 - 2.13.8.10.1** The DBPM shall establish written safeguards which restrict the use and disclosure of information concerning enrollees to purposes directly connected with the performance of the Contract. The DBPM's written safeguards shall:
 - 2.13.8.10.1.1** Be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F (2005, as amended) and state regulations;
 - 2.13.8.10.1.2** State that the DBPM will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

- 2.13.8.10.1.3** Require a written authorization from the enrollee or enrollee's authorized representative before disclosure of information about him or her under circumstances requiring such authorization;
- 2.13.8.10.1.4** Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
- 2.13.8.10.1.5** Specify appropriate personnel actions to violators.

2.13.9 Systems Availability, Performance, and Problem Management Requirements

2.13.9.1 The DBPM shall:

- 2.13.9.1.1** Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the DBPM's span of control;
- 2.13.9.1.2** Allow CMS, LDH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by LDH or the Louisiana Attorney General's Office direct access to its data for the purpose of data mining and review;
- 2.13.9.1.3** Ensure that critical enrollee and provider internet and/or telephone-based IVR functions and information functions are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled system unavailability agreed upon by LDH and the DBPM;
- 2.13.9.1.4** Ensure that at a minimum all other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., Central Time, Monday through Friday;
- 2.13.9.1.5** Ensure that the systems and processes within its span of control associated with its data exchanges with LDH's FI and its contractors are available and operational;
- 2.13.9.1.6** Ensure that in the event of a declared major failure or disaster, the DBPM's core eligibility/enrollment and claims processing systems shall be back online within seventy-two (72) hours of the failure's or disaster's occurrence;
- 2.13.9.1.7** Notify designated LDH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the DBPM's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the DBPM and LDH or LDH's FI. In its notification, the DBPM shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;

- 2.13.9.1.8** Notify designated LDH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in online access to critical systems functions and information during a business day in order for the applicable work activities to be rescheduled or handled based on system unavailability protocol;
- 2.13.9.1.9** Provide information on system unavailability events, as well as status updates on problem resolution, to appropriate LDH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail;
- 2.13.9.1.10** Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled system unavailability of critical functions caused by the failure of system and telecommunications technologies within the DBPM's span of control. Unscheduled system unavailability to all other system functions caused by system and telecommunications technologies within the DBPM's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of system unavailability. Cumulative systems unavailability caused by systems and/or IS infrastructure technologies within the DBPM's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period; and
- 2.13.9.1.11** Within five (5) business days of the occurrence of a problem with system availability, the DBPM shall provide LDH with full written documentation that includes a corrective action plan describing how the DBPM will prevent the problem from reoccurring.
- 2.13.9.2** LDH requires that the DBPM shall interface with LDH, the Medicaid Fiscal Intermediary (FI), and its trading partners. The DBPM must have capacity for real time connectivity to all LDH approved systems. The DBPM must have the capability to allow approved LDH personnel to access internal applications to permit inquiry of eligibility, claims, encounters, reference, provider and other data. The access method must be real-time and may be coordinated with LDH via remote network connections.
- 2.13.9.3** The DBPM's system shall conform and adhere to the data and document management standards of LDH and its FI, inclusive of standard transaction code sets.
- 2.13.9.4** The DBPM's systems shall utilize mailing address standards in accordance with the United States Postal Service.
- 2.13.9.5** Upon direction from LDH, the DBPM shall participate in statewide efforts to incorporate all provider information into a statewide health information exchange.
- 2.13.9.6** The DBPM shall meet, as requested by LDH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce any

healthcare reform initiatives established by LDH.

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

2.13.9.8 If required by LDH, the DBPM shall complete an Information Systems Capabilities Assessment (ISCA), which will be provided by LDH. The ISCA shall be completed and returned to LDH no later than thirty (30) calendar days from the date the DBPM signs the Contract with LDH.

2.13.10 Contingency Plan

2.13.10.1 The DBPM shall have a Contingency Plan that must be submitted to LDH for approval no later than thirty (30) calendar days from the date the Contract is signed, but no later than thirty (30) days prior to the Readiness Review.

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

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

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

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

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

2.13.10.4.3 System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system;

2.13.10.4.4 System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system,

but does prevent access to the system, such as it causes unscheduled system unavailability; and

2.13.10.4.5 The plan shall specify projected recovery times and data loss for mission-critical systems in the event of a failure or declared disaster.

2.13.10.5 The DBPM shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to LDH that it can restore systems functions.

2.13.10.6 In the event the DBPM fails to demonstrate through these tests that it can restore systems functions, the DBPM shall be required to submit a corrective action plan to LDH describing how the failure shall be resolved within ten (10) business days of the conclusion of the test.

2.13.10.7 Emergency Management Plan

2.13.10.7.1 The DBPM shall submit an emergency management plan within thirty (30) days from the date the Contract is signed. The emergency management plan shall specify actions the DBPM shall conduct to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. Revisions to the LDH approved emergency management plan shall be submitted to LDH for approval no less than thirty (30) calendar days prior to implementation of requested changes. The DBPM shall submit an annual certification (from the date of the most recently approved plan) to LDH certifying that the emergency plan is unchanged from the previously approved plan.

2.13.10.7.2 At a minimum, the plan must include the following:

2.13.10.7.2.1 Educating enrollees and providers regarding hurricane preparedness and evacuation planning;

2.13.10.7.2.2 A DBPM contact list (phone and email) for enrollees and providers to contact to determine where healthcare services may be accessed/rendered; and

2.13.10.7.2.3 Emergency contracting with out-of-state healthcare providers to provide healthcare services to evacuated enrollees.

2.13.11 Off-Site Storage and Remote Back-up

2.13.11.1 The DBPM shall provide for off-site storage and a remote backup of operating instructions, procedures, reference files, system documentation, and operational files.

2.13.11.2 The data back-up policy and procedures shall include, but not be limited to:

- 2.13.11.2.1** Descriptions of the controls for back-up processing, including how frequently back-ups occur;
- 2.13.11.2.2** Documented back-up procedures;
- 2.13.11.2.3** The location of data that has been backed-up (off-site and on-site, as applicable);
- 2.13.11.2.4** Identification and description of what is being backed-up as part of the back-up plan; and
- 2.13.11.2.5** Any change in back-up procedures in relation to the DBPM's technology changes.

2.13.11.3 LDH shall be provided with a list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

2.13.11.4 The DBPM shall establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs).

2.13.11.5 The DBPM shall establish appropriate hardware firewalls, routers, and other security measures so that the DBPM's computer network is not able to be breached by an external entity.

2.13.11.6 The DBPM shall establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval of network server data and desktop workstation data.

2.13.11.7 The DBPM shall ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices.

2.13.11.8 The DBPM shall establish independent generator back-up power capable of supplying necessary power for a minimum of four (4) calendar days.

2.13.12 Records Retention

2.13.12.1 The DBPM shall have online retrieval and access to documents and files for six (6) years in live systems for audit and reporting purposes, ten (10) years in archival systems. Services which have a once in a life-time indicator (i.e., Surgical Removal of Erupted Tooth) are denoted on LDH's procedure formulary file and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid member ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The DBPM shall provide forty-eight (48) hour turnaround or better on requests for access to information that is less than six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine-readable form, that is between six (6) to ten (10) years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are

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

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

2.13.12.3 Audit trails shall be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provided in a forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old.

2.14 Claims Management

2.14.1 General Provisions

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

2.14.1.2 The DBPM shall support an Automated Clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.14.1.3 The DBPM shall encourage that its providers submit and receive claims information through electronic data interchange (EDI 837). Electronic claims must be processed in adherence to information exchange requirements as provided in the Contract. As part of this Electronic Claims Management (ECM) function, the DBPM shall also provide on-line and phone-based capabilities to obtain claims processing status information.

2.14.1.4 The DBPM shall inform all network providers about the information required to submit a clean claim at least thirty (30) calendar days prior to the Contract start date. The DBPM shall make available to network providers claims coding and processing guidelines for the applicable provider type. The DBPM shall notify providers sixty (60) calendar days before implementing changes to claims coding and processing guidelines.

2.14.2 Functionality

2.14.2.1 Electronic Claims Management (ECM) Functionality

2.14.2.1.1 The DBPM shall annually comply with LDH's electronic data interchange (EDI) policies for certification of electronically submitted encounters and claims.

2.14.2.1.2 To the extent that the DBPM compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the DBPM shall process the provider's claims for covered services provided to enrollees, consistent with applicable DBPM policies and procedures, the terms of the Contract, and the Systems Companion Guide, including, but not limited to, timely filing guidelines and

compliance with all applicable state and federal laws, rules and regulations. Timely filing guidelines are:

- 2.14.2.1.2.1** Medicaid-only claims must be filed within three-hundred sixty-five (365) calendar days from the date of service.
- 2.14.2.1.2.2** Claims involving third party liability shall be submitted within three-hundred sixty-five (365) calendar days from the date of service. Medicare claims shall be submitted within six (6) months of Medicare adjudication.
- 2.14.2.1.2.3** The DBPM must deny any claim not initially submitted to the DBPM by the three-hundred sixty-fifth (365th) calendar day from the date of service, unless LDH, the DBPM, or subcontractors of the DBPM or LDH created the error. The DBPM shall not deny claims solely for failure to meet timely filing guidelines due to error by LDH, the DBPM, or subcontractors of the DBPM or LDH.
- 2.14.2.1.2.4** For purposes of DBPM reporting on payment to providers, an adjustment to a paid claim shall not be counted as a new claim and electronic claims shall be treated as identical to paper based claims.
- 2.14.2.1.2.5** The DBPM shall not deny claims submitted in cases of retroactive eligibility for failure to meet timely filing guidelines if the claims are submitted within one-hundred eighty (180) calendar days from the beneficiary's enrollment in the DBPM.
- 2.14.2.1.3** The DBPM shall maintain an electronic claims management system that will:
 - 2.14.2.1.3.1** Uniquely identify the attending and billing provider NPI of each service;
 - 2.14.2.1.3.2** Identify the date of receipt of the claim (the date the DBPM receives the claim and encounter information);
 - 2.14.2.1.3.3** Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, pending, appealed, etc. and follow up information on appeals;
 - 2.14.2.1.3.4** Identify the date of payment and the date and number of the check or other form of payment such as electronic funds transfer (EFT);
 - 2.14.2.1.3.5** Identify all data elements as required by LDH for electronic encounter data submission as stipulated in the Contract and the Systems Companion Guide; and

- 2.14.2.1.3.6** Allow submission of non-electronic and electronic claims by providers.
- 2.14.2.1.4** The DBPM shall ensure that an electronic claims management (ECM) system that accepts and processes claims submitted electronically is in place.
- 2.14.2.1.5** The DBPM shall ensure the ECM system shall function in accordance with information exchange and data management requirements as specified in the Contract and the Systems Companion Guide.
- 2.14.2.1.6** The DBPM shall ensure that as part of the ECM function it can provide on-line and phone-based capabilities to obtain processing status information.
- 2.14.2.1.7** The DBPM shall support access to an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.
- 2.14.2.1.8** The DBPM shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the DBPM or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges.
- 2.14.2.1.9** The DBPM shall require that their providers comply at all times with the American Dental Association (ADA) national coding standards, and standardized billing forms and formats, and all future updates for dental and professional claims.
- 2.14.2.1.10** The DBPM agrees that at such time that LDH presents recommendations concerning claims billing and processing that are consistent with industry norms, the DBPM shall comply with said recommendations within ninety (90) calendar days from notice by LDH.
- 2.14.2.1.11** The DBPM shall have procedures approved by LDH, available to providers in written and web form for the acceptance of claim submissions which include:
 - 2.14.2.1.11.1** The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims;
 - 2.14.2.1.11.2** The process for reviewing claims for accuracy and acceptability;
 - 2.14.2.1.11.3** The process for prevention of loss of such claims, and
 - 2.14.2.1.11.4** The process for reviewing claims for determination as to whether claims are accepted as clean claims.

2.14.2.1.12 The DBPM shall have a procedure approved by LDH available to providers in written and web form for notifying providers of batch rejections. The report, at a minimum, should contain the following information:

2.14.2.1.12.1 Date the batch was received by the DBPM;

2.14.2.1.12.2 Date of rejection;

2.14.2.1.12.3 Batch submitters name or identification number; and

2.14.2.1.12.4 Reason batch is rejected.

2.14.2.1.13 The DBPM shall assume all costs associated with claim processing, including the cost of reprocessing/resubmission due to processing errors caused by the DBPM or to the design of systems within the DBPM's span of control.

2.14.2.1.14 The DBPM shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from LDH.

2.14.2.1.15 For purposes of network management, the DBPM shall notify all subcontracted providers to file claims associated with covered services directly with the DBPM, or its contractors, on behalf of Louisiana Medicaid enrollees.

2.14.2.2 Claims Processing

2.14.2.2.1 The DBPM shall ensure that all provider claims are processed according to the following timeframes:

2.14.2.2.1.1 Within five (5) business days of receipt of a claim, the DBPM shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.

2.14.2.2.1.2 Process and pay or deny, as appropriate, at least ninety percent (90%) of all clean claims for each claim type, within fifteen (15) business days of receipt.

2.14.2.2.1.3 Process and pay or deny, as appropriate, one hundred percent (100%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.

2.14.2.3 Rejected Claims

2.14.2.3.1 The DBPM may reject claims because of missing or incomplete information. Paper claims that are received by the DBPM that are

screened and rejected prior to scanning must be returned to the provider with a letter notifying them of the rejection. Paper claims received by the DBPM that are scanned prior to screening and then rejected, are not required to accompany the rejection letter.

2.14.2.3.2 A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system.

2.14.2.3.3 The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, must include the following:

2.14.2.3.3.1 The date the letter was generated;

2.14.2.3.3.2 The patient or member name;

2.14.2.3.3.3 Provider identification, if available, such as provider ID number, TIN or NPI;

2.14.2.3.3.4 The date of each service;

2.14.2.3.3.5 The patient account number assigned by the provider;

2.14.2.3.3.6 The total billed charges;

2.14.2.3.3.7 The date the claim was received; and

2.14.2.3.3.8 The reasons for rejection.

2.14.2.4 Pended Claims

2.14.2.4.1 If a clean claim is received, but additional information is required for adjudication, the DBPM may pend the claim and request in writing (notification via e-mail, website/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all necessary information such that the claim can be adjudicated within established timeframes.

2.14.2.4.2 The DBPM must fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

2.14.2.5 Claims Processing Methodology Requirements

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

2.14.2.5.1 Confirming eligibility on each enrollee as claims are submitted on the basis of the eligibility information provided by LDH and the FI that applies to the period during which the charges were incurred;

2.14.2.5.2 Prior Approval

The system shall determine whether a covered service required prior approval and if so, whether the DBPM granted such approval;

2.14.2.5.3 Duplicate Claims

The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed;

2.14.2.5.4 Covered Services

The system shall verify that a service is a covered service and is eligible for payment;

2.14.2.5.5 Provider Validation

The system shall approve for payment only those claims received from providers eligible to render the service for which the claim was submitted;

2.14.2.5.6 Quantity of Service

The system shall evaluate claims for services provided to enrollees to ensure that any applicable benefit limits are applied; and

2.14.2.5.7 The system shall ensure that dates of services are valid dates, such as not in the future or outside of an enrollee's Medicaid eligibility span.

2.14.2.6 The DBPM shall have the ability to update national standard code sets, such as CDT and ICD-10-CMS, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than thirty (30) days after notification, unless otherwise directed by LDH. This includes annual and other fee schedule updates.

2.14.3 Payments to Providers

2.14.3.1 Prompt Payment to Providers

2.14.3.1.1 To the extent that the provider agreement requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider no later than the time period specified in the provider agreement between the provider and the DBPM, or if a time period is not specified in the Contract:

2.14.3.1.1.1 The tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or

2.14.3.1.1.2 If the DBPM is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting enrollee roster information from LDH.

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

2.14.3.1.3 Within five (5) business days of receipt of a claim, the DBPM shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.

2.14.3.1.4 The DBPM shall fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

2.14.3.2 The DBPM shall pay providers interest at twelve percent (12%) per annum, calculated daily, for the full period in which the clean claim remains unadjudicated beyond the thirty (30) calendar day claims processing deadline. Interest owed the provider must be paid the same date that the claim is adjudicated.

2.14.4 Remittance Advice

2.14.4.1 The DBPM shall generate Explanation of Benefits (EOBs) and Remittance Advices (RAs) in accordance with LDH standards for formatting, content and timeliness.

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

2.14.4.2.1 The name of the enrollee;

2.14.4.2.2 Unique member identification number;

2.14.4.2.3 Patient claim number or patient account number;

2.14.4.2.4 Date of service;

2.14.4.2.5 Total provider charges;

2.14.4.2.6 Enrollee liability, specifying any co-insurance, deductible, copayment, if permitted by the State Plan, or non-covered amount;

2.14.4.2.7 Amount paid by the DBPM;

2.14.4.2.8 Amount denied and the reason for denial;

2.14.4.2.9 Adjustments and Voids shall appear on the RA under "Adjusted or Voided claims" either as approved or denied; and

2.14.4.2.10 The following statement shall be included on each remittance advice sent to providers: “I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws.”

2.14.5 Third Party Liability (TPL)

2.14.5.1 General TPL Information

2.14.5.1.1 Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available third party liability resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid, unless otherwise noted.

2.14.5.1.2 The DBPM shall take reasonable measures to determine third party liability.

2.14.5.1.3 The DBPM shall coordinate benefits so that costs for services otherwise payable by the DBPM are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery. The DBPM shall use these methods as described in federal and state law.

2.14.5.1.4 If the probable existence of third party liability cannot be established then the DBPM must adjudicate the claim. The DBPM must then utilize post-payment recovery as outlined in the Contract.

2.14.5.1.5 The DBPM may require subcontractors or providers to be responsible for coordination of benefits for services provided pursuant to the Contract.

2.14.5.1.6 The DBPM’s system shall identify and track potential collections. The system must produce reports indicating open receivables, closed receivables, amounts collected, amounts written off and amounts avoided. Collection reports shall be available to LDH for inspection within three (3) business days of request.

2.14.5.2 Cost Avoidance

2.14.5.2.1 Unless prohibited by applicable federal or state laws or regulations, the DBPM shall cost-avoid a claim if it establishes the probable existence of Third Party Liability at the time the claim is filed.

2.14.5.2.2 The DBPM shall bill the private insurance within sixty (60) calendar days from date of discovery of liability.

2.14.5.2.3 The DBPM shall adjudicate claims for dental treatment associated with EPSDT in accordance with federal and state law.

2.14.5.3 Post-payment Recoveries

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

2.14.5.3.1.1 The DBPM must have established procedures for recouping post-payments. The DBPM must void encounters for claims that are recouped in full. For recoupments that result in an adjusted claim value, the DBPM must submit replacement encounters.

2.14.5.3.1.2 The DBPM shall identify the existence of potential Third Party Liability to pay for covered dental benefits and services.

2.14.5.3.1.3 The DBPM must report the existence of Third Party Liability in a weekly file to the LDH Fiscal Intermediary in the format to be specified by the Fiscal Intermediary and approved by LDH.

2.14.5.3.1.4 The DBPM shall be required to seek payment in accident/trauma related cases when claims in the aggregate equal or exceed five-hundred dollars (\$500) as required by the Louisiana Medicaid State Plan and federal Medicaid guidelines, and may seek payment when claims in the aggregate are less than five-hundred dollars (\$500).

2.14.5.3.1.5 The amount of any recoveries collected by the DBPM outside of the claims processing system shall be treated by the DBPM as offsets to dental expenses for the purposes of reporting.

2.14.5.3.2 Prior to accepting a Third Party Liability settlement on claims equal to or greater than twenty-five thousand dollars (\$25,000), the DBPM shall obtain approval from LDH.

2.14.5.3.3 The DBPM may retain up to one-hundred percent (100%) of its Third Party Liability collections if all of the following conditions exist:

2.14.5.3.3.1 Total collections received do not exceed the total amount of the DBPM financial liability for the enrollee;

2.14.5.3.3.2 There are no payments made by LDH related to FFS, reinsurance or administrative costs (i.e., lien filing, etc.); and

2.14.5.3.3.3 Such recovery is not prohibited by state or federal law.

2.14.5.3.4 LDH will utilize the data in calculating future capitation rates.

2.14.5.4 TPL Reporting Requirements

- 2.14.5.4.1** The DBPM shall provide LDH Third Party Liability information in a format and medium described by LDH and shall cooperate in any manner necessary, as requested by LDH, with LDH and/or a cost recovery vendor of LDH.
- 2.14.5.4.2** The DBPM shall be required to include the collections and claims information in the encounter data submitted to LDH, including any retrospective findings via encounter adjustments.
- 2.14.5.4.3** Upon the request of LDH, the DBPM must provide information not included in encounter data submissions that may be necessary for the administration of Third Party Liability activity. The information must be provided within thirty (30) calendar days of LDH's request. Such information may include, but is not limited to, individual dental records for the express purpose of a Third Party Liability resource to determine liability for the services rendered.
- 2.14.5.4.4** Upon the request of LDH, the DBPM shall demonstrate that reasonable effort has been made to seek, collect and/or report Third Party Liability and recoveries. LDH shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.
- 2.14.5.4.5** The DBPM must submit an annual report of all health insurance collections for its enrollees plus copies of any Form 1099's received from insurance companies for that period of time.

2.14.5.5 LDH Right to Conduct Identification and Pursuit of TPL

- 2.14.5.5.1** When the DBPM fails to collect payment from the Third Party Liability within three hundred sixty-five (365) calendar days from date of service, LDH may invoke its right to pursue recovery.
- 2.14.5.5.2** If LDH determines the DBPM is not actively engaged in cost avoidance, the DBPM will be responsible for all administrative costs associated with LDH's collection activities.

2.14.5.6 Other Coverage Information

- 2.14.5.6.1** The DBPM shall maintain other coverage information for each enrollee. The DBPM shall verify the other coverage information provided by LDH and develop a system to include additional other coverage information when it becomes available.

2.14.6 Sampling of Paid Claims

2.14.6.1 On a monthly basis, the DBPM shall provide individual explanation of benefits (EOB) notices to a sample group of members, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:

2.14.6.1.1 Description of the service furnished;

2.14.6.1.2 The name of the provider furnishing the service;

2.14.6.1.3 The date on which the service was furnished; and

2.14.6.1.4 The amount of the payment made for the service.

2.14.6.2 The DBPM shall also:

2.14.6.2.1 Stratify paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the DBPM or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may over sample the group. The paid claims sample should be for a minimum of two (2%) percent of claims paid per month to be reported on a quarterly basis;

2.14.6.2.2 Perform surveys at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits); and

2.14.6.2.3 Track any complaints received from enrollees and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or a referral to LDH. The DBPM shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

2.14.6.3 Within three (3) business days, results indicating that paid services may not have been received shall be referred to the DBPM's fraud and abuse department for review and to the LDH Program Integrity contact.

2.14.6.4 Reporting shall include the total number of survey notices sent out to enrollees, total number of surveys completed, total services requested for validation, number of services validated, analysis of interventions related to complaint resolution, and number of surveys referred to LDH for further review.

2.14.7 Claims Dispute Management

2.14.7.1 The DBPM shall develop an internal claims dispute process for those claims or group of claims that have been denied or for which the payment has been reduced. The process must be submitted to LDH for approval within thirty (30) calendar days from the date the Contract is signed by the DBPM.

- 2.14.7.2** The claims dispute management process must include, at a minimum, the following components:
- 2.14.7.2.1** A designated telephone number for provider relations staff so that if a provider has a question or is not satisfied with the information they have received related to a claim, they can contact appropriate staff;
 - 2.14.7.2.2** Specific timeframes during which time all requests for claim reconsideration or adjustment must be received;
 - 2.14.7.2.3** Guidelines for submitting a paper claim for review or reconsideration; and
 - 2.14.7.2.4** A list of required information for submission of requests for claim reconsideration or adjustment in either electronic or paper format.
- 2.14.7.3** The DBPM shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.
- 2.14.7.4** The DBPM shall adjudicate all disputed claims to a paid or denied status within thirty (30) business days of receipt of the disputed claim.
- 2.14.8** Providers shall have the right to an independent review of claims that are the subject of an adverse determination by the DBPM. The review shall be provided and conducted in accordance with La. R.S. 46:460.90.
- 2.14.9** The DBPM shall resolve all claims, including disputed claims, no later than twenty-four (24) months from the date of service.
- 2.14.10** Claims Payment Accuracy
- 2.14.10.1** On a monthly basis, the DBPM shall submit a claims payment accuracy percentage report to LDH. A copy of the report format and instructions is provided in the Systems Companion Guide. The report shall be based on an audit conducted by the DBPM. The audit shall be conducted by an entity or staff independent of claims management as specified in this Section, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred-fifty (250) claims per year, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.
 - 2.14.10.2** The minimum attributes to be tested for each claim selected shall include:
 - 2.14.10.2.1** Claim data correctly entered into the claims processing system;
 - 2.14.10.2.2** Claim is associated with the correct provider;
 - 2.14.10.2.3** Proper authorization was obtained for the service;

- 2.14.10.2.4** Beneficiary eligibility at processing date correctly applied;
- 2.14.10.2.5** Allowed payment amount agrees with contracted rate;
- 2.14.10.2.6** Duplicate payment of the same claim has not occurred;
- 2.14.10.2.7** Denial reason applied appropriately;
- 2.14.10.2.8** Copayment application considered and applied, if applicable;
- 2.14.10.2.9** Effect of modifier codes correctly applied; and
- 2.14.10.2.10** Proper coding.

2.14.10.3 The results of testing at a minimum should be documented to include:

- 2.14.10.3.1** Results for each attribute tested for each claim selected;
- 2.14.10.3.2** Amount of overpayment or underpayment for each claim processed or paid in error;
- 2.14.10.3.3** Explanation of the erroneous processing for each claim processed or paid in error;
- 2.14.10.3.4** Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and
- 2.14.10.3.5** Claims processed or paid in error have been corrected.

2.14.10.4 If the DBPM contracted for the provision of any covered services, and the DBPM's contractor is responsible for processing claims, then the DBPM shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

2.14.11 Encounter Data

2.14.11.1 The DBPM's system shall be able to transmit to and receive electronic encounter data from LDH's FI's system as required for the appropriate submission of encounter data.

2.14.11.2 Within thirty (30) calendar days of operation, the DBPM's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer Coordination of Benefits (COB) format. The DBPM must incur all costs associated with certifying HIPAA transactions readiness through a third party, EDIFECS, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the Dental Benefit Program Systems Companion Guide. All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction format (D – Dental). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

- 2.14.11.3** The DBPM shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.
- 2.14.11.4** The DBPM shall have the ability to update Current Dental Terminology (CDT), Current Procedural Terminology (CPT)/HCPCS, ICD-10-CM and other codes based on HIPAA standards and move to future versions as required. In addition to CDT, CPT, ICD-10-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the DBPM and LDH to evaluate performance measures. The DBPM will not be permitted to submit paper encounters to LDH's FI.
- 2.14.11.5** The DBPM shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to LDH's FI.
- 2.14.11.6** The FI encounter process shall utilize a LDH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from an electronic batch submission by the DBPM. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the DBPM for immediate correction and resubmission.
- 2.14.11.7** LDH and its FI shall determine which edits are appropriate for encounters and shall set encounter edits to "pay" or "deny". Encounter denial codes shall be deemed "repairable" or "non-repairable". An example of a repairable encounter is "Date of Service is not valid". An example of a non-repairable encounter is "exact duplicate". The DBPM is required to be familiar with the FI exception codes and dispositions for the purpose of repairing denied encounters.
- 2.14.11.8** The DBPM shall utilize LDH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The DBPM shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with LDH and its FI's billing requirements.
- 2.14.11.9** Due to the need for timely data and to maintain integrity of processing sequence, the DBPM shall address any issues that prevent processing of an encounter. Acceptable standards shall be ninety percent (90%) of reported repairable errors are addressed within thirty (30) calendar days and ninety-nine percent (99%) of reported repairable errors are addressed within sixty (60) calendar days or within a negotiated timeframe approved by LDH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan, may result in monetary penalties.
- 2.14.11.10** For encounter data submissions, the DBPM shall:
- 2.14.11.10.1** Submit complete and accurate encounter data at least monthly. Data is due in accordance with the encounter reconciliation schedule published by LDH or its contracted review organization, including encounters

reflecting a zero dollar amount (\$0.00) and encounters in which the DBPM or its subcontractor has a capitation arrangement with a provider. If the DBPM fails to submit complete encounter data, including encounters processed by subcontracted vendors as measured by a comparison of encounters to cash disbursements within a five (5) percent error threshold (at least ninety-five (95) percent complete), the plan may be penalized as outlined in the Contract.

2.14.11.10.2 LDH's current FI accepts HIPAA compliant 837 encounters for dental. LDH's FI accepts Pharmacy encounters using the NCPDP D.0 format in a batch processing method. The DBPM shall be able to transmit encounter data to the FI in this manner sixty (60) days after the Contract start date. All encounters are adjudicated at the line level.

2.14.11.11 The DBPM shall ensure that all encounter data from a contractor is incorporated into a single file from the DBPM. The DBPM shall not submit separate encounter files from DBPM contractors.

2.14.11.12 The DBPM shall ensure that files contain settled claims and claim adjustments or voids, including but not limited to, adjustments necessitated by payment errors processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the DBPM has a capitation arrangement.

2.14.11.13 The DBPM shall ensure the level of detail associated with encounters from providers with whom the DBPM has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the DBPM received and settled a FFS claim.

2.14.11.14 The DBPM shall adhere to federal and/or LDH payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the encounter data submissions and will be treated similarly by LDH for the DBPM.

2.14.11.15 Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the DBPM's applicable payment methodology for that service.

2.14.11.16 The DBPM must make necessary adjustments to encounters when the DBPM discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise.

2.14.11.17 If LDH or its subcontractors discover errors or a conflict with a previously adjudicated claim, the DBPM shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by LDH or if circumstances exist that prevent DBPM from meeting this time frame a specified date shall be approved by LDH.

2.14.11.18 The DBPM shall provide LDH with weekly encounter data on all prior

authorization requests. The data shall be reported electronically to LDH in a mutually agreeable format as specified in the Systems Companion Guide. The DBPM shall report prior authorization requests on all services which require prior authorization.

2.14.11.19 The DBPM shall notify LDH of any systemic or widespread issues with its encounters, and provide a root-cause analysis, impact, and remediation plan.

2.15 Subcontracts

2.15.1 LDH shall have a single prime contractor as the result of any contract negotiation, and that prime contractor shall be responsible for all deliverables specified in this Contract.

2.15.2 Unless provided for in the Contract, the Contractor shall not contract with any other party for any of the services herein contracted without the express prior written approval of LDH.

2.15.3 The Contractor shall not substitute any subcontractor without the prior written approval of LDH. The Contractor maintains the ultimate responsibility for complying with all the terms and conditions of the Contract. For subcontractor(s), before commencing work, the Contractor will provide letters of agreement, contracts, or other forms of commitment that demonstrate all requirements pertaining to the Contractor will be satisfied by all subcontractors through the following:

2.15.3.1 The subcontractor(s) will provide a written commitment to accept all Contract provisions.

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

2.15.4 Detailed information of subcontractors must be provided during readiness reviews as outlined in Section 2.16.2.

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

2.15.6 The DBPM shall be responsible to oversee the performance of all subcontractors and shall be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:

2.15.6.1 All subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract;

2.15.6.2 Prior to executing a subcontract, the DBPM must evaluate the prospective subcontractor's qualifications and ability to perform the activities to be delegated;

2.15.6.3 The DBPM must have a written agreement between the DBPM and the subcontractor

that specifies the activities and reporting responsibilities delegated to the subcontractor and the subcontractor must agree to comply with all Contract provisions, and provides for revoking delegation or imposing other penalties if the subcontractor's performance is inadequate;

- 2.15.6.4** The DBPM shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards; and
- 2.15.6.5** The DBPM shall identify deficiencies or areas for improvement, and take corrective action.
- 2.15.7** The DBPM shall submit all major subcontracts for the provision of any services under the Contract to LDH for prior review and approval. To obtain such approval, the DBPM shall submit a written request and a completed subcontractor checklist, which will be provided by LDH. LDH shall have the right to disapprove any and all subcontracts entered into for the provision of any services under the Contract.
- 2.15.8** Notification of amendments or changes to any subcontract which materially affects the Contract, shall be provided to LDH prior to the execution of the amendment.
- 2.15.9** All subcontracts must provide for termination of the subcontract, or specify other remedies, when LDH or the DBPM determines that the subcontractor has not performed satisfactorily.
- 2.15.10** All subcontracts executed by the DBPM shall, at a minimum, include the terms and conditions listed in the Contract. No other terms or conditions agreed to by the DBPM and its subcontractor shall negate or supersede the requirements in the Contract.
- 2.15.11** All subcontracts executed by the DBPM shall specify that the subcontractor agrees that:
 - 2.15.11.1** The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the DBPM's Contract with the State.
 - 2.15.11.1.1** The subcontractor will make available, for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to the DBPM's Medicaid enrollees; and
 - 2.15.11.1.2** The right to audit will exist through ten (10) years from the final date of the Contract Term or from the date of completion of any audit, whichever is later.
 - 2.15.11.1.3** If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

2.15.11.2 The subcontractor shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana’s Medical Assistance Programs.

2.15.11.2.1 When requested by the MFCU, the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the Contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data.

2.15.11.2.2 The subcontractor agrees that the Contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

2.15.12 The DBPM shall require the subcontractor to submit a completed disclosure of ownership, which the DBPM shall submit to LDH with its request approval of the subcontract. The DBPM shall also submit, within ten (10) business days of a request made by LDH, full and complete information about:

2.15.12.1 The ownership of any subcontractor with whom the DBPM has had business transactions totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period ending on the date of the request; and

2.15.12.2 Any significant business transactions between the DBPM and any wholly owned supplier or between the DBPM and any subcontractor, during the five (5) year period ending on the date of the request.

2.15.12.3 For the purpose of the Contract, “significant business transactions” means any business transaction or series of transactions during any state fiscal year that exceeds the twenty-five thousand dollars (\$25,000) or five percent (5%) of the DBPM’s total operating expenses, whichever is greater.

2.15.13 The DBPM shall report to LDH all “transactions” with a “party of interest” as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and State Medicaid Manual (SMM) 2087.6(A-B), as required by Section 1903(m)(4)(A) of the Social Security Act. Federally qualified plans are exempt from this requirement.

2.15.14 Types of business transactions which must be disclosed include:

2.15.14.1 Any sale, exchange, or lease of any property between the DBPM and a party in interest;

2.15.14.2 Any lending of money or other extension of credit between the DBPM and the party in interest; and

2.15.14.3 Any furnishing for consideration of goods, services (including management services), or facilities between the DBPM and the party in interest. This does not include salaries

paid to employees for services in the normal course of their employment.

2.15.15 The information that must be disclosed in the transactions listed above between a DBPM and a party in interest includes:

2.15.15.1 The name of the party in interest for each transaction;

2.15.15.2 A description of each transaction and the quantity or units involved;

2.15.15.3 The accrued dollar value of each transaction during the fiscal year; and

2.15.15.4 Justification of the reasonableness of each transaction.

2.15.16 LDH may require that the information on business transactions be accompanied by a consolidated financial statement for the DBPM and the party in interest.

2.15.17 If the DBPM has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial Contract Term must be disclosed. The business transactions that must be reported are not limited to transactions related to serving Medicaid enrollees. All of the DBPM's business transactions must be reported.

2.15.18 If the Contract is renewed or extended, the DBPM must disclose information on business transactions which occurred during the prior Contract period.

2.16 Implementation and Readiness Reviews

2.16.1 Implementation Plan

2.16.1.1 The DBPM must produce a work plan that demonstrates how it will accomplish required tasks before the Contract start date, including:

2.16.1.1.1 Project management structure;

2.16.1.1.2 Communication protocols between LDH and DBPM;

2.16.1.1.3 Interaction with LDH contractors;

2.16.1.1.4 Schedule for key activities and milestones; and

2.16.1.1.5 Evidence of completion of activities required for readiness review.

2.16.1.2 An updated and detailed plan will be due to LDH within thirty (30) calendar days from the date the Contract is signed by the DBPM.

2.16.2 Readiness Review

2.16.2.1 LDH will complete readiness reviews of the DBPM prior to the Contract start date in accordance with 42 CFR §438.66(c) - (d). LDH will provide the DBPM with the readiness review schedule. The DBPM agrees to provide all materials required to complete the readiness review by the dates established by LDH. The review will include an

evaluation of all deliverables as defined in the Scope of Services. A portion of the readiness review will be performed onsite at the DBPM's administrative office. The DBPM shall be responsible for all travel costs incurred by LDH staff participating in onsite readiness reviews. The results of the readiness review will be submitted to CMS by LDH for CMS to make a determination that the Contract or associated Contract amendment is approved under 42 CFR §438.3(a).

2.16.2.2 The DBPM must disclose any changes to proposed key staff, subcontractors, or value added benefits or services identified in the proposal.

2.16.2.3 The DBPM must have successfully met all readiness review requirements established by LDH no later than sixty (60) calendar days prior to the Contract start date.

2.16.2.4 If the DBPM does not fully meet the readiness review prior to the Contract start date, LDH may impose a monetary penalty for each day beyond the Contract start date that the DBPM is not operational.

2.16.2.5 The DBPM is required to provide a corrective action plan in response to any readiness review deficiency no later than ten (10) calendar days after notification of any such deficiency by LDH. If the DBPM documents to LDH's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by LDH, no corrective action plan is required.

2.16.2.6 System Readiness

2.16.2.6.1 The DBPM will define and test modifications to the DBPM's system(s) required to support the business functions of the Contract. The DBPM will produce data extracts and receive data transfers and transmissions. The DBPM must be able to demonstrate the ability to produce encounters file.

2.16.2.6.2 If any errors or deficiencies are evident, the DBPM will develop resolution procedures to address the problem identified. The DBPM will provide LDH, or designated contractor, with test data files for systems and interface testing for all external interfaces.

PART 3: PERFORMANCE, NON-COMPLIANCE, AND PENALTIES

3.1 Performance Measures

3.1.1 The DBPM shall meet all performance measures as stated in the Contract.

3.1.1.1 All administrative performance measures are reporting measures. Administrative performance measure reporting is required at least monthly upon LDH's request.

3.1.1.2 LDH will establish benchmarks for clinical performance measures utilizing statewide data of the Medicaid population from the previous calendar year(s) with the expectation that performance improves by a certain percentage toward the benchmarks. Clinical performance measures shall be reported at least annually twelve (12) months after services begin.

3.1.1.3 Clinical performance measures include:

3.1.1.3.1 Healthcare Effectiveness and Information Set (HEDIS) Annual Dental Visits (ADV); and

3.1.1.3.2 Total Eligibles Receiving Preventive Dental Services based on data reported on the CMS 416.

3.1.1.4 Baseline data and applicable targets will be provided prior to the start date of the Contract.

3.1.1.5 The DBPM shall publish its clinical performance measures on its website in a manner that allows enrollees and the public to view the performance of the DBPM. The DBPM may meet this requirement by including information about performance measures conducted by LDH and providing a link to LDH's applicable website page.

3.1.2 LDH may add, remove, or amend measures with ninety (90) days' advance notice.

3.1.3 Performance measures may be used to create performance improvement projects.

3.2 Performance Evaluation

3.2.1 The standards by which the DBPM shall be evaluated will be at the sole discretion and approval of LDH.

3.2.2 LDH shall evaluate the DBPM's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by LDH, or as otherwise specified by the Contract.

3.2.3 LDH will evaluate the DBPM's performance against, and ability to achieve, the services identified in the Contract throughout the Contract Term and at the expiration of the Contract.

3.3 Performance Monitoring

3.3.1 All work performed by the DBPM will be monitored by the Medicaid Director or his/her designee.

3.3.2 LDH or its designee will monitor the operation of the DBPM for compliance with the provisions of the Contract, and applicable federal and state laws and regulations. Inspection may include the DBPM's facilities, as well as auditing and/or review of all records developed under the Contract including, but not limited to, periodic dental audits, grievances, enrollments, disenrollment, utilization and financial records, review of the management systems and procedures developed under the Contract and any other areas or materials relevant or pertaining to the Contract.

3.3.3 The DBPM shall provide access to documentation, dental records, premises, and staff as deemed necessary by LDH to monitor performance.

3.3.4 Reporting Requirements

3.3.4.1 LDH will require the DBPM to submit monthly, quarterly, and annual reports that will allow LDH to assess the DBPM's performance. The DBPM shall comply with all reporting requirements and timelines established by LDH.

3.3.4.2 The DBPM must be able to design, develop and implement reports using the electronic formats, instructions, and timeframes specified by LDH. The DBPM shall maintain flexible reporting capabilities and must be able to respond to the reporting requests of LDH and its designees.

3.3.4.3 The DBPM shall certify all submitted data and reports, including, but not limited to, routine performance reports, financial reports and encounter data. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The DBPM must submit the certification concurrently with the certified data and reports. LDH will identify specific data that requires certification.

3.3.4.4 The data shall be certified by one of the following:

3.3.4.4.1 DBPM's CEO; or

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

3.3.4.5 The DBPM shall furnish to LDH or to the HHS, information related to significant business transactions as set forth in federal regulations. Failure to comply with this requirement may result in termination of the Contract.

3.3.4.6 Financial Reporting

3.3.4.6.1 The DBPM shall submit to LDH unaudited quarterly financial statements and an annual audited financial statement, using the required format provided by LDH. Quarterly financial statements shall be submitted no later than sixty (60) days after the close of each calendar quarter. Audited annual statements shall be submitted no later than six (6) months after the close of the DBPM's fiscal year.

3.3.4.6.2 The financial statements shall be specific to the operations of the DBPM rather than to a parent or umbrella organization. Audited annual statements of a parent organization, if available, shall be also submitted.

3.3.4.6.3 All financial reporting shall be based on Generally Accepted Accounting Principles (GAAP).

3.3.4.6.4 Additional financial reporting information is available in the LDH Financial Reporting Guide.

3.3.4.7 Transparency Report

3.3.4.7.1 The DBPM shall designate one staff member to serve as the single point of contact for all requests related to the Transparency Report required by La. R.S. 40:1253.2. The DBPM shall comply with all LDH instructions and definitions related to this report.

3.3.4.8 The DBPM shall comply with all data requests and surveys from LDH or its designee.

3.3.4.9 Ad Hoc Reports

The DBPM shall prepare and submit any other reports as required and requested by LDH, any LDH designee, and/or CMS, that is related to the DBPM's duties and obligations under the Contract. Ad Hoc reports shall be submitted within five (5) business days from request.

3.3.4.10 Submission Process and Timeframes

3.3.4.10.1 The DBPM shall ensure that all required reports or files are submitted to LDH in a timely manner for review and approval. The DBPM's failure to submit the reports or files as specified may result in the assessment of monetary penalties.

3.3.4.10.2 Unless otherwise specified, deadlines for submitting files and reports are as follows:

3.3.4.10.2.1 Daily reports and files shall be submitted within one (1) business day of the reporting date;

3.3.4.10.2.2 Weekly reports and files shall be submitted on the Wednesday following the reporting week;

3.3.4.10.2.3 Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of the reporting month;

3.3.4.10.2.4 Quarterly reports and files shall be based on a calendar quarter and be submitted within thirty (30) calendar days of the end of the reporting quarter; and

3.5 Intermediate Sanctions

3.5.1 The DBPM is subject to 42 CFR Part 438, Subpart I.

3.6 Monetary Penalties

3.6.1 LDH may assess monetary penalties when the DBPM fails to meet Contract requirements. LDH's failure to assess monetary penalties in any instance will not waive the right of LDH to assess monetary penalties for a similar or related instance.

3.6.2 The decision to impose monetary penalties may include consideration of the following factors:

3.6.2.1 The duration of the violation;

3.6.2.2 Whether the violation (or one that is substantially similar) has previously occurred;

3.6.2.3 The severity of the violation and whether it imposes an immediate threat to the health or safety of the Medicaid enrollees; and

3.6.2.4 The "good faith" exercised by the DBPM in attempting to stay in compliance.

3.6.3 For purposes of this section, violations including individual, unrelated enrollees shall not be considered as arising out of the same action.

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

3.6.5 Table of Monetary Penalties

| Number | Requirement | Monetary penalty |
|--------|--|--|
| 1. | Failure to implement project, or any components or systems thereof on or before the operations start date. | \$50,000 for each day beyond the start day. |
| 2. | Failure to meet plan readiness goals set by LDH. | \$5,000 per occurrence. |
| 3. | Failure to accept and process enrollment files specified in the Contract. | \$5,000 per day, per occurrence. |
| 4. | Failure to meet PDP assignment requirements specified in the Contract. | \$2,500 per enrollee, per day, per occurrence. |
| 5. | Failure to provide covered benefits and services specified in the Contract. | \$25,000 per day, per occurrence. |

| Number | Requirement | Monetary penalty |
|---------------|---|--|
| 6. | Failure to acknowledge or act timely upon a request for prior authorization in accordance with the Contract. | \$10,000 per occurrence. |
| 7. | Failure to comply with enrollee notice requirements, including denials, reductions, terminations, or suspensions of services, and/or within the timeframes specified in the Contract. | \$2,500 per occurrence. |
| 8. | Failure to comply with any enrollee materials requirements specified in the Contract. | \$2,500 per occurrence. |
| 9. | Failure to update online provider directory specified in the Contract. | \$5,000 per occurrence. |
| 10. | Failure to comply with any enrollee services or provider services requirements specified in the Contract. | \$10,000 per month, for failure to meet phone line performance measures. \$5,000 per day for failure to operate phone line. \$2,500 per occurrence for every other requirement. |
| 11. | Failure to provide continuation and/or restoration of services during or pursuant to the state fair hearing and/or the DBPM's appeal process specified in the Contract. | The value of the reduced or eliminated services as determined by LDH for the timeframe specified by LDH and \$500 per day for each day the DBPM fails to provide continuation or restoration as required by LDH. |
| 12. | Failure to comply with provider network requirements specified in the Contract. | \$10,000 per occurrence. |
| 13. | Failure to comply with provider agreement and/or termination requirements specified in the Contract. | \$5,000 per occurrence. |
| 14. | Failure to comply with provider payment requirements specified in the Contract. | \$7,500 per day, per occurrence. |
| 15. | Failure to meet clinical performance measures specified in the Contract. | \$50,000 per occurrence in addition to \$10,000 for each percentage point less than the target. |
| 16. | Failure to timely submit PIPs specified in the Contract. | \$1,000 per day after due date. |

| Number | Requirement | Monetary penalty |
|--------|--|---|
| 17. | Failure to comply with encounter data requirements specified in the Contract. | \$10,000 per day for failure to submit and/or correct monthly data. \$10,000 per rejection of data due to exceeding 5% error rate. |
| 18. | Failure to comply with claims management requirements specified in the Contract. | \$2,500 per occurrence for all other requirements. |
| 19. | Failure to comply with DBPM staffing requirements specified in the Contract. | \$1,000 per day, per occurrence. |
| 20. | Failure to receive prior written LDH approval of delegation to a subcontractor. | \$25,000 per occurrence. |
| 21. | Failure to timely submit any complete and/or accurate report specified in the Contract. | \$2,500 per day after due date. |
| 22. | Failure to timely report, or provide notice for network changes specified in the Contract. | \$5,000 per occurrence. |

3.6.6 For any violation not explicitly described in the table, LDH may impose a monetary penalty of up to \$5,000 per occurrence per calendar day.

3.6.7 Payment of Penalties

3.6.7.1 Monetary penalties assessed by LDH will be collected through withholding through future PMPM payments.

3.6.7.2 Any monetary penalty assessed by LDH that cannot be collected through withholding from future PMPM payments shall be due and payable to LDH within thirty (30) calendar days after the DBPM's receipt of the notice of monetary penalties. However, in the event an appeal by the DBPM results in a decision in favor of the DBPM, any such funds withheld by LDH will be returned to the DBPM.

3.6.7.3 LDH has the right to recover any amounts overpaid as the result of deceptive practices by the DBPM and/or its contractors, and may consider trebled damages, civil penalties, and/or other remedial measures.

3.6.7.4 A monetary penalty may be applied to all known affiliates, subsidiaries and parents of the DBPM, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the DBPM is affiliated where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

3.6.8 Attorney's Fees

3.6.8.1 In the event LDH should prevail in any legal action arising out of the performance or non-performance of the Contract, the DBPM shall pay, in addition to any monetary penalties, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

PART 4: PAYMENT AND FINANCIAL PROVISIONS

4.1 General Provisions

- 4.1.1** Contractor will not be paid more than the maximum amount of the Contract. Continuation of payment is dependent upon available funding.
- 4.1.2** LDH shall make monthly capitated Per Member Per Month (PMPM) payments for each beneficiary enrolled into the DBPM. The capitation rate will be developed in accordance with federal regulations regarding actuarial soundness and will include claims for retroactive coverage. The rates will be reviewed annually, at a minimum.
- 4.1.3** The DBPM agrees to accept the monthly capitation payment as payment in full and shall not seek additional payment from an enrollee, including costs incurred during the retroactive period of eligibility.
- 4.1.4** LDH reserves the right to annually defer remittance of the PMPM payment for June until the first fiscal intermediary payment cycle in July to comply with state fiscal policies and procedures.
- 4.1.5** The DBPM will receive a monthly electronic file (ANSI ASC X12N 820 Transaction) from the Fiscal Intermediary (FI) listing all enrollees for whom the DBPM received a capitation payment and the amount received. The DBPM is responsible for reconciling this file against its internal records. It is the DBPM's responsibility to notify the FI of any discrepancies. Lack of compliance with reconciliation requirements may result in monetary penalties.

4.2 Determination of DBPM Rates

- 4.2.1** LDH will develop cost-effective and actuarially sound rates according to all applicable CMS rules and regulations. LDH will not use a competitive bidding process to develop the DBPM capitation. LDH will develop monthly capitation rates that will be offered to the DBPM on a "take it or leave it" basis.
- 4.2.2** Rates will be set using DBPM encounter data, and financial data and supplemental ad hoc data and analyses appropriate for determining actuarially sound rates. Fiscal periods of the base data will be determined based upon the data sources, rate periods and purposes for which the data is used with appropriate adjustments which include the following:
 - 4.2.2.1** Utilization trend and the expected impact of managed care on the utilization services applied to varying sources of data, including managed care savings assumptions and managed care efficiency adjustments;
 - 4.2.2.2** Unit cost trend and assumptions regarding managed care pricing and payments;
 - 4.2.2.3** Third party liability recoveries; and
 - 4.2.2.4** The expected cost of DBPM administration and overhead, including but not limited to premium taxes and the Section 1202 Health Insurer Fee.

4.2.3 LDH reserves the right to adjust the rate in the following instances:

4.2.3.1 Changes to covered services included in the monthly capitation rates;

4.2.3.2 Changes to Medicaid population groups eligible to enroll in the DBPM;

4.2.3.3 Legislative appropriations and budgetary constraints; or

4.2.3.4 Changes in federal requirements.

4.2.4 Any adjusted rate must continue to be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c), and will require an amendment to the Contract.

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

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

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

4.3 Capitation Rates and Payment

4.3.1 The monthly capitated payment shall be based on Medicaid beneficiaries eligible for DBPM participation during the month. The payment schedule is available on www.lamedicaid.com.

4.3.2 The DBPM shall make payments to its providers as stipulated in the Contract.

4.3.3 The DBPM shall not assign its right to receive payment to any other entity.

4.3.4 Payment for items or services provided under the Contract shall not be made to any entity located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

4.3.5 The DBPM shall agree to accept payments as specified in this section and have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions shall be borne by the DBPM.

4.3.6 LDH may make capitation payments on a lump sum basis when administratively necessary.

4.3.7 Withhold of Capitation Rate

4.3.7.1 A withhold of the aggregate capitation rate payment shall be applied to provide an incentive for DBPM compliance with the requirements of the Contract.

- 4.3.7.2** The withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all DBPM enrollees.
 - 4.3.7.3** If LDH has not identified any DBPM deficiencies, LDH will pay to the DBPM the withhold of the DBPM's payments withheld in the month subsequent to the withhold.
 - 4.3.7.4** If LDH has determined the DBPM is not in compliance with a requirement of the Contract in any given month, LDH may issue a written notice of non-compliance and LDH may retain the amount withheld for the month prior to LDH identifying the compliance deficiencies.
 - 4.3.7.5** Monthly retention of the withhold amount may continue for each subsequent month so long as the identified deficiencies have not been corrected. If the same or similar deficiency(s) continues beyond timeframes specified for correction as determined by LDH, LDH may permanently retain the amount withheld for the period of non-compliance consistent with the monetary penalties of the Contract. The timeframe specified in a written notice of action shall be considered the cure period and will be not less than thirty (30) calendar days unless the deficiency reasonably requires resolution in a shorter period after which amounts retained may be permanently withheld.
 - 4.3.7.6** Amounts withheld for failure to achieve established performance measurement goals as defined in the Contract will be permanently retained.
 - 4.3.7.7** No interest shall be due to the DBPM on any sums withheld or retained under this Section.
 - 4.3.7.8** The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under the Contract.
- 4.3.8** The Contractor and LDH agree that LDH may elect to deduct any assessed fees from payments due or owing to the DBPM or direct the DBPM to make payment directly to LDH for any and all assessed fees. The choice is solely and strictly LDH's.
- 4.3.9** The DBPM shall be responsible for payment of all premium taxes paid through the capitation payments by LDH to the Louisiana Department of Insurance according to the schedule established by LDH.
- 4.3.10** Rate Adjustments
- 4.3.10.1** LDH reserves the right to adjust the PMPM rates:
 - 4.3.10.1.1** If the rate floor is removed;
 - 4.3.10.1.2** If a result of federal or state budget reductions or increases;
 - 4.3.10.1.3** If due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated in the monthly capitation rates; or

4.3.10.1.4 In order to comply with federal requirements.

4.3.10.2 Any adjusted rates must continue to be actuarially sound as determined by LDH's actuarial contractor and will require an amendment to the Contract that is mutually agreed upon by both parties. Any alteration, variation, modification, or waiver of provisions of the Contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of LDH and the Director of the Office of State Procurement, Division of Administration.

4.4 Payment Adjustments

4.4.1 In the event that an erroneous payment is made to the DBPM, LDH shall reconcile the error by adjusting the DBPM's future monthly capitation payment.

4.4.2 Retrospective adjustments to prior payments may occur when it is determined that an enrollee's aid category was changed. Payment adjustments may only be made when identified within twelve (12) months from the date of the enrollee's aid category change for all services delivered within the twelve (12) month period. If the enrollee switched from a DBPM eligible aid category to a DBPM excluded aid category, previous capitation payments will be recouped from the DBPM.

4.4.3 The DBPM shall refund payments received from LDH for a deceased enrollee effective the month of service after the month of death. LDH will recoup the payment as specified in the Systems Companion Guide, which can be found in the Procurement Library.

4.4.4 The entire monthly capitation payment shall be paid during the month of birth and month of death. Payments shall not be pro-rated to adjust for partial month eligibility as this has been factored into the actuarial rate setting.

4.4.5 The monthly capitation rates shall be in effect during the period identified in the Contract. Rates may be adjusted during the Contract Term and are subject to CMS review and approval.

4.4.6 The DBPM and LDH both agree that adjustments to the monthly capitation rate(s) required pursuant to this Section shall occur only by written amendment to the Contract. Should either the DBPM or LDH refuse to accept the revised monthly capitation rate, the provisions of this Contract for Contract termination and turnover shall apply.

4.5 Medical Loss Ratio

4.5.1 In accordance with the DBPM Financial Reporting Guide published by LDH, which can be found in the Procurement Library, the DBPM shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year.

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

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

4.5.4 Neither the minimum MLR standard eighty-five percent (85%) nor the refund applicable to the aggregate MLR shall apply to distinct MLRs reported.

4.6 Return of Funds

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

4.6.2 The DBPM shall reimburse all payments as a result of any federal disallowances or sanctions imposed on LDH as a result of the DBPM's failure to abide by the terms of the Contract. The DBPM shall be subject to any additional conditions or restrictions placed on LDH by the United States Department of Health and Human Services (HHS) as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.

PART 5: TURNOVER REQUIREMENTS

5.1 Turnover Requirements

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

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

5.1.2.1 Comply with all terms and conditions stipulated in the Contract, including continuation of covered dental benefits and services under the Contract, until the termination effective date;

5.1.2.2 Promptly supply all information necessary for the payment of any outstanding claims; and

5.1.2.3 Comply with direction provided by LDH to assist in the orderly transition of equipment, services, software, leases, etc. to LDH or a third party designated by LDH.

5.1.3 Effect of Termination on DBPM's HIPAA Privacy Requirements

5.1.3.1 Upon termination of the Contract for any reason, the DBPM shall return or destroy all Protected Health Information received from LDH, or created or received by the DBPM on behalf of LDH, as directed by LDH. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of the DBPM. The DBPM shall not retain any copies of the Protected Health Information.

5.1.3.2 In the event that the DBPM determines that returning or destroying the Protected Health Information is not feasible, the DBPM shall provide to LDH notification of the conditions that make return or destruction not feasible. Upon a mutual determination that return or destruction of Protected Health Information is not feasible, the DBPM shall extend the protections of the Contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as the DBPM maintains such Protected Health Information.

5.2 Turnover Plan

5.2.1 In the event of written notification of termination of the Contract by either party, the DBPM shall submit a Turnover Plan within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the DBPM and LDH. The Plan shall address the turnover of records and information maintained by the DBPM relative to covered dental benefits and services provided to Medicaid enrollees for the timeframe specified by LDH. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by LDH.

5.2.2 If the Contract is not terminated by written notification as provided above, the DBPM shall provide a Turnover Plan six (6) months prior to the end of the Contract Term, including any extensions to such period. The Plan shall address the possible turnover of the records and information maintained to either LDH or a third party designated by LDH. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by LDH.

5.2.3 As part of the Turnover Plan, the DBPM must provide LDH with copies of all relevant enrollee and covered dental benefits and services data, documentation, or other pertinent information necessary, as determined by LDH, for LDH or a subsequent DBPM to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan will describe the DBPM's approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in the media and format specified by LDH and according to the schedule approved by LDH.

5.3 Transfer of Data

5.3.1 The DBPM shall transfer all data regarding the provision of enrollee covered dental benefits and services to LDH or a third party, at the sole discretion of LDH and as directed by LDH. All transferred data must be compliant with HIPAA.

5.3.2 All relevant data must be received and verified by LDH or the subsequent DBPM. If LDH determines that not all of the data regarding the provision of covered dental benefits and services to enrollees was transferred to LDH or the subsequent DBPM, as required, or the data is not HIPAA compliant, LDH reserves the right to hire an independent contractor to assist LDH in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the DBPM.

5.4 Post-Turnover Services

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

5.4.2 If the DBPM does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for LDH or the subsequent DBPM to assume the operational activities successfully, the DBPM agrees to reimburse LDH for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.

5.4.3 The DBPM also must pay any and all additional costs incurred by LDH that are the result of the DBPM's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

PART 6: TERMS AND CONDITIONS

6.1 Amendments

The Contract may be amended at LDH's sole discretion at any time; provided, however, that any revised rates shall be certified as actuarially sound. No modification or change of any provision of the Contract shall be made or construed to have been made unless such modification is mutually agreed to in writing by the Contractor and LDH, and incorporated as a written amendment to the Contract. Any amendment to the Contract shall require approval by LDH and the Division of Administration, Office of State Procurement and may require approval of CMS prior to the amendment's implementation. Unless indicated otherwise by LDH, the Contractor shall implement all provisions of the amendment no later than sixty (60) calendar days from the date the Contractor receives the executed amendment.

LDH reserves the right to provide written clarification for non-material changes of Contract requirements whenever deemed necessary, at any point in the Contract Term, to ensure the smooth operations of the Medicaid dental benefit program. Such clarifications shall be implemented by the DBPM and shall not require an amendment to the Contract.

6.2 Assignment

The Contractor shall assign any interest in the Contract by assignment, transfer, or novation, without prior written consent of LDH. This provision shall not be construed to prohibit the Contractor from assigning to a bank, trust company, or other financial institution any money due or to become due from approved Contracts without such prior written consent. Notice of any such assignment or transfer shall be furnished promptly to LDH.

Any assignment, pledge, joint venture, hypothecation of right or responsibility to any person, firm or corporation should be as explained and detailed in the proposal or otherwise approved of by LDH.

6.3 Audit Requirements

6.3.1 The DBPM shall ensure that their systems facilitate the auditing of individual claims. Adequate audit trails shall be provided throughout the systems. LDH may require the Contractor and/or subcontractors, if performing a key internal control, to submit to financial and performance audits from outside companies to ensure both the financial viability of the program and the operational viability, including the policies and procedures placed into operation.

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

6.3.3 State Audits

6.3.3.1 The DBPM shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid contract exists in whatever format requested. The DBPM shall provide information necessary to assist the state auditor in processing or utilizing the files.

6.3.3.2 If the auditor's findings point to discrepancies or errors, the DBPM shall provide a

written corrective action plan to LDH within ten (10) business days of receipt of the audit report that includes a date certain by which the errors will be corrected when requested by LDH.

6.3.4 Louisiana Legislative Auditor Authority

6.3.4.1 The parties agree and acknowledge that the Louisiana Legislative Auditor (“LLA”) has the authority pursuant to La. R.S. 24:513 to conduct oversight and audit of the Louisiana Department of Health, including the DBPM.

6.3.5 Independent Audits of Systems

6.3.5.1 The DBPM shall submit an independent SOC 2 Type II system audit, or an alternative SOC audit version if deemed necessary or appropriate by LDH or LLA, on a calendar year basis. The audit should review system security, system availability, system confidentiality and processing integrity for the Louisiana Medicaid line of business. The audit period shall be twelve (12) consecutive months, aligning with the DBPM’s fiscal year, with no breaks between subsequent audit periods.

6.3.5.2 The DBPM shall supply LDH with an exact copy of the SOC 2 Type II independent audit no later than six (6) months after the close of the DBPM’s fiscal year.

6.3.5.3 The DBPM shall deliver to LDH a corrective action plan to address deficiencies identified during the audit within thirty (30) business days of the DBPM’s receipt of the final audit report.

6.3.5.4 These audit requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the Contractor. The cost of the audit shall be borne by the DBPM or subcontractor.

6.3.6 Audit Coordination and Claims Reviews

6.3.6.1 The DBPM shall coordinate audits with LDH or its designee and respond within thirty (30) calendar days of a request by LDH regarding the DBPM’s review of a specific provider and/or claim(s), and the issue reviewed.

6.3.6.2 In the event LDH or its designee identifies an overpayment, the DBPM shall have ten (10) business days from the date of notification of overpayment to indicate whether the claims were corrected or adjusted prior to the date of the notification from LDH or designee. The DBPM shall not correct the claims upon notification by LDH or designee, unless directed to do so by LDH.

6.3.6.3 LDH reserves the right to review any claim paid by the DBPM or designee. The DBPM has the right to collect or recoup any overpayments identified by the DBPM from providers of service in accordance with existing laws or regulations. If an overpayment is identified by the State or its designee and the provider fails to remit payment to the State, LDH may require the DBPM to collect and remit the overpayment to LDH. The DBPM shall refund the overpayment to LDH within thirty (30) calendar days. Failure by the DBPM to collect from the provider does not relieve the DBPM from remitting

the identified overpayment to LDH.

6.4 Civil Rights Compliance

The Contractor agrees to comply with the requirements of the following as applicable: Title VI of the Civil Rights Act of 1964 and Title VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972, federal Executive Order 11246 as amended, the Rehabilitation Act of 1973, as amended, the Vietnam Era Veteran's Readjustment Assistance Act of 1974, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, the Fair Housing Act of 1968 as amended, and the Americans with Disabilities Act of 1990.

The Contractor agrees not to discriminate in its employment practices, and will render services under the Contract without regard to race, color, religion, sex, gender, sexual orientation, national origin, veteran status, political affiliation, disability, age, or any other non-merit factor in any matter relating to employment. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of the Contract.

6.5 Claims or Controversies

Any claim or controversy arising out of the Contract shall be resolved by the provisions of Louisiana Revised Statutes 39:1672.2-1672.4.

6.6 Code of Ethics

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

6.7 Compliance with State and Federal Laws and Regulations

6.7.1 The DBPM shall comply with all current state and federal statutes, regulations, and administrative procedures that are in effect or become effective during the term of the Contract. Federal regulations governing contracts with PAHPs are specified in 42 CFR Part 438 and will govern the Contract.

6.7.2 It is the responsibility of the Contractor to stay abreast of applicable federal and state laws which may impact requirements under the Contract.

6.7.3 Debarment/Suspension/Exclusion

6.7.3.1 The DBPM and its subcontractors shall comply with all applicable provisions of 42 CFR §438.608 and §438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. The DBPM and its subcontractors shall screen all employees, contractors, and network providers, at hire or at time of contracting, to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, or any other federal health care programs. To help make this determination, the DBPM shall conduct

screenings to comply with the requirements set forth at 42 CFR §455.436.

6.7.3.2 The DBPM shall search the following websites:

6.7.3.2.1 [Office of Inspector General \(OIG\) List of Excluded Individuals/Entities \(LEIE\)](#);

6.7.3.2.2 [Louisiana Adverse Actions List Search](#);

6.7.3.2.3 [The System of Award Management \(SAM\)](#); and

6.7.3.2.4 Other applicable sites as may be determined by LDH.

6.7.3.3 The DBPM shall conduct a search of the websites monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered must be immediately reported to LDH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim payment from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim payment from Medicaid for that prescription. Civil penalties may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A(a)(6) of the Social Security Act and 42 CFR §1003.102(a)(2).

6.7.3.4 The DBPM shall provide documentation to LDH upon request to support that the initial and ongoing screenings were conducted as required.

6.8 Confidential Information, Trade Secrets, and Proprietary Information

All financial, statistical, personal, technical and other data and information relating to the State's operation which are designated confidential by the State and made available to the Contractor in order to carry out the Contract, or which become available to the Contractor in carrying out the Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. The identification of all such confidential data and information as well as the State's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by the State in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor's data and information are deemed by the State to be adequate for the protection of the State's confidential information, such methods and procedures may be used, with the written consent of the State, to carry out the intent of this paragraph. The Contractor shall not be required under the provisions of the paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Contractor's possession, is independently developed by the Contractor outside the scope of the Contract, or is rightfully obtained from third parties.

Under no circumstance shall the Contractor discuss and/or release information to the media concerning this project without prior express written approval of the Louisiana Department of Health.

6.9 Contract Language Interpretation

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

6.10 Cooperation with Other Entities and Programs

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

6.10.2 The DBPM's failure to cooperate and comply with this provision shall be sufficient grounds for LDH to halt all payments to the DBPM until it becomes compliant with this or any other Contract provision. LDH's determination on the matter shall be conclusive and not subject to Appeal.

6.11 Copyrights

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

6.12 Corporation Requirements

6.12.1 If the DBPM is a corporation, the following requirement must be met prior to execution of the Contract:

6.12.1.1 If a for-profit corporation whose stock is not publicly traded, the DBPM must file a Disclosure of Ownership form with the Louisiana Secretary of State.

6.12.1.2 If the DBPM is a corporation not incorporated under the laws of the State of Louisiana, the DBPM must obtain a Certificate of Authority pursuant to La. R.S. 12:301-302 from the Louisiana Secretary of State.

6.12.1.3 The DBPM must provide written assurance to LDH from the DBPM's legal counsel that the DBPM is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the Contract.

6.13 Entire Contract

6.13.1 The Contract, the RFP and addenda issued thereto by LDH, and the proposal submitted by the Contractor in response to LDH's RFP shall constitute the entire agreement between the parties with respect to the subject matter.

6.13.2 The DBPM shall comply with all provisions of the Contract and shall act in good faith in the performance of the provisions of said Contract. The DBPM agrees that failure to comply with the

provisions of the Contract may result in the assessment of monetary penalties, intermediate sanctions and/or termination of the Contract in whole or in part, as set forth in the Contract.

6.13.3 The DBPM shall comply with all applicable LDH policies and procedures in effect throughout the duration of the Contract Term.

6.13.4 The DBPM shall comply with all applicable LDH provider manuals, rules, regulations, and guides.

6.13.5 LDH, at its discretion, will issue correspondence to inform the DBPM of changes in Medicaid policies and procedures which may affect the Contract. The DBPM will be given sixty (60) calendar days to implement such changes unless otherwise directed by LDH.

6.14 Force Majeure

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

6.15 Governing Law

The Contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana. Venue of any action brought with regard to the Contract shall be in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana.

6.16 Hold Harmless

6.16.1 The DBPM shall indemnify, defend, protect, and hold harmless LDH and any of its officers, agents, and employees from:

6.16.1.1 Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the DBPM in connection with the performance of the Contract;

6.16.1.2 Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by DBPM, its agents, officers, employees, or subcontractors in the performance of the Contract;

6.16.1.3 Any claims for damages or losses resulting to any person or firm injured or damaged by the DBPM, its agents, officers, employees, or subcontractors by DBPM's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;

6.16.1.4 Any failure of the DBPM, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

6.16.1.5 Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

6.16.1.6 Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against LDH or their agents, officers or employees, through the intentional conduct, negligence or omission of the DBPM, its agents, officers, employees or subcontractors.

6.16.2 In the event of circumstances not reasonably within the control of the DBPM or LDH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the DBPM, LDH, or any subcontractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services. Notwithstanding, as long as the Contract remains in full force and effect, the DBPM shall be liable for the covered dental benefits and services required to be provided or arranged for in accordance with the Contract.

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

6.17 Hold Harmless as to the DBPM Enrollees

6.17.1 The DBPM hereby agrees not to bill, charge, collect a deposit from, or seek other forms of compensation, remuneration or payment from, or have recourse against, DBPM enrollees, or persons acting on their behalf, for healthcare services which are rendered to such enrollees by the DBPM and its subcontractors, and which are covered dental benefits and services. This excludes any cost sharing requirements that may be allowed by the Louisiana Medicaid State Plan.

6.17.2 The DBPM further agrees that the Dental Benefit Program enrollee shall not be held liable for payment for covered dental benefits and services furnished under a provider contract, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the enrollee would owe if the DBPM provided the service directly. The DBPM agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by DBPM and insolvency of the DBPM.

6.17.3 The DBPM further agrees that this provision shall be construed to be for the benefit of DBPM enrollees, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the DBPM and such enrollees, or persons acting on their behalf.

6.18 Homeland Security Considerations

6.18.1 The DBPM shall perform the services to be provided under the Contract entirely within the boundaries of the United States. In addition, the DBPM will not hire any individual to perform any services under the Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

6.18.2 If the DBPM performs services, or uses services, in violation of the foregoing paragraph, the DBPM shall be in material breach of the Contract and shall be liable to LDH for any costs, fees, damages, claims, or expenses it may incur. Additionally, the DBPM shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of the Contract.

6.18.3 The prohibitions in this Section shall also apply to any and all agents and subcontractors used by the DBPM to perform any services under the Contract.

6.19 Incorporation of Schedules/Appendices

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

6.20 Indemnification and Limitation of Liability

Neither party shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. The parties shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under Contract.

Contractor shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and hold harmless the state and its Authorized Users from suits, actions, damages and costs of every name and description relating to personal injury and damage to real or personal tangible property caused by Contractor, its agents, employees, partners or subcontractors, without limitation; provided, however, that the Contractor shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the state. If applicable, Contractor will indemnify, defend and hold the state and its Authorized Users harmless, without limitation, from and against any and all damages, expenses (including reasonable attorneys' fees), claims, judgments, liabilities and costs which may be finally assessed against the State in any action for infringement of a United States Letter Patent with respect to the Products furnished, or of any copyright, trademark, trade secret or intellectual property right, provided that the State shall give the Contractor: (i) prompt written notice of any action, claim or threat of infringement suit, or other suit, (ii) the opportunity to take over, settle or defend such action, claim or suit at Contractor's sole expense, and (iii) assistance in the defense of any such action at the expense of Contractor. Where a dispute or claim arises relative to a real or anticipated infringement, the State or its Authorized Users may require Contractor, at its sole expense, to submit such information and documentation, including formal patent attorney opinions, as the Commissioner of Administration shall require.

The Contractor shall not be obligated to indemnify that portion of a claim or dispute based upon: i) Authorized User's unauthorized modification or alteration of a Product, Material or Service; ii) Authorized User's use of the Product in combination with other products not furnished by Contractor; iii) Authorized User's use in other than the specified operating conditions and environment.

In addition to the foregoing, if the use of any item(s) or part(s) thereof shall be enjoined for any reason or if Contractor believes that it may be enjoined, Contractor shall have the right, at its own expense and sole discretion as the Authorized User's exclusive remedy to take action in the following order of precedence: (i) to procure for the State the right to continue using such item(s) or part (s) thereof, as applicable; (ii) to modify the component so that it becomes non-infringing equipment of at least equal

quality and performance; or (iii) to replace said item(s) or part(s) thereof, as applicable, with non-infringing components of at least equal quality and performance, or (iv) if none of the foregoing is commercially reasonable, then provide monetary compensation to the State up to the dollar amount of the Contract.

For all other claims against the Contractor where liability is not otherwise set forth in the Contract as being "without limitation", and regardless of the basis on which the claim is made, Contractor's liability for direct damages, shall be the greater of one hundred thousand dollars (\$100,000), the dollar amount of the Contract, or two (2) times the charges rendered by the Contractor under the Contract. Unless otherwise specifically enumerated herein or in the work order mutually agreed between the parties, neither party shall be liable to the other for special, indirect or consequential damages, including lost data or records (unless the Contractor is required to back-up the data or records as part of the work plan), even if the party has been advised of the possibility of such damages. Neither party shall be liable for lost profits, lost revenue or lost institutional operating savings.

The State and Authorized User may, in addition to other remedies available to them at law or equity and upon notice to the Contractor, retain such monies from amounts due Contractor, or may proceed against the performance and payment bond, if any, as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against them.

6.21 Independent Provider

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

6.22 Insurance Requirements for Contractors

The Contractor shall not commence work under the Contract until it has obtained all insurance required herein, including but not limited to Automobile Liability Insurance, Workers' Compensation Insurance and General Liability Insurance. Certificates of Insurance, fully executed by officers of the Insurance Company shall be filed with LDH for approval. The Contractor shall not allow any subcontractor to commence work on subcontract until all similar insurance required for the subcontractor has been obtained and approved. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of LDH before work is commenced. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) calendar days' written notice in advance to LDH and consented to by LDH in writing and the policies shall so provide.

The Contractor shall obtain and maintain insurance for the life of the Contract.

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.

6.22.1 Minimum Scope and Limits of Insurance

- 6.22.1.1** Workers Compensation insurance shall comply with the Workers Compensation law of the state of the Contractor's headquarters. Employers Liability is included with a minimum limit of one million dollars (\$1,000,000) per accident/per disease/per employee.
- 6.22.1.2** Commercial General Liability insurance, including Personal and Advertising Injury Liability and Products and Completed Operations, shall have a minimum limit per occurrence of one million dollars (\$1,000,000) and a minimum general annual aggregate of two million dollars (\$2,000,000). The Insurance Services Office (ISO) Commercial General Liability occurrence coverage form CG 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy. Claims-made form is unacceptable.
- 6.22.1.3** Professional Liability (Error and Omissions) insurance, which covers the professional errors, acts, or omissions of the Contractor, shall have a minimum limit of five million dollars (\$5,000,000). Claims-made coverage is acceptable. The date of the inception of the policy must be no later than the first date of the anticipated work under the Contract. It shall provide coverage for the duration of the Contract and shall have an expiration date no earlier than thirty (30) calendar days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy, if the policy is not renewed.
- 6.22.1.4** Automobile Liability Insurance shall have a minimum combined single limit per accident of one million dollars (\$1,000,000). ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.
- 6.22.1.5** Cyber Liability insurance, including first-party costs, due to an electronic breach that compromises LDH's confidential data shall have a minimum limit per occurrence of five million dollars (\$5,000,000). Claims-made coverage is acceptable. The date of the inception of the policy must be no later than the first date of the anticipated work under the Contract. It shall provide coverage for the duration of the Contract and shall have an expiration date no earlier than thirty (30) calendar days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy, if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premium.

6.22.2 Deductibles and Self-Insured Retentions

Any deductibles or self-insured retentions must be declared to and accepted by the Agency. The Contractor shall be responsible for all deductibles and self-insured retentions.

6.22.3 Other Insurance Provisions

The policies are to contain, or be endorsed to contain, the following provisions:

6.22.3.1 Commercial General Liability, Automobile Liability, and Cyber Liability Coverages

The Agency, its officers, agents, employees and volunteers shall be named as an additional insured as regards negligence by the Contractor. ISO Forms CG 20 10 (for ongoing work) AND CG 20 37 (for completed work) (current forms approved for use in Louisiana), or equivalents, are to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to LDH.

The Contractor's insurance shall be primary as respects the Agency, its officers, agents, employees and volunteers for any and all losses that occur under the Contract. Any insurance or self-insurance maintained by the Agency shall be excess and non-contributory of the Contractor's insurance.

The Contractor's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the policy limits.

6.22.3.2 Workers' Compensation and Employers Liability Coverage

To the fullest extent allowed by law, the insurer shall agree to waive all rights of subrogation against the Agency, its officers, agents, employees and volunteers for losses arising from work performed by the Contractor for LDH.

6.22.3.3 All Coverages

All policies must be endorsed to require thirty (30) calendar days written notice of cancellation to LDH. Ten (10) calendar day written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in the Contractor's policy. In addition, Contractor is required to notify Agency of policy cancellations or reductions in limits.

Neither the acceptance of the completed work, payment, failure of the Agency to require proof of compliance, nor Agency's acceptance of a non-compliant certificate of insurance shall release the Contractor from the obligations of the insurance requirements or indemnification agreement.

The insurance companies issuing the policies shall have no recourse against the Agency for payment of premiums or for assessments under any form of the policies.

Any failure of the Contractor to comply with reporting provisions of the policy shall not affect coverage provided to the Agency, its officers, agents, employees and volunteers.

6.22.4 Acceptability of Insurers

All required insurance shall be provided by a company or companies lawfully authorized to do business in the jurisdiction in which the Project is located. Insurance shall be placed with insurers

with an A.M. Best's rating of A-:VI or higher. This rating requirement may be waived for workers' compensation coverage only.

If at any time an insurer issuing any such policy does not meet the minimum A.M. Best rating, the Contractor shall obtain a policy with an insurer that meets the A.M. Best rating and shall submit another Certificate of Insurance within thirty (30) calendar days.

6.22.5 Verification of Coverage

The Contractor shall furnish the Agency with Certificates of Insurance reflecting proof of required coverage. The Certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf. The Certificates are to be received and approved by the Agency before work commences and upon any Contract renewal or insurance policy renewal thereafter.

The Certificate Holder shall be listed as follows:

State of Louisiana
Louisiana Department of Health, Bureau of Health Services Financing, Its Officers,
Agents, Employees and Volunteers
628 N. 4th Street, Baton Rouge, Louisiana 70802
Contract number, to be determined

In addition to the Certificates, the Contractor shall submit the declarations page and the cancellation provision for each insurance policy. The Agency reserves the right to request complete certified copies of all required insurance policies at any time.

Upon failure of the Contractor to furnish, deliver and maintain required insurance, the Contract, at the election of the Agency, may be suspended, discontinued or terminated. Failure of the Contractor to purchase and/or maintain any required insurance shall not relieve the Contractor from any liability or indemnification under the Contract.

6.22.6 Subcontractors

Contractor shall include all subcontractors as insureds under its policies OR shall be responsible for verifying and maintaining the Certificates provided by each subcontractor. Subcontractors shall be subject to all of the requirements stated herein. The Agency reserves the right to request copies of subcontractor's certificates at any time.

6.22.7 Workers' Compensation Indemnity

In the event Contractor is not required to provide or elects not to provide workers' compensation coverage, the parties hereby agree that Contractor, its owners, agents and employees will have no cause of action against, and will not assert a claim against, the State of Louisiana, its departments, agencies, agents and employees as an employer, whether pursuant to the Louisiana Workers' Compensation Act or otherwise, under any circumstance. The parties also hereby agree that the State of Louisiana, its departments, agencies, agents and employees

shall in no circumstance be, or considered as, the employer or statutory employer of Contractor, its owners, agents and employees. The parties further agree that Contractor is a wholly independent contractor and is exclusively responsible for its employees, owners, and agents. The Contractor hereby agrees to protect, defend, indemnify and hold the State of Louisiana, its departments, agencies, agents and employees harmless from any such assertion or claim that may arise from the performance of the Contract.

6.23 Integration

6.23.1 The Contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The DBPM also agrees to be bound by the Contract and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties and approved by the Office of State Procurement.

6.24 Interpretation Dispute Resolution Procedure

6.24.1 The DBPM may request in writing an interpretation of the issues relating to the Contract from the Medicaid Director or designee. In the event the DBPM disputes the interpretation by the Medicaid Director's designee, the DBPM shall submit a written reconsideration request to the Medicaid Director.

6.24.2 The DBPM shall submit, within twenty-one (21) calendar days of said interpretation, a written request disputing the interpretation directly to the Medicaid Director. The ability to dispute an interpretation does not apply to language in the Contract that is based on federal or state statute, regulation or case law.

6.24.3 The Medicaid Director shall reduce the decision to writing and provide a copy to the DBPM. The written decision of the Medicaid Director shall be the final decision of LDH.

6.24.4 Pending final determination of any dispute over a LDH decision, the DBPM shall proceed diligently with the performance of the Contract and in accordance with the direction of LDH.

6.25 Misuse of Symbols, Emblems, or Names in Reference to Medicaid

6.25.1 No person or DBPM may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Louisiana Medicaid," or "Louisiana Department of Health" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint, or distribute any LDH form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or LDH terms does not provide a defense. Each piece of mail or information constitutes a violation.

6.26 Non-Discrimination

6.26.1 The DBPM shall not discriminate in the enrollment of Medicaid individuals into the DBPM. The DBPM agrees that no person, on the grounds of handicap, age, race, color, religion, sex, gender, sexual orientation, gender identity, national origin, or basis of health status or need for healthcare services shall be excluded from participation in, or be denied benefits of the DBPM's program or be otherwise subjected to discrimination in the performance of the Contract.

6.27 Non-Waiver of Breach

6.27.1 The failure of LDH at any time to require performance by the DBPM of any provision of the Contract, or the continued payment of the DBPM by LDH, shall in no way affect the right of LDH to enforce any provision of the Contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of the Contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable.

6.27.2 Waiver of any breach of any term or condition in the Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of the Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

6.28 Notices

6.28.1 Any notice given to a party under the Contract is deemed effective, if addressed to the party as addressed below, upon: (i) delivery, if hand delivered; (ii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iii) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

Medicaid Director or his/her designee
Louisiana Department of Health
Bureau of Health Services Financing
628 N 4th Street, 6th Floor
Baton Rouge, LA 70802

Or

Medicaid Director or his/her designee
Louisiana Department of Health
Bureau of Health Services Financing
P.O. Box 91283
Bin 32
Baton Rouge, LA 70821-9283

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

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

6.29 Offer of Gratuities

6.29.1 By signing the Contract, the DBPM signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the State of Louisiana, the Government Accountability Office, DHHS, CMS, or any other federal agency has or shall benefit financially or materially from the Contract. The Contract may be terminated by LDH if it is determined that gratuities of any kind were offered to, or received by, any officials or employees from the state, its agents, or employees.

6.30 Order of Precedence

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

6.30.1.1 The body of the Contract with exhibits and attachments, excluding the RFP and the Contractor's proposal;

6.30.1.2 The RFP and any addenda and appendices;

6.30.1.3 All applicable LDH companion guides;

6.30.1.4 The LDH CF-1; and

6.30.1.5 The Contractor's Proposal submitted in response to the RFP.

6.31 Performance Bond

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

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

6.31.3 The bond amount shall be equal to one hundred percent (100%) of the total capitation payment paid to the Contractor in the first (1st) month of the Contract. The bond amount shall be reevaluated and adjusted annually. The bond must be submitted to LDH by the end of the second (2nd) month of each Contract year.

6.31.4 The original performance bond must be submitted to LDH and have the raised engraved seal on the bond and on the Power of Attorney page. The DBPM must retain a photocopy of the bond.

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

6.32 Political Activity

6.32.1 None of the funds, materials, property, or services provided directly or indirectly under the Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

6.33 Public Records Request

6.33.1 The Contractor shall provide LDH with the name of the individual who will serve as the Contractor's point of contact for handling public records' requests. If this point of contact changes at any time during the Contract Term, the Contractor shall provide LDH with the updated point of contact within one (1) business day.

6.33.2 If LDH receives a request pursuant to the Louisiana Public Records Act for records that are in the custody of the Contractor, the Contractor shall provide all records to LDH that the Department, in its sole discretion, determines are related to the services performed by the Contractor under this Contract that are responsive to the request, pursuant to the timeline and in the requested format established by LDH.

6.33.3 If the Contractor receives the public records' request directly, the Contractor shall forward the request via email to the LDH BHSF Public Records Request Coordinator and Section Chief of Program Operations and Compliance within one (1) business day of receipt. Thereafter, the Contractor shall provide all records to LDH that the Department determines, in its sole discretion, are related to the services performed by the Contractor under this Contract that are responsive to the request, pursuant to the timeline and in the requested format established by LDH.

6.34 Record Ownership

All records, reports, documents, or other material related to this Contract and/or obtained or prepared by the Contractor in connection with the performance of the services contracted for herein shall become the property of LDH and shall, upon request by the State, be returned by the Contractor to LDH, at the Contractor's expense.

6.35 Record Retention

6.35.1 Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of ten (10) years from the date of submission of the final expenditure report, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

6.35.1.1 If any litigation, claim, financial management review, or audit is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken;

6.35.1.2 Records for real property and equipment acquired with federal funds shall be retained for ten (10) years after final disposition;

6.35.1.3 When records are transferred to or maintained by LDH, the ten (10) year retention requirement is not applicable to the recipient; and

6.35.1.4 Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR §75.361(f).

6.36 Reporting Changes

6.36.1 The DBPM shall immediately notify LDH in writing of any of the following:

6.36.1.1 Change in business address, telephone number, facsimile number, and email address;

6.36.1.2 Change in corporate status or nature;

6.36.1.3 Change in business location;

6.36.1.4 Change in solvency that prevents the ability to perform the requirements of the Contract;

6.36.1.5 Change in corporate officers, executive employees, or corporate structure;

6.36.1.6 Change in ownership, including but not limited to the new owner's legal name, business address, telephone number, facsimile number, and email address;

6.36.1.7 Change in incorporation status;

6.36.1.8 Change in federal employee identification number or federal tax identification number; or

6.36.1.9 Change in DBPM litigation history, current litigation, audits and other government

investigations both in Louisiana and in other states.

6.37 Safety Precautions

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

6.38 Taxes

The Contractor shall be responsible for payment of all applicable taxes from the funds to be received under the Contract.

In accordance with La. R.S. 39:1624(A)(10), the Louisiana Department of Revenue (LDR) must determine that the Contractor is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the state and collected by the Department of Revenue prior to the approval of the Contract by the Office of State Procurement. The Contractor shall attest to its current and/or prospective compliance by signing the Certification Statement, and also agrees to provide its seven-digit LDR Account Number to the contracting agency so that the contractor's tax payment compliance status may be verified. Issuance of a tax clearance certificate by the Louisiana Department of Revenue is a necessary precondition to the approval and effectiveness of the Contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to the Contract without penalty and proceed with alternate arrangements should the vendor fail to resolve any identified apparent outstanding tax compliance discrepancies with the Louisiana Department of Revenue within seven (7) calendar days of such notification.

6.39 Termination

6.39.1 Termination of the Contract for Cause

LDH may terminate the Contract for cause based upon the failure of the Contractor to comply with the terms and/or conditions of the Contract, provided LDH shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) calendar days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) calendar days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then LDH may, at its option, place the Contractor in default and the Contract shall terminate on the date specified in such notice. Failure to perform within the time agreed upon in the Contract may constitute default and may cause cancellation of the Contract.

The Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of LDH to comply with the terms and conditions of the Contract provided that the Contractor shall give LDH written notice specifying the state agency's failure and a reasonable opportunity for LDH to cure the defect.

6.39.2 Termination of the Contract for Convenience

LDH may terminate the Contract at any time without penalty by giving thirty (30) calendar days' written notice to the Contractor of such termination or negotiating with the Contractor an effective date. The Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

6.39.3 Termination for Non-Appropriation of Funds

The continuation of the Contract shall be contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the Contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act of Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the Contract, the Contract shall terminate on the date of the beginning of the first fiscal year for which funds have not been appropriated.

6.40 Time is of the Essence

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

6.41 Titles

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

6.42 Use of Data

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

6.43 Warranty of Removal of Conflict of Interest

6.43.1 The DBPM shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The DBPM shall periodically inquire of its officers and employees concerning such conflicts, and shall inform LDH promptly of any potential conflict. The DBPM shall warrant that it shall remove any conflict of interest prior to signing the Contract.

PART 7: GLOSSARY AND ACRONYMS

7.1 Glossary

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| Abuse | Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in payment for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes enrollee practices that result in unnecessary cost to the Medicaid program. |
| Adjudicate | To deny or pay a clean claim. |
| Advance Directive | A written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of healthcare when the individual is incapacitated. |
| Adverse Benefit Determination | The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by LDH), and the failure of the DBPM to act within the timeframes for the resolution of grievances and appeals; and in a rural area with only one DBPM, the denial of a enrollee's right to obtain services outside the provider network. |
| Affiliate | Any individual or entity that meets any of the following criteria: <ul style="list-style-type: none"> • in which the DBPM owns or holds more than a five percent (5%) interest (either directly, or through one (1) or more intermediaries); • any parent entity or subsidiary entity of the DBPM regardless of the organizational structure of the entity; • any entity that has a common parent with the DBPM (either directly, or through one (1) or more intermediaries); • any entity that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the DBPM; or • any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body. |
| Agent | An entity that contracts with LDH to perform administrative functions, including but not limited to fiscal intermediary activities, outreach, eligibility, and enrollment activities, systems and technical support, etc. |
| Appeal | A request for a review of an action. |
| Appeal Procedure | A formal process whereby an enrollee has the right to contest an adverse benefit determination by the DBPM. |
| Beneficiary | An individual who is eligible for Louisiana Medicaid. |
| Bureau of Health Services Financing (BHSF) | The agency within the Louisiana Department of Health, Office of Management and Finance that has been designated as Louisiana's single state Medicaid agency to administer the Medicaid and CHIP programs. |

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| Business Continuity Plan (BCP) | A plan that provides for a quick and smooth restoration of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan. |
| Business Day | Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m., unless the context clearly indicates otherwise. |
| Calendar Day | All seven (7) days of the week. Unless otherwise specified, the term “days” in the Contract refers to calendar days. |
| Can | Denotes a preference but not a mandatory requirement. |
| Capitation Payment | A monthly payment, fixed in advance, that LDH makes to the DBPM for each enrollee covered under the Contract for the provision of covered dental benefits and services and assigned to the DBPM. This payment is made regardless of whether the enrollee receives covered dental benefits and services during the period covered by the payment. |
| Claim | 1) A bill for services; 2) a line item of service; or 3) all services for one enrollee within a bill. |
| Clean Claim | A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. |
| Community Norms | Services and accessibility to services that enrollees are accustomed to in their geographic area. |
| Contract | Means the standard LDH contract form CF-1; the RFP and addenda issued thereto by the State; the proposal submitted by the Contractor in response to the State's RFP; and any exhibits, addenda, appendices, attachments, or amendments thereto. |
| Contract Term | The period during which the Contract is in effect. |
| Contractor | The contracted DBPM. |
| Convicted | A judgment of conviction entered by a federal, state or local court, including a plea of guilty or nolo contendere, regardless of whether an appeal from that judgment is pending. |
| Copayment | Any cost sharing payment for which the Medicaid DBPM enrollee is responsible. |
| Covered Dental Benefits and Services | A schedule of healthcare benefits and services required to be provided by the DBPM to Medicaid enrollees as specified under the terms and conditions of this Contract and the Louisiana Medicaid State Plan. |
| Corrective Action Plan (CAP) | A plan developed by the DBPM that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframe necessary to address and resolve the deficiency. Use of the CAP will be at the discretion of LDH. |
| Cost Avoidance | A method of paying claims in which the provider is not reimbursed until the provider has demonstrated that all available health insurance has been exhausted. |
| Cultural Competency | A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance of and respect for cultural differences and similarities within, among and between groups and the sensitivity to how these differences influence relationships with enrollees. This requires a willingness and ability to |

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| | draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports. |
| Current Dental Terminology (CDT) | A code set with descriptive terms developed and updated by the American Dental Association (ADA) for reporting dental services and procedures to dental benefits plans. DHHS designated the CDT code set as the national terminology for reporting dental services. |
| Current Procedural Terminology (CPT®) | Current version is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other healthcare professional services and procedures under HIPAA. |
| Dental Benefit Program Systems Companion Guide | A supplement to the Contract that outlines the formatting and reporting requirements concerning encounter data, interfaces between the FI and the DBPM, and Enrollment Broker and the DBPM. |
| Deliverable | Any requirement of the contract. |
| Denied Claim | A claim for which no payment is made to the network provider by the DBPM for any of several reasons, including but not limited to, the claim is for non-covered services, an ineligible provider or beneficiary, or is a duplicate of another transaction, or has failed to pass a significant requirement in the claims processing system. |
| Dental Director | The licensed dentist designated by the DBPM to exercise general supervision over the provision of covered dental benefits and services by the DBPM. |
| Documented Attempt | A bona fide, or good faith, attempt, in writing, by the DBPM to contract with a provider, made on or after the date the DBPM signs the Contract with LDH. Such attempts may include written correspondence that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within ten (10) calendar days, the potential network provider rejects the request or fails to respond either verbally or in writing, the DBPM may consider the request for inclusion in the DBPM’s network denied by the provider. This shall constitute one attempt. |
| Duplicate Claim | A claim that is either a total or a 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 twenty-one (21) years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) healthcare, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of “medical assistance”. |
| Eligibility Determination | The process by which an individual may be determined eligible for Medicaid or CHIP. |
| Eligible | An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act. |
| Emergency Dental Condition | A dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average |

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| | <p>knowledge of dentistry and medicine, could reasonably expect the absence of immediate dental attention to result in the following:</p> <ul style="list-style-type: none"> • Placing the health of the individual in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. <p>A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissue; or unusual swelling of the face or gums.</p> |
| Emergency Dental Services | Those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity. |
| Encounter | A distinct set of healthcare services provided to a Medicaid enrollee enrolled with the DBPM on the dates that the services were delivered. |
| Encounter Data | Healthcare encounter data include: (i) All data captured during the course of a single healthcare encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the enrollee receiving services during the encounter; (ii) The identification of the enrollee receiving and the provider(s) delivering the healthcare services during the single encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single encounter. |
| Encounter Data Adjustment | Adjustments to encounter data that are allowable under the Medicaid Management Information System (MMIS) for HCFA 1500, UB 92, and NCPDP version 3.2 claim forms as specified in the Dental Benefit Program Systems Companion Guide. |
| Enrollee | A Medicaid beneficiary who is currently enrolled in the dental benefit plan manager. For marketing and education materials, or other informational materials provided to the enrollee, the term “member” may be used. |
| Enrollment | The process conducted by the DBPM or enrollment broker by which an eligible Medicaid beneficiary becomes an enrollee with the DBPM. |
| Enrollment Broker | The State’s designated contractor that performs functions related to choice counseling, enrollment and disenrollment of potential enrollees and enrollees into an MCO. |
| Experimental Procedure/Service | A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific data may be relatively weak or inconclusive. The term applies only to the determination of eligibility for coverage or payment. |
| Federal Financial Participation (FFP) | This is also known as federal match; the percentage of federal matching dollars available to a state to provide Medicaid and CHIP services. The Federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income. |
| Federally Qualified Health Center (FQHC) | An entity that receives a grant under Section 330 of the Public Health Service Act, as amended (Also see Section 1905(1)(2)(B) of the Social Security Act) to provide |

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| | primary healthcare and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services. |
| Fee-for-Service (FFS) | A method of provider payment based on payments for specific services rendered. |
| Fiscal Intermediary (FI) | LDH's designee or agent responsible for an array of administrative support services including MMIS system development and maintenance, claims processing, pharmacy support services, provider enrollment and support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support. |
| Fraud | As relates to Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain payment or certification; or claiming payment for services which were never delivered or received. |
| Full Time | Forty (40) hours per week. |
| Geocoding | Refers to the process in which implicit geographic data is converted into explicit or map-form images. |
| Geomapping | The process of finding associated geographic coordinates (often expressed as latitude and longitude) from other geographic data, such as street addresses, or zip codes (postal codes). With geographic coordinates, the features can be mapped and entered into Geographic Information Systems, or the coordinates can be embedded into media. |
| Grievance | An expression of enrollee dissatisfaction about any matter other than an adverse benefit determination. 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. |
| HIPAA Privacy Rule | Health Insurance Portability and Accountability Act (HIPAA) federal standards for the privacy of individually identifiable health information, found at 45 CFR Part 164, Subpart E. |
| HIPAA Security Rule | Health Insurance Portability and Accountability Act (HIPAA) federal standards for the security of individually identifiable health information, found at 45 CFR Part 164, Subpart C. |
| ICD-10-CM codes | International Classification of Diseases, 10th Revision, Clinical Modification codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria. |
| Immediate | Without delay, but not more than twenty-four (24) hours. |
| Indian | Any individual defined at 25 USC §1603(13), §1603(28), or §1679(a), or who has been determined eligible as an Indian, under 42 CFR §136.12. This means the individual: <ul style="list-style-type: none"> • Is a enrollee of a Federally recognized Indian tribe; |

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| | <ul style="list-style-type: none"> • Resides in an urban center and meets one or more of the following four criteria: <ol style="list-style-type: none"> 1. Is an enrollee of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such enrollee; 2. Is an Eskimo or Aleut or other Alaska Native; 3. Is considered by the Secretary of the Interior to be an Indian for any purpose; or 4. Is determined to be an Indian under regulations issued by the Secretary; • Is considered by the Secretary of the Interior to be an Indian for any purpose; or • Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native. |
| Indian Health Care Provider (IHCP) | A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. §1603). |
| Indian Managed Care Entity (IMCE) | An MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of Section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service. |
| Information Systems (IS) | A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction. |
| Information Systems Capabilities Assessment (ISCA) | Process to specify the desired capabilities of the DBPM's information system and to pose standard questions to be used to assess the strength of the DBPM with respect to these capabilities. The process will determine the extent to which the DBPM can produce valid encounter data, performances measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its enrollees. |
| Louisiana Medicaid State Plan | The binding written agreement between Louisiana's Department of Health through LDH and CMS which describes how the Medicaid program is administered and determines the services for which LDH will receive federal financial participation. |
| Major Subcontract | Any contract, subcontract, or agreement between the DBPM and another entity that meets any of the following criteria: <ul style="list-style-type: none"> • the other entity is an affiliate of the DBPM; |

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| | <ul style="list-style-type: none"> • the subcontract is considered by LDH to be for a key type of service or function, including: <ul style="list-style-type: none"> ○ administrative services (including but not limited to third party administrator, network administration, and claims processing); ○ delegated networks (including but not limited to vision) ○ management services (including management agreements with parent) ○ reinsurance; ○ call lines (including dental consultation); or ○ any other subcontract that is, or is reasonably expected to be, more than one-hundred thousand dollars (\$100,000) per year. Any subcontracts between the DBPM and a single entity that are split into separate agreements (e.g. by time period) will be consolidated for the purpose of this definition. <p>For the purposes of this contract, major subcontracts do not include contracts with any non-affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware.</p> |
| Material Change | Material changes are changes affecting the delivery of care or services provided under this contract. Material changes include, but are not limited to, changes in composition of the provider network, subcontractor network, the DBPM's complaint and grievance procedures; healthcare delivery systems, services, changes to expanded services; benefits; geographic service area; enrollment of a new population; procedures for obtaining access to or approval for healthcare services; any and all policies and procedures that required LDH approval prior to implementation; and the DBPM's capacity to meet minimum enrollment levels. LDH shall make the final determination as to whether a change is material. |
| May | Denotes an advisory or permissible action. |
| Medicaid | A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving covered individuals. |
| Medicaid Management Information System (MMIS) | Mechanized claims processing and information retrieval system which all state Medicaid programs are required to have and which must be approved by the Secretary of LDH. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid providers and enrollees. |
| Medical Loss Ratio (MLR) | The percentage of PMPM payments received by the DBPM from LDH used to pay medical claims from providers and approved quality improvement and IT costs. |
| Medical Record | A single complete record kept at the site of the enrollee's treatment(s), which documents, medical or allied goods and services, including, but not limited to, outpatient and emergency medical healthcare services whether provided by the DBPM, its provider agreement, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for payment, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media. |

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| Medically Necessary Services | <p>A. Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.</p> <p>B. In order to be considered medically necessary, services must be:</p> <ol style="list-style-type: none"> 1. deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2. those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient. <p>C. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.</p> <p>D. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."</p> <ol style="list-style-type: none"> 1. 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 sixty-five (65) years of age and older and some people with disabilities under age sixty-five (65) |
| Member | As it relates to this contract, refers to a Medicaid enrollee. For marketing and education materials, or other informational materials provided to the enrollee, the term "member" may be used. |
| Member Month | A month of coverage for a Medicaid beneficiary who is enrolled in the DBPM. |
| Must | The term "must" denotes mandatory requirements. |
| Network | As utilized in the contract, "network" may be defined as a group of participating providers linked through provider agreements or Contracts with the DBPM to supply a range of dental services. Also called a provider network. |
| Network Adequacy | A network of dental providers for the DBPM that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to enrollees without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider patient ratios; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations. |
| Non-Covered Services | Services not covered under the Title XIX Louisiana State Medicaid Plan. |
| Non-Emergency | A condition not requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity. |
| Original Signature | Denotes that a document must be signed in ink. |

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| Out-of-Network Provider | An appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the DBPM for the delivery of covered services to the DBPM's enrollees. |
| Ownership Interest | The possession of stock, equity in the capital, or any interest in the profits of the DBPM. |
| Performance Improvement Projects (PIP) | Projects to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effect on health outcomes and enrollee satisfaction. |
| Performance Measures | Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service. |
| Per Member Per Month (PMPM) | The per-member, per-month rate of payment paid to the DBPM by LDH for the provision of dental services to Dental Benefit Program enrollees. The PMPM shall be based on the total number of members included on a monthly reconciliation file. |
| Potential Enrollee | A Medicaid beneficiary who is subject to mandatory enrollment or who may voluntarily elect to enroll in a DBPM, but is not yet an enrollee of a specific DBPM. |
| Prepaid Ambulatory Health Plan (PAHP) | Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates; does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract. |
| Preventive Care | Dental care-related procedures or treatments that are meant to preserve healthy teeth and gums and to prevent dental caries and oral disease. |
| Primary Dental Provider (PDP) | A provider of primary dental services. |
| Primary Dental Services | Dental services and laboratory services customarily furnished by or through a primary dental provider for evaluation, diagnosis, prevention, and treatment of diseases, disorders, or conditions of the oral cavity, maxillofacial areas, or the adjacent and associated structures through direct service to the enrollee when possible, or through appropriate referral to specialists and/or ancillary providers. |
| Prior Authorization | The process of determining medical necessity for specific services before they are rendered. |
| 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). |
| Provider Agreement | An agreement between the DBPM and a provider of services to furnish covered dental benefits and services to enrollees for the DBPM specifically related to fulfilling the DBPM's obligations under the terms of this contract. |
| Provider Appeal | The formal mechanism that allows a provider the right to appeal a DBPM final decision. |
| Provider-Beneficiary Relationship | An existing provider-beneficiary relationship is one in which the provider was a main source of Medicaid services for the beneficiary during the previous year. This may be established through state records of previous enrollment, encounter data, or through contact with the beneficiary. |

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| Provider Complaint | A verbal or written expression by a provider which indicates dissatisfaction or dispute with DBPM policy, procedure, claims processing and/or payment, or any aspect of DBPM functions. |
| Provider Directory | A listing of dental service providers under contract with the DBPM that is prepared by the DBPM as a reference tool to assist enrollees in locating providers that are available to provide services. |
| Prudent Layperson | Person who possesses an average knowledge of health and medicine. |
| Quality Assessment and Performance Improvement Plan (QAPI Plan) | A written plan, required of the DBPM, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve healthcare outcomes for enrollees. |
| Quality Management (QM) | The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge. |
| Readiness Review | Assessment prior to implementation of the DBPM's ability to fulfill the Contract requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of DBPM standards; and review of systems. The review may be done as a desk review, on-site review, or combination of both and may include interviews with pertinent personnel so that LDH can make an informed assessment of the DBPM's ability and readiness to render services. |
| Referral | Dental services provided to the Dental Benefit Program enrollee when approved by the DBPM, including, but not limited to in-network specialty care and out-of-network services which are covered under the Louisiana Medicaid State Plan. |
| Reinsurance | Insurance the DBPM purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of enrollees; also referred to as "stop loss" insurance coverage. |
| Remittance Advice | An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. |
| Representative | Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative or AR. |
| Reprocessing (Claims) | Upon determination of the need to correct the outcome of one or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims. |
| Responsible Party | An individual, often the head of household, who is authorized to make decisions and act on behalf of the Medicaid enrollee. This is the same individual that completes and signs the Medicaid application on behalf of a covered individual, agreeing to the rights and responsibilities associated with Medicaid coverage. |
| Risk | The chance or possibility of loss. The enrollee is at risk only for pharmacy copayments as allowed in the Medicaid State Plan and the cost of non-covered services. |
| Rural Area | Any parish that meets the federal Office of Management and Budget definition of rural. |

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| Rural Health Clinic (RHC) | A clinic located in an area that has a healthcare provider shortage and is certified to receive special Medicare and Medicaid payment rates. RHCs provide primary healthcare and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services. RHCs must be reimbursed by the DBPM using prospective payment system (PPS) methodology. |
| Second Opinion | Subsequent to an initial medical opinion, an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service. |
| Secure File Transfer Protocol (SFTP) | Software protocol for transferring data files from one computer to another with added encryption. |
| Service Authorization | A utilization management activity that includes prior, concurrent, or post review of a service by a qualified health professional to authorize, partially deny, or deny in whole the payment of a service, including a service requested by the DBPM enrollee. Service authorization activities consistently apply review criteria. |
| Shall | Denotes a mandatory requirement. |
| Should | Denotes a desirable action. |
| Significant | As utilized in this contract, except where specifically defined, shall mean important in effect or meaning. |
| Social Security Act | The Social Security Act of 1935 (42 U.S.C.A. §301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI). |
| Solvency | The minimum standard of financial health for the DBPM where assets exceed liabilities and timely payment requirements can be met. |
| Span of Control | Information systems and telecommunications capabilities that the DBPM itself operates or for which it is otherwise legally responsible according to the terms and conditions with LDH. The span of control also includes systems and telecommunications capabilities outsourced by the DBPM. |
| Specialty Dental Services | A dentist, whose practice is limited to a particular branch of dentistry or oral surgery, including one who, by virtue of advanced training is certified by a specialty board as being qualified to so limit his practice. |
| Stratification | The process of partitioning data into distinct or non-overlapping groups. |
| Subcontractor | A person, agency or organization with which the DBPM has subcontracted or delegated some of its management functions or other contractual responsibilities to provide covered services to its enrollees. |
| Subsidiary | An affiliate that is owned or controlled by the Contractor, either directly or indirectly through one (1) or more intermediaries. |
| System Unavailability | Measured within the DBPM's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key. |
| Third Party Liability (TPL) | The legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State Plan. |
| Timely | Existing or taking place within the designated period; within the time required by statute or rules and regulations, the Contract, or policy requirements. |

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| Title XIX | Title of the Social Security Act of 1935, as amended, that encompasses and governs the Medicaid Program. |
| Title XXI | Title 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. |
| Turnover Phase | All activities the DBPM is required to perform in conjunction with the end of the contract. |
| Turnover Plan | Written plan developed by the DBPM, approved by LDH, to be employed during the turnover phase. |
| Urban Area | Any parish that meets the federal Office of Planning and Budget definition of urban. |
| Urgent Care | Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Urgent care requires timely face-to-face medical attention within twenty-four (24) hours of enrollee notification of the existence of an urgent condition. |
| Utilization | The rate patterns of service usage or types of service occurring within a specified period of time. |
| Utilization Management (UM) | The process to evaluate the medical necessity, appropriateness, and efficiency of the use of dental services, procedures, and facilities. UM is inclusive of utilization review and service authorization. |
| Utilization Review (UR) | Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of covered dental benefits and services, procedures or settings, and ambulatory review, prospective review, second opinions, care management, discharge planning, or retrospective review. |
| Validation | The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis. |
| Virtual Private Network | A network that extends a private network across a public network such as the Internet. |
| Waiting Time(s) | Time spent both in the lobby and in the examination room prior to being seen by a provider. |
| Waiver | Medicaid Section 1915(c) Home and Community Based Services (HCBS) programs which in Louisiana are New Opportunities Waiver (NOW), Children’s Choice, Adult Day Healthcare (ADHC), Community Choices, Supports Waiver, Residential Options Waiver (ROW), and any other 1915(c) waiver that may be implemented. |
| Week | The seven-day week, Monday through Sunday. |
| Will | Denotes a mandatory requirement. |
| Willful | Conscious or intentional but not necessarily malicious act. |

7.2 Acronyms

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| ACD | Automated Call Distribution |
| ACH | Automated Clearinghouse |

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| AHRQ | Agency for Healthcare Research and Quality Review |
| ASL | American Sign Language |
| BAFO | Best and Final Offers |
| BCP | Business Continuity Plan |
| BHSF | Bureau of Health Services Financing |
| CAHPS | Consumer Assessment of Healthcare Providers and Systems |
| CAP | Corrective Action Plan |
| CAQH | Council for Affordable Quality Healthcare |
| CDT | Current Dental Terminology |
| CHIP | Children's Health Insurance Program |
| COB | Coordination of Benefits |
| CPT® | Current Procedural Terminology |
| CVO | Credentials Verification Organization |
| DBPM | Dental Benefit Program Manager |
| DRP | Disaster Recovery Plan |
| EA | Enterprise Architecture |
| ECM | Electronic Claims Management |
| EDI | Electronic Data Interchange |
| EFT | Electronic Funds Transfer |
| EOB | Explanation of Benefits |
| EPSDT | Early and Periodic Screening, Diagnosis and Treatment |
| EQRO | External Quality Review Organization |
| FFP | Federal Financial Participation |
| FFS | Fee-for-Service |
| FI | Fiscal Intermediary |
| FMP | Full Medicaid Payment |
| FQHC | Federally Qualified Health Center |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| I/DD | Intellectually and/or Developmentally Disabled |
| ICD-10-CM | International Classification of Diseases, 10th Revision, Clinical Modification |
| IHCP | Indian Health Care Provider |
| IMCE | Indian Managed Care Entity |
| IS | Information Systems |
| ISCA | Information Systems Capabilities Assessment |
| JLCB | Joint Legislative Committee on the Budget |
| LDH | Louisiana Department of Health |
| LDI | Louisiana Department of Insurance |
| LDR | Louisiana Department of Revenue |
| LEIE | List of Excluded Individuals/Entities |
| LLA | Louisiana Legislative Auditor |
| MFCU | Medicaid Fraud Control Unit |
| MLR | Medical Loss Ratio |
| MMIS | Medicaid Management Information System |
| NCQA | National Committee for Quality Assurance |
| NPI | National Provider Identifier |

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| OSP | Office of State Procurement |
| PAHP | Prepaid Ambulatory Health Plan |
| PCD | Primary Care Dentist |
| PDP | Primary Dental Provider |
| PHI | Protected Health Information |
| PIP | Performance Improvement Project |
| PM | Performance Measures |
| PMPM | Per Member Per Month |
| PPS | Prospective Payment System |
| QAPI | Quality Assessment and Performance Improvement |
| QI | Quality Improvement |
| RA | Remittance Advice |
| RAC | Recovery Audit Contractor |
| RFP | Request for Proposals |
| RHC | Rural Health Clinic |
| SFTP | Secure File Transfer Protocol |
| SFY | State Fiscal Year |
| SURS | Surveillance and Utilization Review System |
| TPL | Third Party Liability |
| TTY/TTD | Telephone Typewriter and Telecommunication Device |
| UM | Utilization Management |
| UR | Utilization Review |
| URAC | Utilization Review Accreditation Commission |
| VPN | Virtual Private Network |

DAVID MCKEON, DDS

Louisiana Executive Director

Louisiana Key Personnel Position: DBPM CEO

Degrees and Licensure –Doctor of Dental Surgery, LSU School of Dentistry (1991), Bachelor of Arts in Biology, University of New Orleans (1986); Louisiana Dental License (1991)

Medicaid Project Management Experience – Dr. McKeon has served as Executive Director of Dental Health Resources for the LSU School of Dentistry for 10 years, serving as the Dental Director for the Louisiana Dental Medicaid Program. He joined MCNA in 2014 to continue his leadership in the Medicaid Program as Executive Director and Chief Executive Officer.

Qualifying Experience – Since 2009, Dr. McKeon has provided overall direction for the Louisiana Dental Medicaid Program through strategy development, formulation of policies and the Medicaid Dental Services Manual and other training materials, and the development of special reporting in support of efficient operations and to ensure that deliverables are met.

Location – 40+ hours a week at the LSU School of Dentistry and MCNA's Louisiana Office



Dr. David McKeon has been a licensed dentist in Louisiana since 1991 after graduating from the Louisiana State University (LSU) School of Dentistry. He served Medicaid enrolled children in Louisiana for over a decade before becoming the State's Dental Director for the Medicaid and CHIP programs in 2009. Dr. McKeon joined MCNA in 2014 as our Louisiana Executive Director to provide seamless leadership for our Louisiana plan, and will fulfill the role of MCNA's Louisiana Chief Executive Officer.

Dr. McKeon provides overall direction for our Louisiana plan. He works closely with our Executive Management Team to develop strategies, formulate all Louisiana-specific policies as necessary, and oversee general plan operations to ensure we meet all deliverables in a timely manner. He also oversees provider network recruitment and management activities within the State in collaboration with our Network Development team. Dr. McKeon leads MCNA's Louisiana Dental Advisory Committee, serving as our primary link with the professional dental community to ensure MCNA is responsive to network provider feedback. He also serves as an invaluable liaison to the LSU School of Dentistry, maintaining open lines of communication at all times which facilitates our successful relationship with our state partners.

Experience

Louisiana Executive Director (2014 - Present)

MCNA Insurance Company, New Orleans, Louisiana

Responsible for overall development and management of MCNA Insurance Company's utilization review process for the State of Louisiana.

- Implements the strategic goals and objectives of the organization.
- Takes the lead for provider and stakeholder communications.
- Oversees the Louisiana-based plan staff.
- Serves as a liaison for utilization management and quality improvement activities.
- Assists with Louisiana provider network recruitment and management.
- Oversees the activities of the MCNA's Louisiana Dental Advisory Committee.

Director, Dental Health Resources Dental Authorization Unit (2009 - 2014)

Assistant Clinical Professor, Dental Health Resources (2002 - 2009)

Louisiana State University School of Dentistry, New Orleans, Louisiana

Served as Dental Consultant for the Louisiana Department of Health (LDH).

- Served in an advisory capacity to LDH in regard to dental related issues.
- Assisted LDH in the preparation, review, and revision of the Medicaid Dental Services Manual, training manuals, or other dental related projects upon request of LDH.
- Assisted LDH upon request with the preparation of special reports necessary to ensure the proper function of the Louisiana Dental Medicaid Program.
- Assisted in the recovery of funds paid inappropriately to providers when discovered during the usual scope of work.
- Participated in LDH's statewide dental provider training workshops.
- Attended meetings and other dental related functions as required by LDH.
- Helped LDH apply individual medical necessity reviews, when appropriate, for EPSDT and EDSPW program services that were not otherwise covered by Medicaid.
- Served as a liaison with LDH.

Clinical Reviewer and Staff Dentist (1997 - 2002)

DENTAmax Plus Dental Plan, Metairie, Louisiana

- Served as clinical reviewer for the appropriateness of care provided to DENTAmax plan members.
- Provided comprehensive dental care and preventive services to patients, including oral health education about the appropriate brushing and flossing techniques, tobacco cessation, and proper nutrition.

Private Practice (1991 - 1997)

Michael Adams Family Dentistry, Gretna, Louisiana

David McKeon, D.D.S., Marrero, Louisiana

Altman Family Dentistry, Slidell, Louisiana

Manhattan Family Dentistry, Harvey, Louisiana

- Provided comprehensive general dental care and preventive services for children and families.
- Conducted oral health exams, which included caries risk assessments.
- Treated patients for dental injuries.

- Presented treatment options to and completed informed consent with patient guardians and caregivers.
- Provided oral health education to patients and parents.
- Practiced and enforced patient safety standards and infection control.
- Ensured patient records were documented appropriately.

Education

- **Louisiana State University School of Dentistry**, New Orleans, Louisiana, Doctor of Dental Surgery (1991)
- **University of New Orleans**, New Orleans, Louisiana, Bachelor of Arts in Biology (1986)

Professional Licenses and Associations

- Licensed Dentist – Louisiana (1991)
- Member, American Dental Association
- Member, Louisiana Dental Association
- Member, New Orleans Dental Association

MICHAEL GIORLANDO, DDS, M.ED

Louisiana Dental Director

Louisiana Key Personnel Position: Louisiana Dental Director

Degrees and Licensure – Master of Education, University of New Orleans (1987); Doctor of Dental Surgery, LSU School of Dentistry (1984); Bachelor of Science, Spring Hill College (1980); Louisiana Dental License (1984)

Medicaid Project Management Experience – Dr. Giorlando has served as Administrative Faculty for the Dental Health Resources Department at LSU School of Dentistry and as MCNA's Dental Director for the Louisiana Dental Medicaid Program for over 5 years.

Qualifying Experience – Dr. Giorlando is a Louisiana-licensed Doctor of Dental Surgery with no restrictions or other licensure limitations. Since 2014, Dr. Giorlando has led the formulation of MCNA's quality management policies, our Utilization Review Criteria and Guidelines, to ensure that they comply with all applicable state and federal statutes and regulations. He makes final utilization review decisions in conjunction with MCNA's Clinical Reviewers and addresses all quality of care issues for our Louisiana members.

Location - 40+ hours a week at the LSU School of Dentistry and MCNA's Louisiana Office



Dr. Michael Giorlando has been a Louisiana-licensed Doctor of Dental Surgery since 1984. His career has spanned service as an Assistant Clinical Professor for the LSU School of Dentistry, operation of a private practice serving children and adults through the LSU Faculty Practice, and years of executive leadership as the Director of Athletics at Loyola University. In 2014, he returned to the LSU School of Dentistry as an administrative faculty member in the Dental Health Resources Department. That same year he joined MCNA as our Louisiana Dental Director to provide expert guidance for the authorization of medically necessary dental services.

Dr. Giorlando provides expert oversight of the clinical review process for our members. He oversees development and adoption of our Utilization Review Criteria and Guidelines to ensure that they comply with all applicable state and federal statutes and regulations. In addition to making final utilization review decisions in conjunction with our Clinical Review team and addressing quality of care issues for our Louisiana members, Dr. Giorlando supports our relationship with the professional dental community. He regularly participates in all Louisiana Dental Advisory Committee activities and facilitates peer-to-peer consultations between network providers and MCNA Clinical Reviewers.

Experience

Louisiana Dental Director (2014 – Present)

MCNA Insurance Company, New Orleans, Louisiana

Provides oversight and management of MCNA Insurance Company's Clinical Reviewers for the State of Louisiana.

- Represents MCNA regarding clinical issues, utilization review, and quality of care issues.
- Complies with applicable federal and state statutes and regulations.
- Guides the dental service authorization process for Medicaid members.
- Responsible for maintaining current Louisiana utilization review guidelines and criteria.
- Assists with Louisiana provider network recruitment and management.
- Facilitates peer-to-peer discussions between participating providers and MCNA's Clinical Reviewers.
- Participates in MCNA's Louisiana Dental Advisory Committee meetings.

Administrative Faculty (2014 – Present)

Louisiana State University School of Dentistry, Dental Health Resources Department, New Orleans, Louisiana

Director of Athletics and Wellness / Head Men's Basketball Coach (2004 – 2014)

Loyola University New Orleans, New Orleans, Louisiana

- Served in dual role as Director of Athletics and Head Men's Basketball Coach with oversight over the nine sports making up the university's athletics program.
- Managed annual budget of \$1.6 million, including the development of effective fundraising opportunities to drive capital improvements and fund athletic scholarships.
- Oversaw all medical and insurance contracts and claims, and negotiated all contracts pertaining to sports medicine and physician staff.
- Oversaw continuous student athlete recruitment and ensured academic eligibility and compliance for all sports.
- Oversaw sports information activities including press and media relations, news releases, statistics, news conferences, and game management.

NCAA Certified Recruiter (1997 – 2004)

Assistant Men's Basketball Coach (1997 – 2004)

*Louisiana State University, Baton Rouge, Louisiana
University of New Orleans, New Orleans, Louisiana*

- Oversaw day-to-day coaching and player development.
- Organized, presented, and implemented \$2 million men's basketball budget at Louisiana State University.
- Developed and implemented the first Academic Support Service Program for the men's basketball program at University of New Orleans.

Assistant Clinical Professor (1984 – 1992)

*Louisiana State University School of Dentistry, Oral Medicine and Radiology
Department, New Orleans, Louisiana*

- Provided clinical instruction to first, second, and third year dental students.
- Courses taught included oral medicine and radiology, treatment planning, and hands-on clinical labs.

Private Practice (1984 – 1992)

Louisiana State University School of Dentistry Faculty Practice, New Orleans, Louisiana

Provided comprehensive general dental care and preventive services to children and families through the LSU School of Dentistry's on-campus dental clinic.

- Conducted oral health exams, which included caries risk assessments.
- Performed general dental procedures including operative, veneers, dental implants, root canals, extractions, and fixed and removable prosthetics with traditional techniques.
- Presented treatment options to and completed informed consent with patient guardians and caregivers.
- Provided oral health education to patients and parents.
- Practiced and enforced patient safety standards and infection control.
- Ensured patient records were documented appropriately.

Education

- **University of New Orleans**, New Orleans, Louisiana, Master of Education (1987)
- **Louisiana State University School of Dentistry**, New Orleans, Louisiana, Doctor of Dental Science (1984)
- **Spring Hill College**, Mobile, Alabama, Bachelor of Science (1980)

Professional Licenses and Associations

- Licensed Dentist – Louisiana (1984)
- Member, Louisiana Dental Association
- Member, American Dental Association
- Member, Academy of General Dentistry
- Member, New Orleans Dental Association

SHANNON BOGGS-TURNER

Executive Vice President

Shannon Boggs-Turner has over 20 years of experience in the analysis and implementation of state and federal regulations, and oversight of plan operations in cooperation with state regulatory agencies, including her service as Medicaid Commissioner for the Commonwealth of Kentucky. In 2012, Shannon joined MCNA as Vice President of Operations to implement our Texas Medicaid and CHIP plan. She continues this operational focus in the role of Executive Vice President.



Shannon is a proven executive with superb analytical skills and a wealth of experience in the management of both government sector and commercial health plans.

Shannon provides daily oversight of all non-clinical operational functions in-house and from our affiliated third-party administrator, Managed Care of North America, Inc., including claims processing, quality improvement, utilization management, provider relations, network development, case management, call center operations, and credentialing. Under her guidance, MCNA continuously works to optimize business processes through interdepartmental integration, ensuring the expectations of our state partners are met. Shannon regularly represents MCNA with LDH, other state regulatory agencies, and professional dental organizations such as the Louisiana Dental Association. Her skills in the analysis and implementation of state and federal regulations help to ensure that MCNA's operational focus in Louisiana is compliant with all requirements.

Experience

Executive Vice President (2018 - Present)

Vice President of Operations (2012 - 2018)

MCNA Insurance Company, San Antonio, Texas

Provides overall direction and guidance to the non-clinical operational activities of the company, with the objective of optimizing business processes, integrating all operational departments, and ensuring client service level agreements are met.

- Member of Executive Management Team.
- Provides daily oversight of non-clinical operational functions including claims processing, quality improvement, utilization management, provider relations, network development, case management, call center operations, and credentialing.
- Represents MCNA with state regulatory agencies and organizations such as the Texas Dental Association, Texas Academy of Pediatric Dentistry, and Texas Academy of General Dentists.

- Decreased Medicaid dental program costs by approximately 25% for the State of Texas through the implementation of managed care using evidence-based utilization management criteria.
- Created the first comprehensive dental pay-for-quality model known as the Stellar Treatment and Recognition Reward (STARR) Program.

Managing Partner (2010 - 2012)

Consulting Strategies Team, LLC, Frankfort, Kentucky

As a founding partner of the firm, delivered consulting services to clients in both public and private sector health care programs.

- Provided full service health care consulting services including grant writing, RFP response preparation, client strategy development, revenue cycle management, contract negotiations, and project management.
- Facilitated client understanding of the impact of the Patient Protection and Affordable Care Act.
- Responsible for several highly successful RFP responses in 2011.

Executive Vice President (2006 - 2011)

University Health Care, Inc., d/b/a Passport Health Plan, Louisville, Kentucky

Provided oversight for plan operations and reported directly to the CEO and Board of Directors.

- Oversaw all aspects of daily operations for the Medicaid and Medicare Advantage lines of business for the plan with annual revenues of \$1 billion.
- Implemented quality initiatives that led to the consistent national ranking of Passport as one of America's Top 25 Medicaid Managed Care plans by the National Committee for Quality Assurance (NCQA).
- Increased the health plan reserves by nearly \$50 million.

Associate Vice President for Health Affairs (2007 - 2010)

University of Louisville, Louisville, Kentucky

Provided leadership for the operation of health care services for the university and advisory assistance to other associated university health care facilities.

- Helped lead the university's initiative to lower employee health care costs through the implementation of disease state management programs.
- Served as health care policy advisor to the University President.

Medicaid Commissioner (2004 - 2006)

Commonwealth of Kentucky, Frankfort, Kentucky

Oversaw a nearly \$5 billion program with direct management of over 150 employees.

- Received approval for the nation's first Deficit Reduction Act based Medicaid Transformation.

- Introduced the State's first pharmacy benefits administrator, procured a new MMIS system, and contracted a Medicaid Administrative Agent to provide disease and case management services.

Compliance Officer and Director of Governmental Relations and Appeals (2001 - 2004)

Bluegrass Family Health, Lexington, Kentucky

Oversaw compliance program and corporate relationships with governmental regulatory agencies.

- Responsible for all plan compliance with applicable state and federal laws and regulations.
- Implemented all aspects of HIPAA including privacy, security, and transaction code sets.

Education

- **Villanova University**, Radnor Township, Pennsylvania, Lean Six Sigma Black Belt Master Certificate (2017)
- **University of Kentucky College of Law**, Lexington, Kentucky, Juris Doctor (2000)
- **Georgetown College**, Georgetown, Kentucky, Bachelor of Arts in Political Science/Psychology (1997)

**MCNA INSURANCE COMPANY
UNANIMOUS WRITTEN CONSENT OF DIRECTORS**

June 14, 2019

The undersigned, being all of the members of the board of directors (the "*Board of Directors*") of MCNA Insurance Company, a Texas accident and health insurance company (the "*Corporation*"), hereby consent to the following actions:

WHEREAS, the Louisiana Department of Health (the "*LDH*") desires to contract with the Corporation to administer the dental benefits of its Medicaid and Children's Health Insurance (CHIP) program enrollees for a period of one year commencing on July 1, 2019 (the "*Contract*");

WHEREAS, the Chief Executive Officer of the Corporation, has reviewed the Contract and recommends that the Corporation enter into the Contract with LDH; and

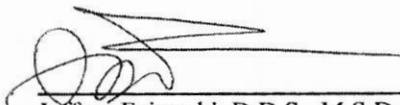
WHEREAS, the terms and conditions of the Contract have been reviewed by the undersigned members of the Board of Directors;

IT IS THEREFORE, RESOLVED, that Glen Feingold, Executive Vice President and Chief Operating Officer, or in his absence, Carlos Lacasa, Senior Vice President and General Counsel, are hereby authorized to execute the Contract and any additional documents ancillary thereto, and to take such other actions as necessary to complete the contracting process with LDH.

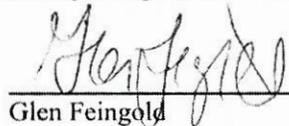
BE IT FURTHER RESOLVED, that any and all actions taken, done or performed in connection with the Contract and the authority granted by the foregoing resolution, as well as any and all actions, of any nature whatsoever, heretofore taken by any director, officer, employee, agent, attorney or other representative of the Corporation incidental to, contemplated by, arising out of or in connection with, or otherwise relating to, in any manner whatsoever, the subject of the foregoing resolution, are hereby approved, ratified and confirmed in all respects as the act and deed of the Corporation.

[Signature Page Follows]

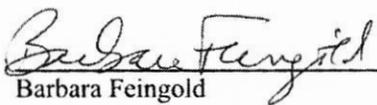
IN WITNESS WHEREOF, the undersigned have executed the unanimous written consent in multiple counterparts, to be effective as of the date first written above, each of which together shall be considered one original, and whether by original or facsimile signature shall be effective in all respects as though an original.



Jeffrey Feingold, D.D.S., M.S.D.

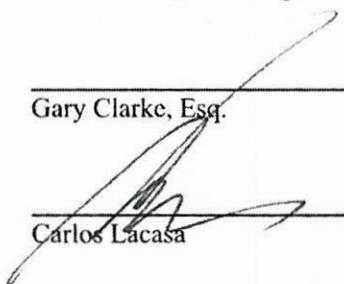


Glen Feingold



Barbara Feingold

Gary Clarke, Esq.



Carlos Lacasa

Albert Hawkins

Jack Greenman

Sam Hammer

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Jeffrey Feingold, D.D.S., M.S.D.

Glen Feingold

Barbara Feingold



Gary Clarke, Esq.

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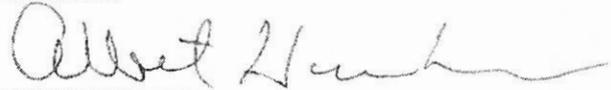
Jeffrey Feingold, D.D.S., M.S.D.

Glen Feingold

Barbara Feingold

Gary Clarke, Esq.

Carlos Lacasa

A handwritten signature in cursive script, appearing to read "Albert Hawkins", written over a horizontal line.

Albert Hawkins

Jack Greenman

Sam Hammer

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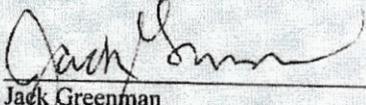
Glen Feingold

Barbara Feingold

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Jeffrey Feingold, D.D.S., M.S.D.

Glen Feingold

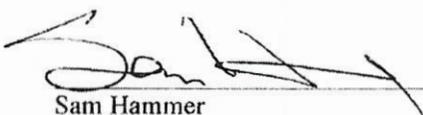
Barbara Feingold

Gary Clarke, Esq.

Carlos Lacasa

Albert Hawkins

Jack Greenman



Sam Hammer



Trade Name Details

Type(s) Registered: TRADE NAME
Registered Name: MCNA DENTAL PLANS
Applicant: MCNA INSURANCE COMPANY, TEXAS
200 WEST CYPRESS CREEK ROAD
SUITE 500
FORT LAUDERDALE, FL 33309
Type Of Business: THIRD PARTY ADMINISTRATOR
Book #: 60-2276
Current Status: ACTIVE

Dates

Registration Date: 6/20/2008
Expiration Date: 6/20/2028
Date First Used: 10/13/1997
Date First Used (in La.): 6/1/2008

Current Classes

No Current Classes

Expired Classes

No Expired Classes

Amendments On File

| Group | Type | Date |
|-------|------|-----------|
| TSRNW | | 4/11/2018 |
| TSASG | | 7/16/2019 |

Print



James J. Donelon

COMMISSIONER OF INSURANCE

CETIFICATE OF AUTHORITY

Whereas, MCNA Insurance Company located in Texas has applied for a certificate of authority and made the filings required of such Insurer. Therefore, I, James Donelon, the undersigned Commissioner of Insurance, do hereby certify that the said MCNA Insurance Company is authorized to transact its appropriate business of Health and accident Insurance in this state, in accordance with the laws thereof. This certificate shall remain in effect until cancelled, suspended, revoked or the renewal thereof refused.

In Testimony Whereof, I hereunto subscribe my name,

and affix the seal of my office at Baton Rouge this

26th day of December A.D. 2012

James J. Donelon
James J. Donelon
Commissioner of Insurance





State of Louisiana
Louisiana Department of Health
Bureau of Health Services Financing

July 2, 2020

LaGov# 2000506243
Exhibit 5

Ms. Pamela Bartfay Rice, Esq
Assistant Director, Professional Contracts
DOA-Office of State Procurement
P.O. Box 94095
Baton Rouge, Louisiana 70804-9095

RE: LaGov# 2000506243
Justification for Multi-Year Contract

Dear Ms. Rice:

Please consider this justification for the Louisiana Department of Health to enter into a multi-year contract with MCNA Insurance Company, d/b/a MCNA Dental Plans (MCNA). Funds for the first fiscal year of the contract are available and payment and performance for subsequent fiscal years shall be subject to the availability of funds.

The Contractor will function as a risk-bearing, Prepaid Ambulatory Health Plan health care delivery system that provides specified core dental benefits and services for eligible Louisiana Medicaid enrollees as defined in the Louisiana Medicaid State Plan, administrative rules, and Medicaid Policy and Procedures manuals.

The estimated requirements covering the period of the contract are reasonably firm and continuing and such a contract will serve the best interests of the State by encouraging effective competition or otherwise promoting economies in state procurement.

If further information is needed, please contact Stacy Guidry at 337-857-6115.

Sincerely,

A handwritten signature in cursive script that reads "Ali Bagbey".

Ali Bagbey
Medicaid Program Manager 1-B